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Health Overview and Scrutiny Panel

Thursday, 29th January, 2015
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Stevens (Chair)
Councillor White (Vice-Chair)
Councillor Bogle
Councillor Claisse
Councillor Mintoff
Councillor Noon
Councillor Parnell

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

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

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

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

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

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

COUNCIL'S PRIORITIES:

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

CONDUCT OF MEETING

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

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

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

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

DISCLOSURE OF INTERESTS

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

DISCLOSABLE PECUNIARY INTERESTS

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

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

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

Other Interests

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

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

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

Dates of Meetings: Municipal Year 2014/2015

2014	2015
24 July	29 January
25 September	26 March
27 November	

AGENDA

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

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

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

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

3 DECLARATIONS OF SCRUTINY INTEREST

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

4 DECLARATION OF PARTY POLITICAL WHIP

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

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

(Pages 1 - 4)

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

7 SOUTHAMPTON WHOLE SYSTEM WINTER PLAN AND EMERGENCY DEPARTMENT PERFORMANCE

(Pages 5 - 26)

Report of the Chief Executive of the University Hospital Trust detailing the performance of the Emergency Department and the winter plan, attached.

8 PROGRESS REPORT: PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL REVIEW
(Pages 27 - 42)

Report of the Head of Transport, Highways and Parking providing updated information on actions taken in line with the recommendations set out in the Panel's inquiry into Public and Sustainable Transport Provision to Southampton General Hospital, attached.

9 VASCULAR SERVICES UPDATE
(Pages 43 - 50)

Report of the Interim Director of Commissioning (South) detailing an update on the provision of Vascular Services, attached.

10 SOUTHAMPTON CLINICAL COMMISSIONING GROUP COST IMPROVEMENT AND QUALITY REPORT
(Pages 51 - 62)

Report of the Director of Quality and Integration detailing the Cost Improvement Programme and quality report of the Southampton City Clinical Commissioning Group, attached.

11 CARE ACT: UPDATE
(Pages 63 - 78)

Report of the Director, People providing an update for the Panel on the Care Act and the consultation outline for the Care Act, attached.

Wednesday, 21 January 2015 HEAD OF LEGAL AND DEMOCRATIC SERVICES

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 27 NOVEMBER 2014

Present: Councillors Stevens (Chair), White (Vice-Chair), Bogle, Claisse, Mintoff and Noon and Parnell

Also in attendance: Councillor Shields – Cabinet Member for Health and Adult Social Care
Councillor Chaloner – Cabinet Member for Children's Safeguarding

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

The Panel noted that Councillor Bogle was an appointed representative of the Council as a Governor of the University Hospital Southampton NHS foundation Trust and that Councillor Noon worked for a care provider.

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

RESOLVED: that the minutes for the Panel meetings held on 25th September and the 30th October 2014 be approved and signed as a correct record with the following amendments.

Minute number 19 be amended to detail the "Disclosure of Personal and Pecuniary Interests" declared at the meeting. Minute to read:

> "The Panel noted that Councillor Bogle was an appointed representative of the Council as a Governor of the University Hospital Southampton NHS foundation Trust and Councillor Noon worked for a care provider.
>
> In addition the Panel noted that Councillor Smith was a parliamentary candidate for Southampton Itchen and had approached the CCG for additional information and noted that Councillor Baillie was a Council appointed member of the Health and Wellbeing Board."

Minutes relating to the Bitterne Walk-in-Centre to be re numbered as Minute Number 20 and that the wording for recommendation (ii) be changed and an additional recommendation (iii) be added. Minute recommendations to read:

"**RESOLVED** that the Panel:

(i) noted that there were opportunities for improvement to the provision of community health care services that did not rely on the release of funding made available from the temporary closure of the Bitterne Walk-in-Centre;
(ii) recommended that the Southampton City Clinical Commissioning Group and the Solent NHS Health Trust do not change the provision of services through the Bitterne Walk-in-Centre prior to a meaningful consultation with residents; and
(iii) requested that due care should be taken to ensure that the practicalities of holding a meaningful consultation."

23. **MINOR INJURIES UNIT**

The Panel considered the report of the Chief Executive of the Southampton Clinical Commissioning Group providing an update on the Minor Injuries unit (MIU).

Penny Daniels, Paula Friend (Southampton Care UK) and Peter Horne (Southampton Clinical Commissioning Group) were in attendance and with the consent of the Chair, addressed the meeting.

The Panel noted that the MIU opened in August and the numbers of attendees had been steadily rising. It was noted that arrangements had been put into place that allowed patients to transfer car parking charges to the Royal South Hants Hospital if they had paid to park at the General Hospital Emergency Department to enable them to go to the MIU, if they were directed there as a more appropriate care pathway, without additional expense. In addition the Panel noted that the contract provision of the MIU was under constant review. It was noted that as a response to the review and service demand the MIU now had the ability to X-ray children under the age of 2.

The Panel was informed that a communications plan to advertise the MIU was in place incorporating GP surgeries and pharmacies. The Panel was assured that pharmacies would have similar chaperonage arrangements to a GP's surgery and would be able to direct patients correctly. In addition it was noted that representatives of the MIU were working closely with the Emergency Department in order to ensure that patients were aware of the potential to receive treatment at an alternative venue.

It was noted that data was being collected that would enable a thorough assessment of patient numbers and the care pathways that had lead them to attend.

RESOLVED that the Panel would review data from Minor Injuries Unit at a future meeting.

24. **2015/16 BUDGET: OUTLINE OF HEALTH AND ADULT SOCIAL CARE PORTFOLIO PROPOSALS**

The Panel noted the report of the Cabinet Member for Health and Adult Social Care, detailing the 2015/2016 Budget proposals for the Portfolio.

Councillor Shields, Cabinet Member for Health and Adult Social Care was in attendance for this item.

The Panel discussed the budgetary considerations set out in the report in regard to Learning Disability Residential Placements. The Panel noted that the cost of residential care to the City was £1.5 million. The Panel was informed that effort was being made to reduce the cost to the City by the provision of specialist care and the adaption of properties within the City.

The Panel discussed the importance of providing suitable, long term accommodation that enabled those with care needs to live independently. It was noted that the aim was, where possible, to provided houses with the care adaptions and specialist support within the City. The Panel noted that the Council was reviewing a number of options to provide this accommodation, including working with housing associations.

The Panel noted that the strategic review of rehabilitation and reablement services would now be considered by Cabinet in September 2015. It was additionally noted that the review was revisiting how the proposed new customer engagement services or "front door" would be involved in the reablement programme.

The Panel discussed the review of commissioning contracts to make further efficiencies. The Panel noted that 41% of all respondents made suggestions for improving efficiency. The Panel was assured of the importance of keeping members of the public informed of any changes and or potential effect of changes on their services.

25. **MULTI-AGENCY SAFEGUARDING HUB (MASH) - PROGRESS REPORT AND OUTLINE OF EARLY OUTCOMES**

The Panel considered the report of the Interim Head of Service, Children and Family Service providing a progress report for the Multi-Agency Safeguarding Hub (MASH).

Councillor Chaloner, Cabinet Member for Children's Safeguarding was in attendance.

The Panel noted that the Hub became live in April 2014 and that the early indications were that the system had bedded in well. The Panel also noted that the City's hub was the best performing multi-agency safeguarding hub in Hampshire.

It was explained that the Hampshire Fire and Rescue Services had not been involved in the initial stages of the setting up of the MASH. However, it was expected that as the system became more established additional agencies would be invited to participate.

The Panel noted that there were still some minor technical issues in sharing data and that these were being addressed. It was explained that the close proximity of colleagues from other services allowed effective sharing of expertise and information.

RESOLVED that the Panel will continue to monitor the progress of the Multi-Agency Hub and the item will return for consideration at a future meeting.

26. **OFSTED ACTION PLAN**

The Panel considered the report of the Interim Head of Service, Children and Families Service detailing the Children's Services Action Plan.

Councillor Chaloner, Cabinet Member for Children's Safeguarding was in attendance.

It was noted that the action plan was due to go live on 22nd December 2014. The Panel discussed the need for clarity with the data sets as they would be produced against the action plan.

The Panel noted that the Council had established a new scrutiny panel that would be revisiting the action plan to monitor performance against it. It was explained that the members of the new scrutiny panel would be given additional training to help them with the analysis of the data.

27. **UNIVERSITY HOSPITAL SOUTHAMPTON FOUNDATION TRUST, WHOLE SYSTEM WINTER PLAN AND EMERGENCY DEPARTMENT PERFORMANCE**

The Panel considered the report of the Chief Executive of the University Hospital Southampton Trust (UHS) detailing the winter plan and providing the opportunity to discuss the Trust's Emergency Department performance.

Fiona Dalton and Jane Hayward (UHS) were in attendance and, with the consent of the Chair, addressed the meeting.

It was explained that the introduction of the Minor Injuries Unit (MIU) at the Royal South Hants hospital was beginning to have an effect on the figure of those attending the emergency department. That the Trust continued to assess its working practices to enable quicker resolution for those attending and it was noted that additional funding had been received.

The Panel expressed concern about the fragility of the service especially over a winter period and was informed that the winter response funding will allow the Trust to ensure that there was sufficient staffing. The Panel was informed that the hospital continued to struggle to employ junior doctors to work in the emergency department but had the support of the consultants to ensure that staff coverage, especially over the weekends and evenings, remained constant.

The Panel noted that the Winter Plan aimed to build in an operational resilience over the winter period by reviewing work flow systems and pinch points in the system and was being supported by some additional funding.

The Panel noted that the discharge of patients from the emergency department with an appropriate care package continued to cause delay. It was noted that the Trust had hired a private ambulance to help patients to return to either their homes or care homes as appropriate.

In response to a question from a member of public the Panel discussed the mix of patients attending the Emergency Department that are in need of a psychiatric assessment. It was explained that the Southern Health Trust and the UHS were working closely together but, that there had been recent changes to the method the Police used to direct patients had caused an increase in numbers.

RESOLVED that the Trust's performance against the Emergency Departments targets be set as the first item of each agenda for future Health Overview and Scrutiny Panel meetings.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON WHOLE SYSTEM WINTER PLAN AND EMERGENCY DEPARTMENT PERFORMANCE		
DATE OF DECISION:		29 JANUARY 2015		
REPORT OF:		CHIEF EXECUTIVE, UHS AND SYSTEM PARTNERS		
CONTACT DETAILS				
AUTHOR:	**Name:**	Jane Hayward	**Tel:**	023 8079 6241
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The University Hospital Southampton Foundation Trust and system partners will update the committee on the latest Emergency Department performance, the recent meeting with Simon Stephens, NHS CEO and the progress on the whole system plan.

RECOMMENDATIONS:

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

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the HOSP's terms of reference the panel has a role to respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. At the last Panel meeting, on 27th November 2014, the University Hospital Southampton and partners in the healthcare system outlined their latest Emergency Department's (ED) performance and the whole system action plan. The Panel remained concerned about the continued poor performance. It was agreed by the panel to continue to receive the whole system Winter Action Plan for 2014 and consider how effective this will be in relieving winter pressures. The South West System Winter Action Plan, agreed by System Chiefs, is attached at Appendix 1.

4. The December Emergency Department performance is attached at Appendix 2; the latest update will be made available at the meeting. This will be set in context against of the national picture.

5. The Panel are asked to note the outcome of the meeting with the CEO of the

NHS and consider how this panel alongside the Health and Wellbeing Group are able to support whole system capacity and workforce planning in 2015.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None

Property/Other

7. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

15. None

POLICY FRAMEWORK IMPLICATIONS

16. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	South West System – System Resilience Group / ORCP Briefing: Urgent Care Whole System Action Plan
2.	Emergency Department Report for Overview and Scrutiny Panel – January 2015

Documents In Members' Rooms

	None

Equality Impact Assessment

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

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

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

APPENDIX 1

South West System – System Resilience Group / ORCP Briefing: Urgent Care Whole System Action Plan

Topic Area	Update on Urgent Care Whole System Action Plan (WSAP)
Purpose	The South West System Resilience Group (SRG) agreed that a common paper would be taken to all organisational boards to provide an agreed update on the key actions being taken to address poor performance in urgent care. This paper is prepared monthly by the Unscheduled Care Delivery Group (USDG)
Information	• The WSAP was developed by the system with support from ECIST to drive improvements in the urgent care system. • The WSAP provides an overview of the key work streams that are being progressed. There are detailed plans for each project which underpin this overview. • It has been agreed that the report will be brought to organisational boards in order to increase the levels accountability. • Delivery of the plan is supplemented by the additional funding that has been received as part of the ORCP activity which commenced in September. The aim of the ORCP funding is to stabiles the system through winter and to accelerate delivery. • The ORCP plan focusses onto the key system, priorities areas which are: ○ Primary care ○ In-reach to acute hospital ○ In hospital therapy ○ Frailty pathway ○ Reducing DTOCs ○ Mental health ○ ED flow • The key messages for January are: ○ The Pre-Hospital workstream that is aimed at avoiding attendances at ED on pre-hospital continues to be effective. ○ In terms of system resilience, we need to ensure that the lessons identified from the Xmas period are captured quickly and then fed into future planning cycles. ○ The main priority area remains the work that covers patient flow in acute hospitals and post-acute discharge. The relevant projects are established and the emphasis has now switched to performance management and early evaluation. There needs to be an increased emphasis on ensuring that the basics including coordination at the operational level are being delivered consistently. This action plan is reviewed monthly at the SW Hants Unscheduled Care Delivery Group by system partners.
Key issues	ED performance remains below operational standards.
Which meetings this document has already been to	SW Hampshire Unscheduled Care Delivery Group
Principal risk(s) relating to this paper	• Delivery of ED performance • Potential delays to implementation of Better Care Plans
Report Author	Lucie Lleshi, Senior Commissioning Manager
Date of paper	09/01/15 – plan updates provided at 07/01/15
Actions requested /Recommendation	To note the actions being taken in the Urgent Care Whole System Action Plan.

South West Hampshire System Urgent and Emergency Care Whole System Action Plan 2014/15

The urgent and emergency care action plan is structured around three main programmes of work:

1. **Urgent and emergency response**
2. **Building and sustaining operational resilience**
3. **Patient discharge and flow**

These programmes report monthly into the Urgent Care Delivery Group, in turn reporting up to the System Resilience Group.

The system has been working to an action plan that was derived from recommendations made by the Emergency Care Intensive Support Team (ECIST) in Quarter two 2012/13. The primary focus for work in 2013-14 was around improvements to discharge and patient flow; the focus for 2014-15 will shift to ED and associated front door pathways, while continuing to improve whole system discharge processes and sustain operational resilience.

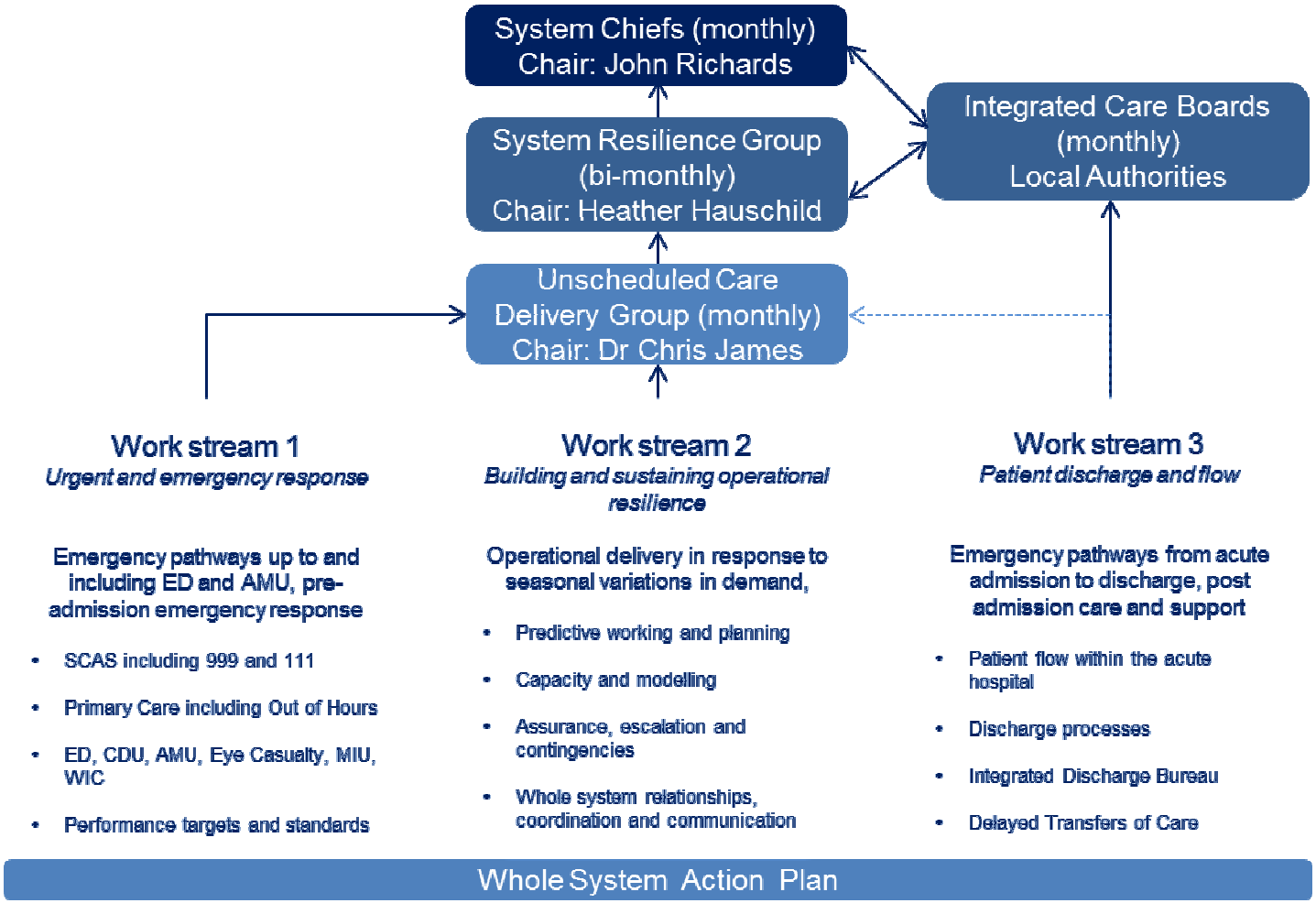
This plan has been refreshed following an ECIST review of 2013/14 winter and a system-wide evaluation of the joint resilience fund and winter monies funded initiatives. Winter monies for 2014/15 will be monitored via the ORCP implementation tracker, with each scheme supporting one of the three main work streams of this plan.

This plan reflects system resilience learning from 2013/14, continued implementation of the UHS ED remedial action plan to achieve the 4-hour standard, CCG QIPP and CQUIN proposals and links to the Better Care Fund and Integrated Care work stream.

This plan is intended to provide a summary of more detailed project tasks being delivered within the governance structure on page 2. It is supported by a set of system-wide metrics which are reviewed monthly. Performance against completed actions will continue to be monitored through the UCDG via the metrics dashboard and/or reports as appropriate.

Please note that this plan DOES NOT INCLUDE admissions avoidance actions being led through the Integrated Commissioning Units, but does still include complex discharge which has transferred to Integrated Commissioning Units and is overseen by the Integrated Care Boards.

South West System – Urgent Care Programme Governance



Work stream 1: urgent and emergency response

This work stream incorporates:

- GP tools and information: manage patients' use of urgent and emergency service (see GP urgent care dashboard in completed actions section)
- Minor Injuries Unit (Care UK) and Walk in Centre (Solent): appropriate alternative services to ED for minor injury and minor illness (see completed actions section for MIU)
- Public access : SCAS 111 and 999, GP out of hours (OOH, Care UK) and GP extended hours: 24/7 access to out of hours primary care, advice and onward referral including emergency response and managing patients outside of hospital (also see completed actions section)
- UHS Emergency Department (ED, including Clinical Decisions Unit (CDU)) and Acute Medical Assessment Unit (AMU): managing demand at the hospital front door, incorporating the ED RAP

Ref	Action and Milestones	Expected impact/KPIs	Project Lead	Lead Org (support org)	Expected delivery date	Progress	In month progress	Delivery against plan (as at Dec)
1.1	**BWIC:** review functions and activity as part of wider stakeholder engagement on urgent access to primary care. **Demonstrate value for money and appropriate use of commissioned services**	Patients have equitable access across the city to appropriate care for minor illness Reduce avoidable ED attendances	Lucie Lleshi	SCCCG	May 2015	**Work programme on track** Options currently being appraised with stakeholders.	G	Not yet due
1.2	**Emergency response and pre-hospital care action group:** (replacing SCAS ambulance group) multi-agency group established to share experience and identify potential areas for system reform within the context of pre-hospital urgent care **Group to identify and implement work programme for Q3 and Q4**	Reduce ED attendances and emergency admissions Reduce hand-offs between urgent care providers	Sarah Owen	WHCCG (SCCCG and providers)	March 2015	**In month progress on track** - Terms of Reference, membership and priority areas agreed. Group currently developing an action plan.	G	Not yet due
1.3	**GP OOH direct booking:** implement direct booking directly into Primary Care Centres for patients requiring a face to face appointment with a GP	Improve response and waiting times for patients. Out of hours access to primary care to avoid attendances to ED	Justin Cankalis	Care UK (CCGs)	October 2014	**Progress delayed** due to other pressures (contract dispute, performance issues, RAP) Slip to Q4 or beyond. Best model yet to be defined.	R	R

Ref	Action and Milestones	Expected impact/KPIs	Project Lead	Lead Org (support org)	Expected delivery date	Progress	In month progress	Delivery against plan (as at Dec)
1.4	**ED Remedial Action Plan (RAP):** work stream 1 (ED/CDU/AMU) incorporating ECIST recommendations, winter funding priorities and ED action plan Monthly progress meetings between UHS and commissioners to sign off completed milestones and agree next phase of actions as relevant **Demonstrate delivery of all agreed milestones on time**	Improve flow Reduce breaches Reduce non-elective admissions Delivery of 4 hour standard as per agreed trajectory	Jane Hayward	UHS (CCGs)	March 2015	See enclosed 14/15 plan updated Dec 141208 ED RAP Nov Milestone Sign Off.xls November milestones complete and signed off 08/12/14 subject to confirmation of evidence. Next check point January 2015	See enclosed plan	
1.5	**Abdominal pain pathway:** clinically led multi-disciplinary group established to develop and implement a comprehensive pathway for patients presenting with abdominal pain Single point of entry into pathway irrespective of admission route, with early access to senior decision maker, early diagnostics and timely streaming in to appropriate specialty arm of pathway 7 days a week **Pathway to be agreed and implemented by end of Q4**	Improved patient experience Reduce (repeat) ED attendances and emergency admissions Reduce LoS for patients requiring admission Patient managed with in the appropriate specialty	Clare Handley	SCCCG (UHS)	March 2015	**Work in progress** - pathway working group meeting regularly and progressing. However, engagement with some specialties continues to be an issue (may lead to slippage) Pilot MDT proposal for patients presenting to ED frequently with abdominal pain being progressed – may require substantial business case work up Referral decision support tool being developed	G	Not yet due
1.6	**Front door model:** review, reconfirm and specify the front door model within the emerging strategic context and adjust joint plans and priorities accordingly	Current front door model mapped out and future recommendations defined based on learning from ORCP initiatives e.g. Pit stop model	Lisa Sheron Chris Bailey	CCGs	January 2015	**Work in progress**	G	Not yet due
1.7	**ED re-attendances**: review 7 day un-planned re-attendances **Review re-attendances and define improvement opportunities by end of Q4**	Review of ED re-attendances	Leanne Parmenter	WHCCG (SCCCG UHS)	April 2015	Current re-attendance rate remains at ~9% Slippage against original delivery date (Oct 14) due to data issues. These have now been resolved and **project currently being re-scoped.**	G	Not yet due

Ref	Action and Milestones	Expected impact/KPIs	Project Lead	Lead Org (support org)	Expected delivery date	Progress	In month progress	Delivery against plan (as at Dec)
1.8	**Mental health in ED:** improve psychiatric service responding to support patients in ED **Improved service implemented by end of Q4**	Improved quality of care and patient experience Reduce ED attendances and non-elective admissions Reduce ED breaches and 12 hour trolley waits	Katy Bartolo-meo	CCGs SHFT UHS	March 2015	**Actions progressing (currently showing as amber on ORCP tracker, partial implementation)** Verbal agreement reached on the way forward. Written confirmation of the risk share agreement between CCGs, UHS & SHFT for ED element of AMH SLA for 14/15 has been drafted by CSU. However, UHS are currently not willing to sign off on the finances for 2015/16 which will affect the amount of money that is available for reinvestment in the ED element. CSU and SHFT are currently trying to organise a date with UHS to work through this. Once agreement has been finalised, from 15/16 UHS will pay for all inpatient psychiatric liaison including AMH and OPMH. CCGs will pay for the front door element of psychiatric liaison service. This will ensure that the current level of service continues. On the basis of the 2014/15 part of the above being signed off, £35,000 per CCG to pay the current level of service within the ED will come from the ORCP bid. This leaves £70,000 from this bid and £75,000 from the Mental Health resilience bid to enhance the current service. All parties have agreed a proposed enhancement to the ED psychiatric liaison service to include liaison from 6pm to 12/2am 7/7 and morning cover over weekends.	R	Not yet due

Ref	Action and Milestones	Expected impact/KPIs	Project Lead	Lead Org (support org)	Expected delivery date	Progress	In month progress	Delivery against plan (as at Dec)
						An enhanced service is currently being delivered to the ED on a short term basis through extensions to the AAT team whilst recruitment is agreed for the ED psychiatric liaison team. The VAST service is being extended within its current format using winter pressures funding. From 15/16 if the above negotiations are concluded, there will be extra funding from CCGs and the intention is to provide the long term funding for VAST which will ensure 2pm-10pm cover 7/7.		
1.9	**Mental health pathway:** develop mental health pathways to ensure patients' needs are met in a timely manner Ensure that patients are appropriately defined and managed according to their physical and mental health care needs Include out of hospital urgent and emergency services (GPs, MIU, WIC, OOH, SCAS 999 and 111) **Mental health workers in police and SCAS call centres by end of Q3** **Street triage initiative to be implement by end of Q4**	Improved quality of care and patient experience Reduce ED attendances and non-elective admissions	Katy Bartolo-meo	SCCCG SHFT (other providers)	March 2015	**Actions on track** CCGs across Hampshire have been successful at securing mental health resilience funding to place mental health workers within the police and ambulance call centres for one year. This will be for both children and adults. Funding will be released by end the end of November for commencement in December/January, depending on speed of recruitment. SCCCG has also put in a further bid for a street triage initiative which will look to ensure that patients' needs are met in a timely manner in the community to reduce the burden on secondary services. Links with 1.4.4	G	Not yet due

Work stream 2: building and sustaining operational resilience

This Work stream incorporates:

- Operational daily system resilience: escalation, alerts, daily dashboards, communications and predictive working
- Operational resilience planning: system-wide seasonal plans, incorporating provider plans and contingencies and lessons learned, system-wide activity and capacity planning

Ref	Objective / Action	Expected impact	Project Lead	Lead Org (support org)	Expected delivery date	Progress this month	In month progress	Delivery against plan (as at Dec)
2.1	**Triggers for escalation and predictive working:** enhanced daily dashboard and escalation framework to use as an interactive whole system predictive tool Matrix to include agreed measures, thresholds and actions to trigger appropriate responses across the system to manage points of pressure in a pro-active rather than reactive manner **All providers to identify relevant measures, apply a threshold to trigger escalation and submit information daily**	Reduction in red and black alerts Forecast pressure to enable a consistent, proactive system response	James Lawrence Parr Rob Chambers	CCGs (providers)	September 2014	System Resilience processes have been proven to work quite well over the Christmas period, despite high pressure. Daily dashboards have mostly been completed and/or updated via TCs. Most organisations have responded with reps to daily or twice daily TCs. When UHS has been on Black Alert other providers have been following the escalation protocols. Not all providers have been submitting daily data (111, OOH, 999, UHS, SCC)	G	G
2.2	**System resilience management system:** longer term solution to supersede the in-house tool (see 2.1.1) when all of the required information, data, communication lines and behaviours are established and embedded **Implement a system-wide electronic system to strengthen predictive working, facilitate management of system pressures and support the sharing of system resilience alerts/information across all organisations on a daily basis**	Reduction in red and black alerts Forecast pressure to enable a consistent, proactive system response Improve system-side communications	James Lawrence Parr Rob Chambers	CCGs. (providers)	April 2015	**'SHREWD' work stream progressing** Procurement advise sought IT interoperability explored with providers – most sensible way forward is for stage 1 of the project to be sourced by manual feeds and then stage 2 by live data feeds	G	Not yet due

Ref	Objective / Action	Expected impact	Project Lead	Lead Org (support org)	Expected delivery date	Progress this month	In month progress	Delivery against plan (as at Dec)
2.3	**System communications:** develop improved methods of system communication and further strengthen provider-to- provider communications Ensure relevant information is obtained and ahead in a timely manner to support pro-active response to pressure Maintain contact list to ensure all relevant and up to date contact details **Demonstrate that the right people receive the right information at the right time to reduce pressure across the system**	Improved system-wide relationships Reduction in red and black alerts All organisations feel informed and supported	James Lawrence Parr Rob Chambers	CCGs (providers)	October 2014	System Resilience processes have been proven to work quite well over the Christmas period, despite high pressure. Most organisations have responded with reps to daily or twice daily TCs. When UHS have pushed to Black Alert there has been general agreement. When UHS has been on Black Alert other providers have been following the escalation protocols.	G	G
2.4	**Activity and capacity planning**: produce annual profiled activity plans for expected seasonality across planned and unscheduled pathways, with matched capacity (staff and facilities), for normal business continuity Resource gaps highlighted to inform Seasonal Plans and flex requirements **Implement Demand Modelling Tool for Wessex region**	Annual plans reflect usual seasonal variation and plans to maintain delivery, including performance standards	Named provider /CCG planning leads	WHCCG	July 2014	Wessex Demand Modelling Tool under development for all CCGs and providers. At December 14, phase 1 development of tool complete enabling activity modelling across South West system. CCGs will take forwards as part of their activity planning	R	R
2.5	**Winter 2014 review for 2015/16 planning:** post winter review, including review of dashboard, plan, escalation and communication processes, predictors identified and lessons learned for next winter **Summary review to demonstrate lessons learned complete in Q1 2015/16**	Further improve processes for proactive management of system pressures to prepare for winter 2015	James Lawrence Parr Rob Chambers	CCGs (providers)	May 2015	**To be carried out April 2015 and presented to UCDG in May 2015**	N/A	Not yet due

Work stream 3: patient discharge and flow

This work stream incorporates:

- Patient flow within the acute hospital: operating standards, post admission care and support and discharging planning
- Complex discharge: Integrated Discharge Bureau, health and social care discharge processes, incorporating the whole system complex discharge action plan

Ref	Objective / Action	Expected impact	Project Lead	Lead Org (support org)	Due Date	Progress this month	Delivery against plan (as at Dec)
3.1	**ED Remedial Action Plan (RAP):** work stream 2 (patient discharge and flow) incorporating ECIST recommendations, winter funding priorities and ED action plan Monthly progress meetings between UHS and commissioners to sign off completed milestones and agree next phase of actions as relevant **Demonstrate delivery of all agreed milestones on time**	Improve patient flow and timely discharge Reduce internal discharge delays Improve patient outcome Reduce length of stay Reduce readmission rate Delivery of 4 hour standard as per agreed trajectory	Jane Hayward	UHS	March 2015	See enclosed 14/15 plan updated Dec (work stream 2) 141208 ED RAP Nov Milestone Sign Off.xls November milestones complete and signed off 08/12/14 subject to confirmation of evidence Next check point January 2015	See enclosed plan
3.2	**Complex discharge action plan (CDAP):** revised plan with more ambitious milestones and executive sponsors to partner managerial leads for each sub-theme ECIST recommendation **Demonstrate delivery of all agreed milestones on time**	Clearly defined plan with senior support for key themes Clearly defined expected impacts for each action, supported with metrics Increase to ≥60% of patients discharged within 3 days of a section 5 being issued	Rachel King Donna Chapman	CCGs UHS Solent SHFT HCC SCC	December 2014	See enclosed 14/15 plan updated Dec Dec 14 CDAP.xlsx Plan monitored through Integrated Care Board	See enclosed plan

Completed actions

The following work streams have been completed/implemented and performance will be monitored through the Unscheduled Care Delivery Group metrics dashboard and/or reports to the Unscheduled Care Delivery Group as required

Work stream	Objective / Action	Expected impact	Project Lead	Lead Org (support org)	Date moved to completed action	Progress at moved to completion date	Monitoring /reporting
1	**GP urgent care dashboard**: rolled out to all Southampton GPs in 2013/14 Pro-active use of information to understand, monitor and actively manage patients' use of emergency services	Reduction in avoidable/repeat ED attendances, non-elective admissions and 999 calls	Ali Howett	SCCCG	December 2014	All practices now using the tool and reporting bi-annually Supports the reducing non-elective admissions DES Q1/2 submissions summary reported to UCDG December 14 meeting 2014/15 end of year report due to UCDG May 15	Bi-annual summary review to UCDG to demonstrate proactive use and impact
1	**Minor Injury Unit**: new service commenced 1st August 14, extended to children over the age of 2 years Review activity and performance monthly Demonstrate impact of new service and related communications work against KPIs	Further shift of minor injury activity from ED to MIU Reduction in ED attendances in minors work stream at UHS	Katy Collins	SCCCG (Care UK UHS)	December 2014	U12 x-ray demonstrating benefit (~ 30 patients per week currently) Actively working with ED to identify and direct patients	Monthly via metrics dashboard
1	**SCAS 111 Directory of Services:** improvement to directory of services so that callers are able to signpost patients to the most appropriate services. Closely monitor dispositions in line with plans Demonstrate impact of improved DoS against KPIs	Reduction in ED attendances Reduction in number of patients advised to attend ED Increase MIU and self-care/pharmacy dispositions	Judith Collyer	SCAS 111 (CCGs)	December 2014	DoS had been updated to include eye casualty and MIU. Continue to identify further opportunities	Monthly via metrics dashboard

Work stream	Objective / Action	Expected impact	Project Lead	Lead Org (support org)	Date moved to completed action	Progress at moved to completion date	Monitoring /reporting
1	***SCAS 111 performance and capacity:*** *improve clinical cover to ensure call staff are able to check with a clinician regarding a disposition to dispatch an ambulance or attend ED* *Improve staff fill rates to sustain performance against KPIs* *Review activity and performance monthly* *Demonstrate impact of improved staffing levels – sustained performance of calls answered/abandoned* *Demonstrate impact of improved clinical cover – improved performance against KPIs*	*Patients are managed in the most appropriate service (or through education and self-care) to avoid ED attendances and 999 calls* - *conversion to 999 threshold of 10%* - *conversion to ED below threshold of ≤5%* - *calls answered within 60 seconds above threshold of ≥95%* - *calls abandoned rate below threshold of ≤5%*	*Mark Rowell*	*SCAS 111* *(CCGs)*	*December 2014*	*Improvement in staffing levels, demonstrated by 96% calls answered within 60s and a very low call abandonment rate. Formal contract notice closed.* *Lack of clinical cover not evidenced as a current issue.*	*Monthly via metrics dashboard*
1	***SCAS 999 pathways:*** *transition to NHS pathways, aligned with 111.* *Provide the right care, first time.* *Optimise the benefits of closer working between 999 and 111 services and explore the potential for a fully integrated clinical assessment and signposting service.*	- *reduce number of vehicles dispatched* - *single, consistent triage tool* - *increase in amount of call auditing* - *enables 999 emergency call takers to directly refer patients safely to alternative care pathways, via the local DoS* - *right outcome for patients based on commissioned services available* - *reduce re-contact rates* - *increase hear and treat capability* - *integration: 999 and 111 operations centres to become fully integrated, with improved resilience*	*Deb Ingram*	*SCAS 999*	*December 2014*	*Transition complete June 2014* *Hear and treat performance dropped significantly from plan for May, the opposite of what was expected. Assurance received from SCAS that performance is looking much improved* *Continue to monitor closely through contract performance route*	*Monthly via metrics dashboard*

Work stream	Objective / Action	Expected impact	Project Lead	Lead Org (support org)	Date moved to completed action	Progress at moved to completion date	Monitoring /reporting
1	**GP OOH performance and capacity:** improve staff fill rates to improve performance and ensure all NQR12 targets are met across the system Review performance monthly and rectify through contract management	Out of hours access to primary care to avoid attendances to ED All response times for emergency, urgent and routine home visits and primary care centre appointments above the threshold of ≥95%	Justin Cankalis	Care UK (CCGs)	December 2014	Staff fill rates have improved but not to the level where performance is consistently succeeding. NQR12 performance improved but must be sustained. This is being managed through the contract review process and staff fill rates are being monitored closely	Monthly via metrics dashboard
1	**30 Day Readmissions:** complete re-admissions audit and build on existing action plans	Reduction in 30 day re-admissions	Sarah Knight	WHCCG (UHS SCCCG)	December 2014	Audit carried out 24th Sept 2014 Summary of audit outcomes and next steps circulated	Annual audit and report to UCDG
1	**Support patients to make good choices:** promoting choose well principles through patient and public engagement, communication and education Communication and education programme for 14/15 developed and linked to Seasonal Plans Implement comms and education plan and demonstrate impact	Raise awareness and confidence in 111 Raise awareness of MIU Increase use of 111 Increase self-care/use of community pharmacies Reduce minor illness and injury attendances to ED	Chris Bailey Eleanor Freeman	CCGs (providers)	December 2014	111 awareness, 'phone first' campaign MIU awareness and promotion Choose Well / Think First campaign Self-care and use of community pharmacies awareness Regular tweets and media messages Radio and bus advertising, leaflet drops	Monthly via metrics dashboard
2	**Seasonal Planning for 2014/15:** review seasonal plan, implement 13/14 learning into practice and produce a revised plan for 14/15 Complete and assured plan cascaded to all relevant organisations	Updated seasonal plan and processes accessible to system	James Lawrence Parr Clare Handley	CCGs (providers)	December 2014	**Plan complete and assured** Exploring best mechanism for cascading/access to all relevant organisations in the system 14/15 lessons learned summary report due to UCDG May 15	Related issues to be highlighted in monthly work stream update report

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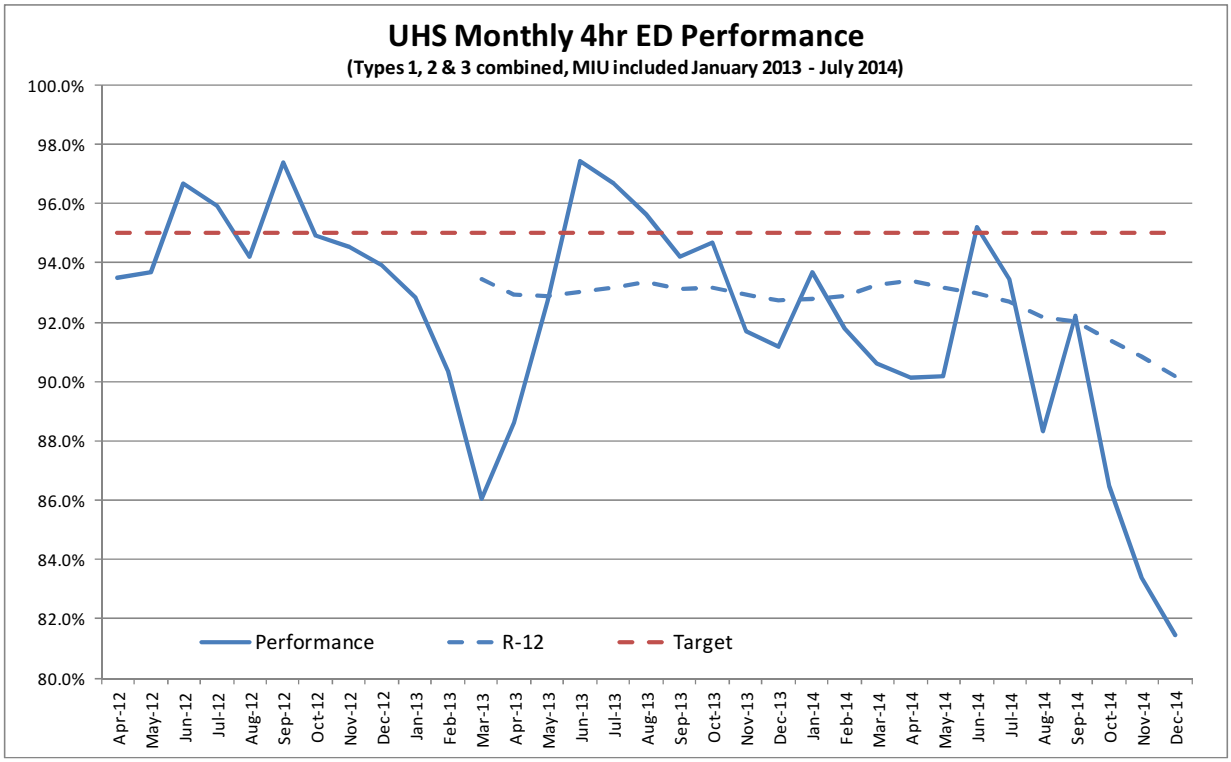
University Hospital Southampton NHS
NHS Foundation Trust

Emergency Department Report for Overview and Scrutiny Panel – January 2015

The Trust is monitored on its ED performance across all emergency departments – the main SGH Emergency Department (a Type 1 Dept.), Eye Casualty (a Type 2 Dept), and until August 1st when management was transferred, the RSH Minor Injuries Unit (a Type 3 Dept).

Whilst the Trust met the target to treat and admit or discharge more than 95% of patients within 4 hours during June 14, this performance has not been sustained.



It should be noted that the removal of the MIU data from August makes it significantly harder for UHS to achieve the 95% target. Nationally, Type 1 Emergency Departments have not collectively achieved the ED 95% target in any given week for since July 2013. In most weeks the national performance for Type 1 EDs is between 92% and 93%, although since the week ending October 12, 2014, the highest national performance has been 90.8%, with the lowest being 83.1% for the week ending December 21, 2014).

As can be seen in the table below, no major English teaching hospital (taking major trauma etc) consistently achieves this target for Type 1 activity although other hospitals (notably Birmingham and Newcastle) do much better at this target than UHS.

Week Endir	UHS	Birmingham	Bristol	Cambridge	Leicester	Newcastle	Nottingham	Oxford	Sheffield
23/11/2014	85.9%	95.4%	90.9%	78.6%	77.0%	92.8%	89.5%	81.0%	88.2%
30/11/2014	88.7%	95.2%	83.5%	70.8%	80.6%	96.0%	91.5%	83.9%	90.4%
07/12/2014	79.4%	94.2%	89.6%	76.2%	78.6%	88.8%	85.1%	80.7%	86.3%
14/12/2014	77.4%	94.3%	80.1%	67.1%	69.4%	90.8%	81.4%	88.7%	73.8%
21/12/2014	79.2%	91.5%	78.5%	70.9%	67.3%	87.8%	78.4%	76.3%	78.6%
28/12/2014	75.3%	95.1%	86.7%	66.0%	76.1%	90.7%	81.6%	82.8%	82.4%

Whole System Approach

Since this was last discussed at the Overview and Scrutiny Committee performance the performance against the 4 hour target has been formally reviewed.

In December the whole system, including Alison Elliott from Southampton City Social Services attended a tri-partite meeting with NHS England, the Trust Development Authority and Monitor. A letter summarising this meeting is attached as appendix 1. Prior to this meeting a detailed presentation was prepared, this can be made available to Councillors if required, which summarised the plans in place and the issues currently faced by the system. In summary this formal review concluded:

Overall the system partners were able to assure us that there was a good understanding of the issues facing the system, and that a clear action plan was in place to deliver the 95% target from January 2015. We will continue to work with you over the coming months to gain assurance that the action plans are being delivered and that risks to delivery are being appropriately managed.

This conclusion was drawn from the following statement.

You agreed that the target performance can only be achieved if all partners deliver against the action plan.

In particular the system has agreed to increase discharges to 26 per day, increase the number of patients discharged within 3 days to 60% of those deemed to be medically fit. The Trust agreed to increase the number of patients discharged before 11am to 20% of all patients discharged that day (currently they are discharged much later in the day) and increase the number discharged at the weekend to 23% of all patients discharged over the 7 day period.

The meeting and the presentation was based on the whole system operational resilience capacity plan (ORCP, attached). This action plan is presented monthly to a senior committee within each organisation in the local system and is overseen by the System Resilience Group. SRG is lead by a CCG Chief Accountable officer and attended by the local system chiefs.

The ORCP is supported by over £8m of one off funding, this money is currently being deployed and it is believed services available to patients will peak in January and be sustained through to the end of March 2015.

As set out in the ORCP and the response letter from the tri-partite meeting it is important that there continues to be a focus on flow out of the Hospital as well as flow though the Hospital.

Going forward, and using the Better Care Fund as a vehicle, I am sure you will recognise that there needs to be more long term planning for workforce and capacity in the City to meet the needs of the population. I believe this is something the Overview and Scrutiny Committee and Health and Wellbeing Board need to take a joint view on in 2015.

Fiona Dalton
Chief Executive

22 December 2014

By email to
Fiona Dalton
Katrina Percy
Sue Harriman
John Richards
Gill Duncan
Alison Elliot
Heather Hauschild
John Trewby

Dear all,

Southampton Urgent Care System

Thank you for meeting with us on 15 December. The purpose of the meeting was to discuss and understand how you plan to improve the performance of the urgent care system in Southampton and specifically how you plan to recover and sustain performance against the NHS constitution standard for A&E.

Key issues

You set out your analysis that the system had demonstrated improvement in three of the five key areas identified by the Emergency Care Intensive Support Team (ECIST), namely:

- Minimising type 1 attendances;
- Reducing growth in non-elective admissions; and
- Creating capacity through elective choice and outsourcing.

However, further action is required to address the remaining two areas:

- The flow of discharges to the community; and
- Internal flow within the hospital.

We discussed the implication of workforce capacity constraints downstream of the hospital, in particular in relation to social care and the planned action by the local authorities to address the challenges in this market.

Key actions

You set out a range of actions you are taking which the system considers is sufficient to return the system to compliance with the 95% standard from January 2015. In particular, as a system you committed to:

 Additional capacity within the hospital: 6 beds from January and 23 further beds from February;

 Action to improve matching of admissions and discharges within the hospital to make more effective use of capacity;

 20 'virtual' beds within the city and extended use of discharge to assess and trusted assessor;

 Hampshire County Council and Southampton City Council will be re-tendering adult social care in April 2015 with the aim of securing a more stable and attractive market.

You agreed that the target performance can only be achieved if all partners deliver against the action plan. You also highlighted that delivery will be put at risk by factors outside of the systems control, such as Norovirus, and availability of domiciliary capacity in the private sector. We expect you to escalate any significant risks to delivery early to the national tripartite partners and ensure that mitigating plans are in place and ready to be enacted.

Better Care Fund

During the meeting we discussed the local commitments under the Better Care Fund (BCF). Consequently we reviewed the feedback on your BCF plans, which suggested there could be more ambition around reduction in delayed transfers of care (DTOCs) for both councils. Southampton City Council need to assure the care system that changes to social care services introduced earlier in the year will result in more timely services with a model that meets demand and protects services next year; and for Hampshire County Council there needs to be greater clarity in how changes to social care planned through the BCF are effectively overseen by multiple partners. It is imperative that there is transparency about how NHS resources are being used to protect social care services as a result of the BCF investment, and we expect the respective councils to quantify the expected impact on domiciliary care in particular and reduction in DTOCs

Conclusion

Overall the system partners were able to assure us that there was a good understanding of the issues facing the system, and that a clear action plan was in place to deliver the 95% target from January 2015. We will continue to work with you over the coming months to gain assurance that the action plans are being delivered and that risks to delivery are being appropriately managed.

Yours Sincerely,
PAUL STREAT
Regional Director (South)
Monitor

ANDREW RIDLEY
Regional Director (South)
NHS England

JIM LUSBY
Director of Delivery and Development
NHS TDA

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DECISION-MAKER:		HEALTH AND OVERVIEW SCRUTINY PANEL		
SUBJECT:		PROGRESS REPORT: PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL REVIEW		
DATE OF DECISION:		29 JANUARY 2015		
REPORT OF:		HEAD OF TRANSPORT, HIGHWAYS AND PARKING		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Simon Bell**	**Tel:**	**023 8083 3814**
	E-mail:	**simon.bell@southampton.gov.uk**		
Director	**Name:**	**Stuart Love**	**Tel:**	**023 8091 7713**
	E-mail:	**stuart.love@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
n/a

BRIEF SUMMARY

To report on the progress made with the recommendations to the Public and Sustainable Transport Provision to Southampton General Hospital Review.

RECOMMENDATIONS:

(i) That the panel note and discuss the progress against their recommendations made to date.

(ii) That the panel agree for a further progress report to be brought to the Health Overview and Scrutiny Panel (HOSP) in September 2015.

REASONS FOR REPORT RECOMMENDATIONS

1. To update the panel on the progress being made with regards to the recommendations in the review.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

n/a

DETAIL (Including consultation carried out)

2. The Health Overview and Scrutiny Panel undertook a Public and Sustainable Transport Provision to Southampton General Hospital Review in 2012/13, with the final report and 17 recommendations agreed at their meeting on 21 March 2013.

3. At their meeting on 20 August 2013, Cabinet accepted all the recommendations that the Council is responsible for delivering and agreed to work in partnership with others to achieve the additional recommendations, as outlined in the HOSP Action Plan.

4. The recommendations from the review are outlined at Appendix 1, with progress reported to date.

5. The panel is invited to note the progress made to date, and considering any comments or issues they may have, agree to have a further update by September 2015.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None

Property/Other

7 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. None

Other Legal Implications:

9. None

POLICY FRAMEWORK IMPLICATIONS

10. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	List of recommendations and progress made to date

Documents In Members' Rooms

	None

Equality Impact Assessment

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

Other Background Documents

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

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	Final Report and Recommendations: Review of Public and Sustainable Transport Provision to Southampton General Hospital	

OSMC Summary of Recommendations & Current Status

	Recommendation	Lead Organisation	OSMC Target date for completion	Current Status
1.	***Ensure that staff, visitors and patients are aware of the public and sustainable transport routes to and from the general hospital.*** ***a) UHS to review, improve and provide evidence of the information provided to staff, visitors and patients in relation to travel to the hospital – including in patient appointment letters and the website;***	UHS	Sept 2013 **January 2015**	UHS will work with SCC to review and improve the information available to those accessing the SGH site with consideration content and method of communication should be informed by the data and information collated by undertaking a survey of patients and visitors as indicated by (10) below. UHS suggest the bus companies have a critical role in promoting sustainable transport options and should be identified as one of the lead organisations in delivering this action. First Hampshire has produced a timetable for access to the hospital for their services. Due to the number of patients (over 600,000) being treated at the hospital each year it is not in a position to survey information on how travel to the hospital but they will continue working with the bus companies and the Council on sustainable travel. Letters sent to patients with details are as per a template by NHS England so it is not possible to put any information directly on the letter. However the

				hospital web site on how to access the hospital provides information on public transport first and parking last. SCC is working with the hospital to deliver a bus departure display in the new hospital entrance which will help and reassure visitors to the hospital of where to get their bus home from and what time it is due. SCC has produced a new leaflet showing all bus companies' bus services to the hospital giving details of routes, frequencies and bus stops (see 1 b below).
b	***SCC to develop leaflets to publicise sustainable transport options to the general hospital from various parts of the city for distribution at relevant places including the hospital, GP surgeries, libraries, community facilities and the information provided on the 'My Journey' website.***	SCC	Sept 2013 **January 2015 Completed**	To be put into work programme to be in place following September service changes (changes traditionally happen in September due to school/University year start). This should be in partnership and joint funded by UHS as part of the Travel Plan for the site. Following a further change to the operator of council supported service S1 this will be delayed until October 2013. ***Update:*** *Following further changes to bus services in early January 2014 it is proposed that information be provided at this date.* There have been continual service changes and bus company ownership for some bus services at the hospital over the last year. These have now stabilized and the Council has produced a leaflet which shows routes to the hospital, bus

				stops and how connections from train, ferry and longer distance bus service can be made with ease. The leaflet will be distributed across the city into doctor's surgeries, libraries, transport operators and other locations where users to the hospital may find the information of use. The hospital will promote it on their web site, it will be put on the MyJourney website and distributed around the hospital site. The leaflet will be updated on line as bus services change and re printed when there are major service changes.
2	***To establish a representative passenger group for public transport in Southampton including service providers (buses and trains), transport users and councilors. The group should meet at least twice a year with scope for extra meetings if required and minutes available publicly.***	SCC	July 2013 **January 2015 Completed**	SCC liaising with UHS on best way to set up group (including tapping into existing groups). It is anticipated that the group will meet for the first time in September/October 2013. ***Update:*** *This will take place in January where the latest changes to bus service will be discussed* A bus users group meeting has been set for 18 February 2015 in the city centre which the hospital wish to be involved in. This meeting will be chaired by Councilor Rayment, Cabinet Member for Environment and Transport and posters and a press release will be issued for the meeting. Future dates for the meeting will be set later in the year. The meeting with be promoted across the City and anyone interested in bus services will be able to attend. In addition First are reviewing their Passenger Panel which

				meets quarterly as the panel has been sitting for nearly two years but it has not been as effective as those in other areas. They are very keen to secure some representation from hospital staff and are working with the UHS to achieve this.
3	***That UHS ensure there is early engagement with public transport providers, allowing time to consult with the passenger group mentioned in recommendation 2 where possible, over services changes that are likely to affect staff and patient travel – including the proposed extension of working hours at the hospital.***	UHS	June 2013 **January 2015**	UHS will ensure this is the case and will work via the passenger group once it has been established. This is delayed until the passenger group is established (see 2 above). ***Update:*** *The latest changes are to First commercial services.* There has been limited improved engagement between transport operators and the UHS over planned service changes and there has been no consultation on the latest service change by First in January 2015. The UHS has established an internal Travel Planners Group which has representatives from clinical and non-clinical staff. Bus companies are being encouraged to provide information on their service proposals to the group.
4	***Bus companies to ensure that bus drivers are encouraged to share information with passengers – for example that it is quicker to wait and get the next bus, as a matter of course, particularly for vulnerable and elderly passengers and for this to be included in mandatory training***	Bus Companies	Sept 2013	New signage to be included at locations highlighted at (5) below will assist in general information as Real Time where provided. Leaflets as set out at (1b) above will also help. In a competitive and unregulated market it is unrealistic to expect private bus operators to encourage passengers to use services of another

			January 2015 Completed	operator both in terms of commercial approach and knowledge of other operators services (e.g. it would be unexpected that B&Q would advise on Homebase products for example). The Customer Service Charter being developed as part of the Better Bus Area Fund project aims to bring a standard approach to customer service including improved driver training. In addition First Group CPC training includes a module written in partnership with the CPC Alzheimer's Society in terms of dealing with elderly and vulnerable people. ***Update:*** *Ongoing training by bus companies* First have revised their training to improve the information that staff are given and encouraging them to provide information to customers.
5	***SCC to work with bus companies, Network Rail and Red Funnel to improve signposting to bus services to the hospital from central station and Town Quay linking into the legible cities and legible bus networks.***	SCC	Sept 2013	New Signs to be installed at Town Quay and Southampton Central station during August 2013 in partnership with Island Line Community Rail Partnership with details of bus routes to Hospital. Totems installed at City Centre Locations with local area maps which shows bus departures and a map to assist in identifying "which bus goes where". Signs also due to be installed at both sides of Central Station as part of the project, the North Side due to go live August 2013, South Side September 2013 delayed due

				to electrical connection issues with South West Trains. ***Update:*** *A new totem has been installed on the south side exit from the rail station which gives live bus departures from the bus stops around the station. The north side totem has been erected but is not connected to the power supply yet so is not providing any information. A notice board has been provided on the south-side of the station which gives information on how to get to the station.* **January 2015** The totem on the north side of the railway station is now live and gives bus departure information and shows the location of bus stops in the locality. At the present times highway improvements around the north side of the station are making access to bus stop more difficult. Once all this work is completed in November 2015 the interchange been bus and rail will be more attractive and easier. There is no longer a direct bus service from Town Quay to the hospital but it is possible to make an easy interchange using the same bus stop and the leaflet produced by the Council explains this.
6	***SCC and UHS to work together to improve signposting to bus stops and cycle routes in and around the hospital including consideration of a potential cycle route through the cemetery. If this is not deemed***	SCC/UHS	Sept 2013	UHS approached regarding provision of additional RTI signs/Totems on site at UHS but were viewed unsuitable due to potential infection concerns and land redevelopment

	appropriate, the Panel would urge the Council and partners to consider alternative routes which are physically segregated from motor vehicles as much as possible.			issues. Cycle links to be developed with UHS travel plan working group. Current improved routes to the Hospital part of DfT Cycling to Prosperity Bid, award decision due August 2013. Routes in and around the Hospital are on private land and responsibility of UHS through the Travel Plan. ***Update:*** *Confirmation of available funding has not been secured to develop the cycle route across the cemetery* **January 2015** The UHS is reviewing its internal cycle routes and in September 2014 set up a cycle user group meeting. An additional 176 cycle parking spaces will be provided across the hospital site in 2015 with funding from SCC and UHS. SCC reviews the network of cycle routes each year and whenever an opportunity for funding arises we submit bids for funding to extend and enhance the network. The last bid was unsuccessful which would have provided a cycle way to link Millbrook to the General Hospital. Currently there are no funds to develop any cycle routes adjacent to the General Hospital.

				SCC are about to undertake a major audit and review of cycle routes across the City – this will establish continuity, user demand, and identify where works are required to make the route more user friendly and safer. This will establish were priority measures may be required.
7	***SCC to work with the UHS to improve bus stop information around the general hospital site to ensure time tables and real-time information are available both in the hospital and at bus stops.***	SCC/UHS	July 2013 **January 2015**	UHS approached regarding provision of additional RTI signs/Totems on site at UHS but were rejected due to potential infection concerns and land redevelopment issues. However, a location has now been identified to install the freestanding bus departure display unit. New legible bus network bus stop will be installed in August to improve the information around the hospital. ***Update:*** *Bus stop poles and flags have now been ordered and will be delivered and erected by the end of November 2013* The bus stop signs and timetable cases have be replaced in the new legible bus network style at all bus stops around the hospital including the introduction of a bus stop lettering scheme assist in identifying which bus stop to go to. New tube style maps and where to catch your bus listing have been put in these bus stops showing passengers the services from the hospital.

8	***SCC to priorities improvements to street lighting on Tremona Rd and Dale Rd Junction around bus stops, to ensure that passengers feel safer.***	SCC	July 2013 Completed	Under the existing Street Lighting PFI Contract, Coxford Ward, the street lighting for Dale Road has already been up graded to a ' white' light source, 90 Watt, road lighting lantern, using 8 metre mounting height lamp columns. It is planned to continue with the same lighting specification for Coxford Road and Tremonia Road, with the lighting installations being brought forward and completed by Scottish & Southern Energy before the end of the Summer months and the return of the dark evenings. Street lighting in the roads of Dale Road, Coxford Road, and Tremonia Road, will all be exempt from any future Councils Street Lighting Dimming Policy, and will continue to be operated at full brilliance.
9	***All bus companies to feed their live data into the SCC real time information systems.***	Bus Companies	Sept 2013	This is subject to a legal Service Level Agreement being signed between SCC and the bus operator to ensure data on system is of high quality. Bluestar are already on system. Unilink due on system August/September. Negotiations with First suggest an October date but this is subject to further negotiation. ***Update:*** *Unilink Information is now live on the system. First should be available in the first*

				quarter of 2014 First data will be going live on the system by the end of March 2015. The Council is working with Xelabus who have taken over the operation of bus service S1 this month to add them to the system.
10	***SCC, UHSFT, Southampton University, Unison, S-LINkS-LINK and Bus Companies to work together to explore options for undertaking a survey to establish how patients and visitors are currently travelling to and from the general hospital and the results are used to inform future service planning and improve reliability. The results should also be reported back to HOSP and fed into the key local health documents: the Joint Strategic Needs Assessment and the Health and Well-being Strategy, the latter of which, following the Panel's recent review, now is agreed to contain transport as a consideration.***	All	Sept 2013 **January 2015**	UHS are developing a new Travel Plan as the previous Travel Plan is no longer being used. The revised version is due to be submitted to SCC for review and approve in March 2014. The timetable by OSMC needs to be amended to reflect this. ***Update:*** *A survey of patients and staff which include information on how they travel is being undertaken during November 2013* UHS have carried out their annual staff survey and will be submitting their revised travel plan by March 2015. The hospital "You Say" feedback form which is available in all departments across the hospital and on line. Comments received concerning transport are sent to the Travel Plan team to deal with and reply.
11	***Regardless of decisions taken by bus companies in relation to continuing, or otherwise, to run evening and weekend buses to the General Hospital, the Panel would like SCC to review the effects of the bus subsidy reductions on access to the general hospital six***	SCC	Dec 2013	This is due in December 2013. ***Update:*** *A verbal update on service changes and their impact will be given at the meeting.*

	months after they come into effect. A report on the review should be provided to HOSP.		**January 2015 Completed**	Following withdrawal of Council support for evening bus service all those routes and journeys to the hospital have been taken on commercially by the bus operators. For this reason no review has been necessary. In addition from June 2014 First improved the frequency of services 3 and 12 daytimes and evenings which serve the general hospital. The evening frequency enhancement on service 3 has now reverted to its original frequency this month. Further changes this month have seen improvements to Saturday daytimes on service S1 which will operate all day. The UHS is pleased with the way the city council keeps them informed of changes to all bus services at the hospital.
12	***At a meeting in the 2013-14 municipal year, HOSP to consider the Patient Transport Service and other dedicated modes of patient transport in more detail in order to improve understanding of how the services are managed, publicised to patients and concerns with the current service. Commissioners and providers, including the voluntary sector, of the service to be invited. If recommendations are necessary to improve the service, they will be made at that meeting***	HOSP	Sept 2013 **January 2015**	Noted The chair of HOSP to schedule this review for a Panel meeting in June/July 2015.
13	***UHS to be asked to consider reviewing the zones used in relation to parking permits to consider areas where there are regular direct bus routes which fall outside***	UHS	Oct 2013	UHS zones were designed with available bus routes in mind as below: • Staff living in zone 2 (based on a combined 15

	of the inner zone but provides attractive transport to the hospital within 30 minutes. This should help improve the viability of bus services and encourage sustainable transport use *("getting people out of their cars").*		**January 2015**	min walk and 30 min bus journey) will be allocated a parking space if they work nights, shifts or travel off and on site several times per day. UHS acknowledge however that these zones were designed three years ago and are willing to consider revising the zones in light of current bus routes. This will need careful consideration and possible consultation with staff prior to any changes being implemented. ***Update:*** *As part of the Hospital travel plan recently submitted they are proposing to look at the zones* UHS has reviewed its staff car parking permit scheme criteria. The use of the previous zones is not now a major factor when decisions are made about how staff parking is allocated. A recruitment and retention panel which meets monthly considers all applications for parking permits.
14	***Consideration is given to the development of a bus hub within the general hospital site and how SCC can work with the hospital to facilitate this.***	SCC/UHS	Dec 2013	This is subject to issues on redevelopment proposals and funding opportunities as well as a demonstrated business case. There is a desire amongst both parties to deliver a solution that is being investigated through both through the development control process and in terms of funding in partnership between SCC and UHS

			January 2015	with bus operators. UHS held a meeting with SCC and bus companies in October 2014 to identify what options maybe available and which part of the site is likely to be most suitable for bus operations. Traffic counts have been undertaken and traffic modeling of how the site would operate are being undertaken.
15	***Encourage bus companies to work together to develop a cross company bus ticket for use within Southampton to enable easier travel from the City to the hospital. This should be priced competitively with existing operator day tickets – e.g. First day ticket rather than the Solent Travelcard which covers a greater area and is therefore more expensive. Consideration also be given to how they can work better with train providers on this issue and the promotion of Plusbus add-on tickets.***	Bus Companies	Dec 2013	A Solent Travelcard already exists for this purpose. This is due to transfer to a "smart ticket" in late 2014 with a Southampton only version to be introduced late 2014. Plusbus is a commercial product which allows bus travel on all companies services within to be added to a return or season train ticket at a discount over a Solent or bus operator specific ticket. There are strict rules laid down by both the Competition Commission and DfT on multi-operator ticketing including pricing which is reflected in the existing Solent Travelcard. Specific Multi-Operator tickets to one specific location may be in conflict with these and are not planned to be developed as this will be covered by the Solent Travelcard migration to smartcard referred to above. ***Update:*** *The target date for the introduction of a Southampton version of the Solent Travelcard is July 2014.*

			January 2015 Completed	The city version of the Solent Travecard (now SolentGo) was launched in December 2014. The price is £5 per day and £20 per week, £65 for 28 days and £185 for 3 months. The UHS has leaflets and information on the scheme.
16	***UHS to share their forthcoming travel plan with SCC Transport Officers by April 2013 and ensure that the plan details clear lines of accountability for actions and is refreshed yearly and fully updated every three years. The final plan should also be shared with HOSP. SCC officers to support UHS to complete the implementation of the travel plan. UHS should ensure they share and learn from best practice on travel planning including working with Southampton University.***	UHS	July 2013 **January 2015**	UHS are developing a new Travel Plan as the previous Travel Plan is no longer being used. The revised version is due to be submitted to SCC for review and approval later in the year. The timetable by OSMC needs to be amended to reflect this. ***Update:*** *A draft travel plan has now been submitted to the Council* The UHS submitted a revised travel plan to SCC in May 2014 and this was approved by SCC in June 2014. UHS have carried out their annual staff survey and will be submitting their revised travel plan by March 2015. UHS meets regularly with SCC Workplace Travel Plan Officer
17	***Chair of HOSP to write to all partners with recommendations, seeking a response on what they accept, what timings they can commit to, and detailing any additional resources they are willing to provide.***	HOSP	May 2013	Noted

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		VASCULAR SERVICES UPDATE		
DATE OF DECISION:		29 JANUARY 2015		
REPORT OF:		INTERIM DIRECTOR OF COMMISSIONING (SOUTH)		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY

The purpose of this report is to provide an interim update to Southampton City Health Overview and Scrutiny Panel (HOSP) on progress of the first tranche of the NHS England (Wessex) Vascular Programme, the reconfiguration of vascular services across Southern Hampshire, provided by the two hospital sites of University Hospital Southampton NHS Foundation Trust (UHS) and Portsmouth Hospital Trust (PHT). The recommendation to centralise vascular services at UHS was deferred when discussions identified gaps in impact analysis that required further work to develop a robust Business Case. Recipients are asked to note the progress made to date and the next steps to be taken. It is anticipated that the iterative feedback process and additional detailed analysis will culminate in a Final Business Case being produced in Spring 2015.

RECOMMENDATIONS:

(i) To note the progress made to date and the next steps to be taken

REASONS FOR REPORT RECOMMENDATIONS

1. To provide the Panel an update of Vascular Services within the region.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None.

DETAIL (Including consultation carried out)

BACKGROUND

4. The Vascunet 2008 report (cited in the Vascular National Service Specification (NSS)[1], identified that the UK had the highest mortality rates in Western Europe following elective abdominal aortic aneurysm (AAA) (7.9% vs 3.5% Europe). The Vascular Society of Great Britain and Ireland (VSGBI) initiated changes to improve clinical outcomes and in 2013 reported[2] that the mortality rate for elective AAA in the UK was now 2.4%. In 2013, the NSS published evidence-based models of care to continue to improve patient diagnosis and treatment, and ultimately

[1] A04/S/a 2013/14 NHS Standard Contract For Specialised Vascular services (Adults)
[2] National Vascular Registry 2013 Report Organisational Outcomes

improve patient mortality and morbidity rates associated with vascular disease.

5. There have been several vascular reviews since 2009, which have included Southern Hampshire although there has been no implementation of associated recommendations to date. During March and April 2014 NHS Wessex consulted with the requisite four Health Overview and Scrutiny Committees and Panels, on implementing and approach that became known as 'Option 4':

> *Option 4 - Establish a Southern Hampshire Vascular Network and move, on a phased basis, all major complex arterial vascular surgical procedures to Southampton. (Options for surgery following a TIA or stroke (such as carotid endarterectomy CEA) and major amputations will be considered at a later date following the successful implementation of the initial phases.)*

6. Three of the four HOSCs/HASCs did not consider the plans to be a substantial change, the exception being Portsmouth HOSC which did view the proposed change as substantial and therefore requiring formal consultation.

7. Option 4, centralisation of vascular services at UHS, has not had the support of all parties, and there has been considerable media and public opposition in Portsmouth, as this model was perceived as potentially destabilising to PHT with unintended consequences not fully understood. In order to clarify the impact on individuals and organisations, work has commenced on developing a Business Case.

8. A number of vascular reviews have signalled potential capacity issues in transferring the majority of vascular services to UHS. These issues will be worked through as part of the Business Case. During this period, close attention will be paid to the quality of service of both Trusts.

9. As part of the programme management arrangements put in place to oversee this work, it was agreed to explore collaborative opportunities in parallel to undertaking the business impact analysis of the options identified. A critical first step towards collaboration was an externally facilitated clinical meeting involving the clinical teams from both UHS and PHT, which took place on 1st July 2014. At this meeting a clinical lead was elected from each trust and it was agreed that clinicians would form a joint Multi-Disciplinary Team (MDT) to develop areas of joint working between the clinical teams.

10. At the time of writing, both Trusts are meeting key service outcome measures defined in the NSS for both elective AAA and CEA procedures although compliance with all NSS measures has not yet been fully achieved. Analysis has also identified that not all outcome data specified in the NSS is compiled by the Trusts; this will be included as a contractual obligation going forwards. A detailed review of each element of the NSS has mapped current capability and performance.

Current Position

11. In discussions, two possible models of care/strategic options have now been identified :

- UHS and PHT to remain as two arterial centres, but to collaborate to provide a single clinical service where possible; it should be noted that the number of

complex vascular patients needed to be centralised is low.

- Centralise vascular services at UHS – Move on a phased basis all major complex arterial vascular surgical procedures to Southampton (UHS) (Option 4).

12. A strategic evaluation of both options listed above is currently underway to assess impact in terms of suitability, feasibility and acceptability and as an aid for effective decision making. A first draft has been prepared. This demonstrates the areas requiring further detailed work before a final Business Case can be developed. It is hoped to produce a final Business Case in Spring 2015.

13. NHS England (Wessex) has embraced this further opportunity to agree a model for implementation. There is renewed energy and transparency across the system and opportunities are emerging that should support both UHS and PHT as providers of optimized vascular care through collaborative working arrangements.

14. The collaboration is being treated as a pilot whilst the impact assessment and Full Business Case is developed. The collaborative pilot has been approved to continue until 31st March 2015, but it is anticipated that the pilot will continue until a strategic decision has been made.

15. An update was presented to the Wessex Senate in December 2014. The Senate agreed that the collaboration was a valuable step forward and reiterated its recommendation that there should be a single clinical service across both sites with one clinical director and one rota. The Senate expressed concern about aspects of diabetic care and emphasised the benefit of ensuring that current work on improving vascular services should also include reviewing links and pathways with diabetic services.

16. The Project approach and progress is being undertaken according to the NHSE Service Re-configuration Guidelines and the project structure which has been put in place is attached at Appendix A . A Gateway review of the process was also undertaken in October 2014. The aim was to review the basic project structure and progress to ensure that best practise processes are followed. The findings are detailed below:

17. Overall The Review Team considers the Delivery Confidence Assessment (DCA) to be: **AMBER-RED.**

	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed.

Below is a summary of the key Recommendations made by the Review Team:

Ref. No.	**Recommendation**	**Timing**
1.	Ensure that the Full Business Case is comprehensive and compelling, and follows a best practice format.	Now
2.	Review the current stakeholder analysis and create a comprehensive communication strategy and plan for Vascular Service reconfiguration.	Now
3.	Benefit realisation management plans should be developed.	By end Jan 15
4.	Any change of programme approach should be formally and expeditiously communicated to all external stakeholders, especially overview and scrutiny bodies.	Now
5.	The Programme's formal risk management processes should be reviewed and augmented.	Now
6.	A revised and detailed Programme plan should be formally communicated to stakeholders.	By end Dec 14

Next Steps

18. A copy of the first draft of the Business Case has been shared with both hospitals and feedback has been requested by 14th Jan 2015. This will be incorporated with the on-going business analysis into a second draft. The team will work with both Trusts to develop a shared understanding of both models and their impacts, ensuring that this is done in sufficient detail to enable an informed discussion with all relevant partners, Oversight Groups and the public. The team will keep HOSCs/ HASCs updated on progress.

RESOURCE IMPLICATIONS

Capital/Revenue

19. None

Property/Other

20. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

21. The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

22. None.

POLICY FRAMEWORK IMPLICATIONS

23. None.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Wessex Vascular Programme Governance

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

Other Background Documents

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

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

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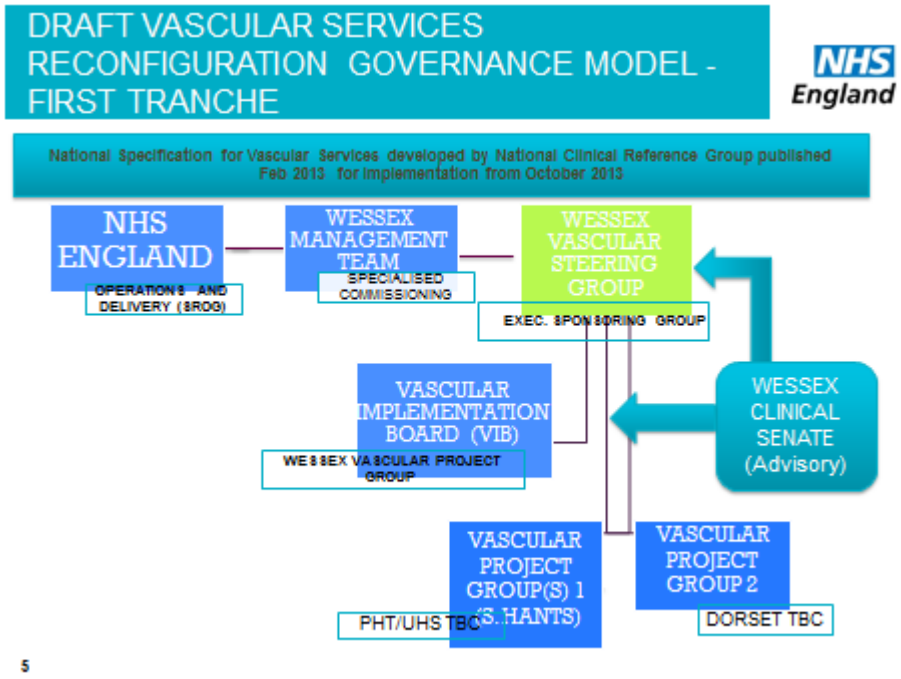
Appendix 1 Wessex Vascular Programme Governance:

1. NHS England (Wessex) has an established formal and transparent Vascular Programme governance structure for implementation of the agreed vascular services proposals. This has been agreed with our relevant stakeholders.



2. The Vascular Programme structure includes a Steering Group chaired by Dominic Hardy, Director of Commissioning Operations, with Accountable Officers from CCGs representing East and West Hampshire, and both UHS and PHT Chief Executives, as a minimum quorum.

3. Implementation of sanctioned proposals will be overseen by the Vascular Implementation Board, which is chaired by Susan Davies Interim Director of Commissioning, with both UHS and PHT Medical Directors as a minimum quorum. The Board also has patient representation in the form of Healthwatch.

4. The joint UHS/PHT Collaborative Pilot will report directly into the Vascular Implementation Board and the project team will ensure all plans are fully scrutinised.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON CLINICAL COMMISSIONING GROUP COST IMPROVEMENT AND QUALITY REPORT		
DATE OF DECISION:		29 JANUARY 2015		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY None

BRIEF SUMMARY

This report provides an overview of the Cost Improvement Programme processes for University Hospitals Southampton Foundation Trust (UHSFT), Solent NHS Trust and Southern Health NHS Foundation Trust for 2015/16. Health Trusts, as other public sector organisations, have to make efficiencies and Cost Improvement Programmes are the approach used. Quality Impact Assessments are required and clear governance and accountability routes. The Clinical Commissioning Group, as commissioner of the services, also oversees the impact of the savings being made on patient safety and quality standards. The aim of this report is to set the context for Cost Improvement Programmes as organisations are still in the process of finalising their 15/16 plans.

RECOMMENDATIONS:

(i) Health Overview and Scrutiny Panel notes the progress towards of Cost Improvement Plans for each of the providers

(ii) Health Overview and Scrutiny Panel supports the assurance processes outlined for the monitoring of the Cost Improvement Programmes for University Hospitals Southampton Foundation trust (UHSFT), Solent NHS Trust and Southern Health NHS Foundation Trust for 2015/16.

(iii) That the Health Overview and Scrutiny requests University Hospitals Southampton Foundation Trust (UHSFT), Solent NHS Trust and Southern Health NHS Foundation Trust to present their annual report and quality account to the panel as part of their assurance on the impact of savings.

REASONS FOR REPORT RECOMMENDATIONS

1. Overview and Scrutiny Management Committee requested that the Health Overview and Scrutiny Panel monitors progress of Cost Improvement Programmes being implemented by major NHS providers to:
    - Assess the impact on quality and outcomes for patients.
    - Review the approach being taken by local major providers to balancing the sometimes conflicting demands of financial savings and patient safety / quality standards.
2. This report aims to provide assurance to the Panel that actions and effective monitoring processes are in place.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None. The report was requested by the Overview and Scrutiny Management Committee.

DETAIL (Including consultation carried out)

4 **Cost Improvement Programmes**

4.1 From 2011/12, there has been no significant real terms increase in the resources available to the NHS despite growth in demand for services, new technologies and the continuing need for quality improvement. NHS organisations have used Cost Improvement Programmes (CIPs) for many years to deliver and plan the savings they need to make.

4.2 There is no single approach to developing a CIP. However, organisations that develop, deliver and sustain CIPs have several factors in common*. They have effective, coordinated and well-executed leadership and management which impacts positively on organisational culture and means that organisational performance is strong and consistent. A successful organisation:

- Sets out clearly its overall vision, improvement strategy and philosophy;
- Commits to ensuring that the organisational culture facilitates the transformation of services and improves patient experience;
- Develops a five-year forecast that supports the need to plan longer-term transformation programmes;
- Involves all local health economy stakeholders at an early stage;
- Identifies suitable, tailored CIP targets for each division or department that reflect their relative efficiency, using benchmarking data; and
- Sets up a programme management office to oversee the CIP, or define clear governance and lines of accountability.

(*Delivering sustainable cost improvement programmes Audit Commission and Monitor January 2012)

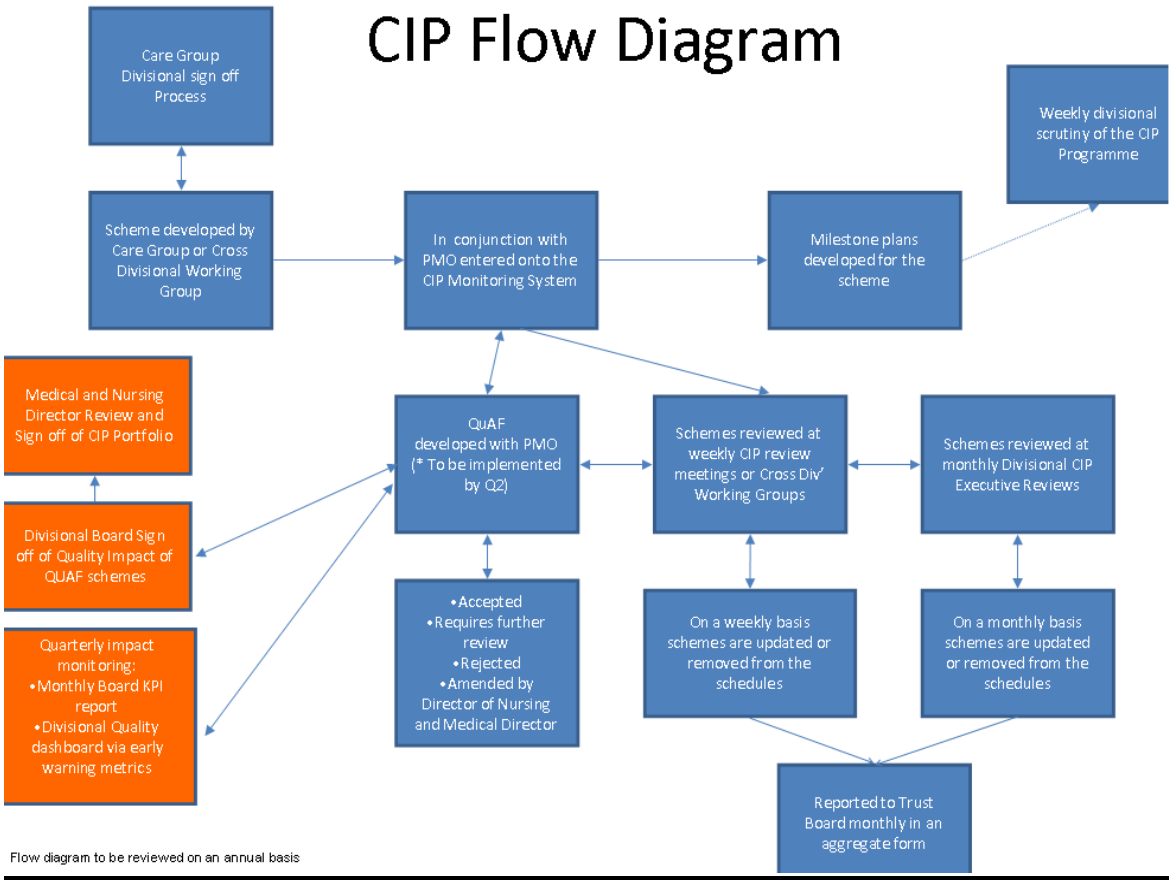
4.3 Governance of CIPs is led by the Nursing and Medical Director within each organisation and includes oversight at Board level. Each scheme has a Quality Impact assessment.

4.4 The Clinical Commissioning Group oversees the impact and outcomes of CIPs

via the Nursing and Medical Director meeting with providers as well as through formal Contract and Clinical Quality Review meetings. CCG assurance on the quality of providers is via the Clinical Governance Committee and an exception report to the Board. The latest report is attached at Appendix 1.

4.5 Each organisation has a policy for developing, assessing and monitoring the development of CIPs. For example the University Hospitals Southampton Foundation trust (UHSFT) one is summarised below. However each organisation has a similar, documented process.

UHS Annual CIP Flow chart



5. University Hospitals Southampton Foundation trust (UHSFT) resume of CIP process provided by their Director of Nursing

5.1 University Hospitals Southampton Foundation trust (UHSFT) report that they operate a fully devolved model where the cost improvement target of around 5% is delegated out to local teams. This delegated model results in a large number of locally owned schemes, over 500 in any given year. The ethos of the programme is to maximise efficiency achieved via improvements in the quality of care (getting patients better sooner) and reducing waste.

5.2 Ownership at ward and department level is the key to success with clinical input from the very outset. This helps to ensure quality/safety considerations are taken into account before items even get onto the CIP schedules. UHSFT then have a local divisional review process which should again deal with quality/safety

issues in any schemes that are still of concern.

5.3 December 2014/15 - CIP Themes and Associated Values are:

	2014/15 £'000
Care Pathways	5,185
IMT	36
Workforce	6,063
Local Non Pay	3,513
Income	8,974
Procurement	2,086
Miscellaneous	163
Cross Divisional Schemes/ Innovation bids	2,445
Total	28,465

5.4 The largest area of cost reduction (excluding new income) comes from the largest area of spend - workforce/pay. This is achieved through workforce re-design, with local teams training staff to their full potential at every level of the organisation, and effectively matching resources to patient need. Reductions in frontline staffing are kept to a minimum and controlled through a robust assurance process. Any staff reduction of over 5 WTE or with a value over £100k has to be signed off by the divisional board and executive medical or nursing director.

5.5 As cost reduction has become more challenging UHSFT have been promoting a greater focus on transformational change, shown in the table above under income and care pathways. This is where a service has redesigned their model of care to either absorb growth in demand without the need for additional resources or reduce cost. For example changing models of care to help patients recover more quickly and leave hospital earlier with a reduced length of stay. This includes:

- Enhanced recovery pathways
- Reduced avoidable readmissions
- Reduced medical length of stay, working in partnership with community colleagues
- Early mobilisation of patients in intensive care (HSJ Value Award winner 2014)
- Hospital care from home
- Outpatient operational improvements and alternative follow-up pathways.

5.6 Combined with delegated responsibility UHSFT have a system of tight central controls to ensure consistent and robust governance of the overall process.

Members of the executive team meet the divisions on a monthly basis to review their progress with CIP. Corporate quality monitoring and metrics are also in place to assure cost improvement doesn't negatively impact on quality, for example the monthly staff status reviews and risk registers. UHSFT review allocation of target each year and make adjustments dependent on areas ability to either deliver a saving within their own budget, or contribute to improved efficiency in another area, e.g. currently reduce support services target by 20% with a requirement they support cost improvement and transformation in other care groups.

6 Solent NHS Trust resume of CIP process provided by their Director of Nursing

6.1 The Director of Nursing states that since its inception Solent NHS Trust has delivered a consistent set of acceptable annual financial results. In 14/15 financial performance came under severe pressure and the result of this is that the Trust will post a deficit for 14/15. A recovery programme was initiated early in 14/15 and was enhanced in July 2014. This programme has a full structure of efficiency programmes driving it, all overseen by the executive team, and a complementary set of quality risk processes to support ensuring Solent's current good CQC rating is sustained. Work is now focusing on continuing the improvement plan to return to a position of ensuring sustainable financial surpluses.

6.2 It is recognised by the Trust that the challenging financial environment in which all public sector providers are operating, is going to require significant service reconfiguration which realise tangible financial efficiencies whilst maintaining the safety and quality of services provided to patients/service users. To this end the Trust Cost Improvement Programme (CIP) is being centrally co-ordinated and monitored.

6.3 Solent NHS Trust are only part way through development of their CIP plans as whilst the service lines have submitted draft plans for 2015/2016 the full Quality Impact Assessment process has not yet been completed against each plan. Key themes and approaches being progressed for 2015/2016 include:

- Estates rationalisation; the expansion of some services, whilst reducing the footprint of others. The implementation and maximisation of mobile working capability will be key to underpinning achievement in new ways of working whilst ensuring that staff are in the right place at the right time to deliver safe, effective and timely care.
- Improving productivity through skill mix, process improvement and technology including the delivery of the new Clinical Records System.
- Improvements to non-pay cost control with consideration of collaboration re 'back office' functions.

7 Southern Health NHS Foundation Trust resume of CIP process provided by their Director of Nursing

7.1 Southern Health NHS Foundation Trust plans are at an early stage currently as have been awaiting the operating framework announcements. Currently their CIP plans broadly cover the following themes:

- Better internal management of bank and agency
- Maintaining and improving on use of out of area inpatient capacity (i.e. reducing such use)
- Reduction in divisional management/admin posts
- Contracting out peer support workers (in effect replacing 2 inpatient Health Care Support workers (HCSW) per unit with 2 HCSW with lived experience of mental health services-peer workers-employed by the third sector).

7.2 Further work is required as plans are still at an early stage. There is a clear process in place within service areas to develop plans which will be agreed through Trust governance routes and implementation will be monitored. Quality Impact Assessments will be undertaken on relevant schemes.

8 The Panel is asked to note the progress and supports the assurance processes in place for the monitoring of the Cost Improvement Programmes for University Hospitals Southampton Foundation trust (UHSFT), Solent NHS Trust and Southern Health NHS Foundation Trust for 2015/16.

RESOURCE IMPLICATIONS

Capital/Revenue

9 The forecast income for each organisation for 2015/16 is:

	£'000s
University Hospitals Southampton Foundation Trust	648,300
Solent NHS Trust	178,798
Southern Health NHS Foundation Trust	340,350

Income for each organisation is from a range of commissioners and other sources. Southampton is just one contributor

Property/Other

10 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11 The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

12 None.

POLICY FRAMEWORK IMPLICATIONS

13 None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	CCG Board Quality Exception Report – January 2015

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

Other Background Documents

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

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

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Appendix 1

NHS
Southampton City
Clinical Commissioning Group

Report for the Board

Quality Exception Report – January 2015

This Quality Report highlights, by exception, to Southampton City Clinical Commissioning Group (SCCCG) the key quality successes and challenges.

1. Safety

1.1 Infection prevention and control

Overall the CCG position is good to the end of December 2014, with no MRSA bacteraemia cases so far this year and 41 Clostridium difficile cases which one case over the expected limit at this point in the year against, a maximum of 57 for the whole year. During December University Hospital Southampton NHS Foundation Trust (UHSFT) suffered from a Norovirus outbreak which saw a significant increase in the number of C.difficile cases identified, which is often the case. The Infection Prevention and Control Lead Nurse is working with UIHSFT and others to minimise the risks where possible.

The recent Norovirus outbreak at UHSFT had a significant impact on bed availability at the hospital, contributing to the difficulty in managing emergency patient flow through the hospital. UHSFT responded well to the outbreak, bringing the situation under control and identifying learning to reduce the risk of further spread during the outbreak.

No new MRSA bacteraemia cases have been reported at UHSFT since July, however this remains under close review to ensure the actions taken are embedded in practice

1.2 Serious incidents

At the December Clinical Governance Committee meeting an update was provided on progress with the management of Serious Incidents. Following the significant work undertaken by Dr Majid Jalil Clinical Lead, Gemma Seymour Clinical Quality Assurance officer and Joan Wilson Quality Manager, NHS England are now fully assured that SCCCG has robust mechanisms in place for the management of serious incidents. They no longer attend panel meetings and other CCG's are attending our panel as observers to learn from the processes we have in place.

1.3 Safer Staffing

Following on from the update provided in November 2014 Solent NHS Trust have confirmed that they will publicly report on safer staffing in January 2015 and the details will be shared with CQRM in February 2015.

1.4 Emergency Department (ED)

The challenges continue with the ED 4 hour target at UHSFT, and across the wider Wessex system. At a recent NHS England Wessex Quality Surveillance Group it was agreed that a system of reviewing quality assurance relevant to emergency care should be considered and work is underway in the Portsmouth and South East Hampshire area. Julia Barton, Chief Nurse for Fareham and Gosport and South East Hampshire CCG's is leading this work and will report to the Directors of Nursing group on progress. It is anticipated that this will not create additional work for the acute Trusts in the system but focus on quality assurance already provided but linked specifically to emergency and urgent care pathways.

1.3 Mortality

SCCCG Associate Director of Quality has provided an update the NHS England Wessex Quality Surveillance Group on mortality rates at UHSFT. This update included analysis of the impact of Countess Mountbatten House (CMH) on the Hospital Standardised Mortality Ratio and as anticipated this does push the figures into the higher risk range. When considering the HSMR at Southampton General Hospital, excluding the figures for CMH and Princess Anne Hospital, the HSMR is within the expected range.

SCCCG is confident that UHSFT are responding appropriately to HSMR alerts; this includes regular mortality review meetings at clinical level and formal discussion at public board meetings.

UHSFT CQRM will continue to monitor mortality rates on a quarterly basis to ensure they are within expected ranges.

1.4 Safeguarding Children

SCCCG Quality Team and the Head of Safeguarding (Designated Nurse) continue to closely monitor the performance of Solent NHS Trust in the management of Looked After Children. Performance in ensuring health assessments are undertaken within the required timeframes is being monitored, to ensure the health and well-being of this vulnerable group of children.

2. Outcomes

2.1 CQC compliance

The current picture of CQC compliance with the essential standards to the end of October 2014 was mixed across the city

Health Providers

- Southern Health NHS Foundation Trust have had their full CQC inspection and are awaiting the final report which is anticipated to be released late

February or March with the Quality Summit being held in advance of this release.

- UHSFT have also had their full CQC inspection and have been advised that it will be March before the report is ready.

Nursing Homes

Compliance issues continue at 4 nursing homes in the City, these are

- St Anne's Nursing Home last assessed by CQC September 2014, this home is currently has a variation to its registration in place from CQC which means they are unable to admit new residents without CQC consent. 5 areas of enforcement action are identified in the report and staff from the Integrated Commissioning Unit are visiting the home on a weekly basis
- Oak Lodge are now fully compliant with the CQC essential standards
- Sunrise of Bassett have also had a CQC visit resulting in compliance actions. The ICU have been monitoring progress with the action plan arising from this inspection and are confident that the home is now meeting the essential standards of quality and safety.

2.2 Quality Assurance in Nursing and Residential Homes and Domiciliary Care Agencies

At the end of December 2014

- Only 1 Nursing Home remains suspended from placements. In January one other Nursing Home had an influenza outbreak which was well managed by the home and the temporary suspension on admissions is due to be lifted on 20th January 2015.

- 2 Residential Homes remain suspended from placements. One of these is making good progress with ICU staff feeding back on a good response to new management and leadership in the home. The second home, due to problems with CQC registration, closed on the 9th January 2015 with all residents being moved to suitable alternative accommodation.

2.3 Outcomes Data

Work is underway to develop outcome based reporting and this is being presented to the February 2015 Clinical Governance Committee

3. Experience

3.1 Single sex accommodation

No further non-clinically justified breaches of single sex accommodation have taken place at UHSFT since the last incident in July. UHSFT, CCGs and NHS England

continue to work together to ensure compliance and agreement has recently been reached on clinically justifiable breaches in the hyper acute trauma bay.

3.2 Complaints and Compliments

During October and November 2014 SCCCG received 3 formal complaints relating to issues at UHSFT (2) and Millbrook wheelchair services (1)

In addition 18 PALS type calls were received relating to a wide range of services, no specific themes or trends emerging.

One compliment was received in October in relation to the efficient service at the Minor Injuries Unit, and one in November in relation to end of life care.

Two complaints closed in November; one was closed as no consent was received. The other complaint was upheld and communications are to be improved by Care Group. They are to provide specific time for consultant to speak with family of inpatient either by telephone or face to face when updating them about treatment/care.

4. Conclusion

This new style report attempts to provide an overview of the current quality assurance work underway within the Integrated Commissioning Unit Quality Team. Any feedback on this report would be very welcome to enhance it for Governing Body Members going forward

Report compiled by

Carol Alstrom, Associate Director of Quality

19th January 2015

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		CARE ACT UPDATE		
DATE OF DECISION:		29 JANUARY 2015		
REPORT OF:		DIRECTOR, PEOPLE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Rebecca Ayres**	**Tel:**	**023 8083 4804**
	E-mail:	**Rebecca.ayres@southampton.gov.uk**		
Director	**Name:**	**Alison Elliott**	**Tel:**	**023 8083 2602**
	E-mail:	**Alison.Elliott@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE

BRIEF SUMMARY

This report provides an update on the progress made in relation to implementation of The Care Act ("The Act"). The Act is a significant piece of legislation which alters the way in which some care and support is provided to Adults and their carers. This report focuses on progress which has been made in order to prepare for the Act's implementation in April 2015. The report also briefly considers the potential requirement for a public consultation on matters permitted by the Act.

RECOMMENDATIONS:

(i) To Panel are requested to consider and note the contents of this report.

REASONS FOR REPORT RECOMMENDATIONS

1. Report requested by HOSP.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None this is a legislative requirement

DETAIL (Including consultation carried out)

3. This paper provides an updated summary of the progress and actions completed regarding the Care Act. It also details the next steps to be carried out to ensure SCC is prepared for the changes brought by the Act in April 2015.

4. The majority of the requirements of the Care Act will come into force in April 2015. Each aspect which is required to be implemented by April 2015 is detailed in appendix 1 alongside a progress report. A number of powers (as detailed below) do not come into force until April 2016.

5. Changes which come into force in April 2016 include:

- The requirement for the LA to provide a Care Account for all people with eligible needs. This monitor's the accumulated cost of care and will support both LA's and adults to understand their current position in regards to the cap on care costs.
- Self-funders with eligible needs are able to request an Independent Personal Budget to record the cost of meeting their eligible needs.
- Overhaul to the funding reforms which changes the funding thresholds. Currently people with less than £23,250 receive help from the state. Changes introduced by the Care Act mean people with £118,000 or less worth of assets will start to receive financial support should they need to go to a care home.

6. Further updates on these aspects will be provided when more details on the implementation of such matters become available.

7. The Act provides a single legal framework for charging for care and support under section 14 and 17 of the Act. The framework is intended to make charging fairer and more clearly understood by everyone. Some of the principles which encompass the framework on charging include:

- Ensuring people are not charged more than is reasonable practicable for them to pay;
- Be comprehensive, to reduce variation in the way people are assessed and charged;
- Be clear and transparent so people know what they will be charged;
- Promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control;
- Support carers to look after their own health and wellbeing and to care effectively and safely;
- Be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- Apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- Encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so; and
- Be sustainable for local authorities in the long term.

8. SCC are currently awaiting detailed proposals from Finance colleagues as to whether or not any proposed changes to appropriate policies are required in line with the Act guidance. Should proposals suggest that amendments need to be made, then, in accordance with SCC's history of providing public consultation on similar matters, it is anticipated that these proposals would be subject to a public consultation.

9. Areas on which SCC are currently considering whether or not we have policies compliant and in line with the Acts intention include:

- A change to the current administration fee charged for the provision of a deferred payment agreement (DPA)
- An amendment to the rate of interest which is charged for DPA's.

- Charging policy related to appointee and deputyship costs.
- Charging policy related to Self-funding individuals.
- Charging policy related to Carers.

10. Once SCC Finance colleagues have completed their review, the final list of matters for consultation will be discussed with the Cabinet members and a consultation process agreed. Discussions with colleagues in the Council's Legal Team have advised that a consultation programme of six weeks is likely to be required

11. These matters remain under consideration and public consultation would only be initiated should they fall in line with the guidance and frameworks provided by the Act.

12. Some matters are required under the new legislation so therefore SCC will not be required to initiate consultation on these areas.

RESOURCE IMPLICATIONS

Capital/Revenue

13. Southampton City Council, along with other LA's were allocated a grant from central government to be used for help cover the costs of implementing the Care Act. SCC were granted £125,000. The funding is being used for a number of matters including the appointment of a project manager on a 1 year fixed term contract.

It is currently under consideration how to spend the remaining amount however proposals identified have included:

- Commissioning of Independent Advocacy services to assist with aiding adults complete Deferred Payment Agreement's. Consideration would be required regarding on-going costs for this provision.
- Commissioning of a voluntary organisation to undertake further awareness session for Carers. A tiered workshop (stage one already completed) would also allow a stage 2 workshop to give detailed information about the eligibility criteria to allow carers expectations to be managed in a realistic manner.
- Additional legal support appointed on a fixed term contract to create depth of knowledge in the particulars relating to the Care Act. A further proposal suggests a permanent position is required to support the likely increases in demand for DPA applications, appeals, legal advice, Cop applications and private law applications. Should the latter option be considered thought would be required regarding on-going costs of this provision.
- Funding to support the Communication campaign. It is proposed that some funding will be allocated to SCC's Communication Team so they are able to produce materials and support the project through publication of the Care Act and the likely consultation. Any communication strategy decided upon will support the national campaign to reduce duplication and costs.

Property/Other

14. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15. The Care Act 2014 repeals a wide range of current legislation and places a legal requirement on all Local Authorities to undertake necessary steps to achieve compliance.

Other Legal Implications:

16. None

POLICY FRAMEWORK IMPLICATIONS

17. The principles of the Care Act include promoting wellbeing, ensuring prevention and supporting care are consistent with the Council's plan for improving health and keeping people safe and making better lifestyle choices.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Implementation Update
2.	Option Appraisal for Proportionate Assessments

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

Other Background Documents

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

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

Update on SCC's implementation of the Care Act.

Area of Act	Item	Description	Progress	Risks/Area of Concern	RAG Rating
General Responsibilities & Universal Services	Information and Advice	The Act requires an information and advice service to be available to all people in the local authority's area (regardless of whether or not they have eligible care needs). The LA must ensure the service is accessible to all, proportionate, and provides adequate information to allow informed decision to be made. Additionally information and advice must also inform individuals how they can reduce, delay or prevent the need for care and support, this is particularly relevant for individuals who as yet do not meet the eligibility criteria. LA's will need to ensure services are in place to enable people to get independent financial advice about how to fund their care and support. LA's will be required to provide independent advocates to support people to be involved in key processes such as assessment and care planning, where the person would be unable to be involved otherwise.	• Southampton Information Directory (SID) underwent a soft launch on 6th October 2014. It is expected that the service will be fully live and publicised by the end of January. Due to feedback received, the Adults information has been re-designed to ensure the availability of information has been maximised. • In conjunction with SID a 'wellbeing plan' function is being developed. This will allow non-eligible adults to have a plan created for them which will aids safe, healthy and independent living. It is anticipated that this function will support preventative work also being undertaken. • The steering group are current liaising with the Communication team to ensure any work undertaken compliments the national communication campaign. By successfully implementing this work we hope to ensure individuals understanding of the changes brought by the Care Act are realistic and accurate.	SID and alternative sources of information need to be appropriately publicised so all residents of Southampton are aware of sources of help and support available.	**Green**
	Market Shaping	Local Authorities have a duty to help shape the local care and support market. This should enable adults to have a choice of sustainable and quality provisions through which their care and support can be provided. Specific aspects which LA's should focus upon include designing strategies that meet local needs, engaging with providers and local communities, understanding the market and securing supply in the market and assuring its quality through contracting.	• A concept paper in relation to the market position statement has been agreed. The first three statements (Accommodation based care, community capacity & direct payments) are expected to be drafted by March 2015. Intelligence gathering is already underway to support this requirement. • Scoping of the market development offer has been agreed at CCG's Management Team.	Predictions regarding numbers of self-funders are unclear. Planning for future demand has therefore been difficult. Capacity to develop the market and coordinate provisions is considered limited.	**Amber**
	Provider Failure	In any market, at times providers are likely to leave a market for one of a number of reasons. It remains the LA's responsibility to ensure no matter the state of a market, that adults continue to have their care and support needs met. This will be a temporary	• CCG and SCC are jointly working with a number of providers regarding concern regarding their service level. It is hoped that this approach will prevent provide failure and acts as a preventative service.	Existing contracts do not include new responsibilities which the Care Act makes a	**Re**

Area of Act	Item	Description	Progress	Risks/Area of Concern	RAG Rating
		duty and is required to ensure that the individual receiving care does not experience any gap in obtaining the care. The duty will be a temporary one which is applicable when a provider is unable to carry out relevant activities to care and support for adults due to business failure.	• Additional resources of two identified members of staff have been identified to begin work in January. Their work will include the adaptation of a Community and Care Provider Closure Protocol to ensure it meets local needs.	legal requirement. Absence of clear protocols for identifying provider failure will provide risks which need to be mitigated.	
First Contact & Identifying Need	Assessments & Eligibility	Many of the requirements regarding assessments remain similar to current requirements. However the act brings with it a requirement to have a more outcome based focus. The outcome focus is particularly significant in regards to the outcomes that are desired by the individual. The act also reinforces the need for assessments to be proportionate to the needs of the individual being assessed. The type of proportionate assessments may include, but are not restricted to, providing assessments online, via phone or face to face.	• See Appendix 1 for option appraisal on proportionate assessments • A provision to enable adults to under-go a self-screening process is being developed. The online system will take individuals through a series of questions which will enable individual to understand whether they are likely to be eligible for care and support. Should the responses hit a certain criteria, it is proposed that a Senior Practitioner within the Single Customer Service will review the process and should further assessment be required, this can be carried out within the Single Customer Service processes. • It is proposed that the new Single Customer Service are likely to ensure initial assessments and eligibility work is undertaken in a different manner. This will align with the Acts focus on proportionate assessments. SCC will adopt an approach where significant numbers experience a telephone assessment as a form of proportionate assessment. • A new long term assessment form is being developed in PARIS. The changes allow for a clearer focus on needs, goals, how they are achieved and outcomes, as per guidance. • The eligibility criteria is a focal area for workforce development. Plans will ensure adults new to SCC receive the level of care and support they are entitled to but also ensures adults already known to SCC are treated in accordance with the new legislation.	The application of new eligibility criteria needs to be understood by the Single Customer Service Team in order for it to be appropriately applied.	**Amber**
	Carers	Local authorities will be required to assess carers where it appears they may be in need of support. Such an assessment	• SCC is expecting to carry out up to 1800 carers assessments within the two years following the introduction of the Care Act.		**Amber**

Area of Act	Item	Description	Progress	Risks/Area of Concern	RAG Rating
		can also be requested by the carer if they believe they may be in need of support. Currently, LA's only need to assess carers if they provide a 'substantial amount of care on a regular basis'; this requirement and definition is removed in the Care Act 2014. A new eligibility framework for carers will be introduced and, for the first time, councils will be under a duty to provide support for carers who have eligible needs. Currently, councils do not have a statutory duty to meet carers' needs.	Funding to cover the additional assessment requirement is to be made available via a government grant. Details regarding the amount SCC are likely to receive has yet to be released, however nationally £55.5 million is to be available for this purpose. • Awareness raising workshops have been held with carers to help them understand how the implications of the Care Act may affect them.. It will be further explored as to whether sessions can be provided to ensure expectations are managed appropriately and realistic expectations are held by carers. • Development of carers assessment form is underway. This will be stored on the Carers file and options are being explored to ensure required information is shared and stored on the adults file as well. Current completion rate of forms is low, but with the statutory changes demand is expected to increase so a user-friendly option is being developed.		
Charging & Financial Assessment	Charging	The Care Act bring into legislation changes regarding the ability (in some circumstances) for a LA to charge for an individual's care and support needs. It is the Act's intention to make charging fairer and more clearly understood by everyone. The Act is explicit in its advice that all information should be provided in a range of formats which are suited to an individual's needs.	• Detailed proposals are currently being developed as to the areas that SCC will be required to consult upon for changes made to charging policies. The requirement for a consultation is largely driven by SCC's history which has seen similar aspects undergo consultation in previous years.	Until proposals for a new charging policy are provided by Financial Planning plans regarding how this will be managed through consultation cannot be explored.	**Red**
	Deferred Payments	This scheme allows people to enter into an agreement with the local authority when they have been assessed as having sufficient capital to meet the cost of their residential care, but may have to sell their property to release the funds to pay for care home fees. This arrangement will allow individuals to retain the ownership of their property with the local authority meeting the cost of the placement, via a loan secured by way of a legal charge on the property which is enforced when the estate is disposed of. Local authorities will be able to charge interest on these payment arrangements.	• Detailed proposals are currently being developed as to the areas that SCC will be required to consult upon for changes made to charging policies. The requirement for a consultation is largely driven by SCC's history which has seen similar aspects undergo consultation in previous years. • Regardless of potential changes made to the charging policy regulations for deferred payment agreements will change on 1st April 2015. SCC will at that time be required to provide DPA's in line with the new regulations. A working group has been set up to ensure that the new requirements will be met.	Until proposals for a new charging policy are provided by Financial Planning plans regarding how this will be managed through consultation cannot be explored.	**Red**

Area of Act	Item	Description	Progress	Risks/Area of Concern	RAG Rating
Person-centred care and support planning	Care Planning & Reviews	The Act requires changes in the way service users' contributions are determined. Currently, different systems for determining charges to service users exist, depending on the type of care being provided including CRAG (Charging for Residential Accommodation Guide) and Fairer Charging for community based care and support.	• A module on PARIS is being developed which will allow the effective monitoring of contributions adults have made to their care. This will support the requirement to monitor an individual's progress towards the care cap (£72,000) which comes into force in April 2016.		**Green**
	Personal Budgets	A personal budget is a statement which tells the adult/ carer how much it will cost the LA to meet their needs, how much the adult must contribute and the difference the LA will pay. New requirements by the Care Act consolidate duties in respect of direct payments for LA's. LAs must grant requests for direct payments where they meet certain conditions, either to an individual or to an authorised person. LAs must end direct payments if the conditions are breached, and may do so if the money is not spent on meeting the adult's needs.	• A project brief is currently being compiled for Direct Payments which aim to increase the take up across Adult Social Care. This will be achieved by reducing the current barriers to obtaining direct payments, ensuring adults understand and are supported to take up direct payments as well as having an informed workforce who are able to offer advice to direct individuals to further independent advice. It is anticipated that the changes will be implemented by March 2015.	Work is required to positively promote the use and uptake of Direct Payments within SCC. Current uptake rate is low and a high failure rate exists, these need to be reversed.	**Amber**
	Self-Funders	The level of involvement LA's have with self-funders is likely to be increased with the changes directed by the Care Act. Individuals who fund their own care and support will be able to request LA to arrange care on their behalf. LA's are given powers to charge for such services as long as the charges are cost neutral and based upon the cost of providing this service.	• Revised financial modelling has been undertaken using the Surrey Model. This has highlighted predicted budgets pressures over the following 20 years. Particular pressures relate to the expected change in numbers of ASC funded users and self-funders (particularly for the age range of 65 or over). • Development is underway for a new module creation in PARIS. The module will allow tracking of an individual's contribution to their care so to inform whether or not the cap of care costs will apply to their situation. This will be a live function from April 2016. A local mechanism of recording expressions of interest from October 2015 is being explored.	Understanding demand for Self-funders is difficult and the reliability of figures is as yet unknown. This therefore provides a risk.	**Amber**
	Independent Advocacy	The Act provides Local Authorities with responsibilities to provide advocacy for all adults. The act gives the LA duties to arrange advocates for all adults as part of their own assessment and care planning and care reviews and to those in the role of a carer.	• The tender process for providing independent advocacy is now underway, this process will close on 23rd January 2015. It is anticipated that this tender will reduce all outstanding risks which include uncertainty regarding expected demand. Furthermore it is expected that further guidance to be provided from the government will reduce the potential risk regarding uncertainty of definitions used in the guidance. • Consideration has been given to the requirement for any adult		**Green**

Area of Act	Item	Description	Progress	Risks/Area of Concern	RAG Rating
			subject to a safeguarding review/enquiry to be assisted in having an independent advocate support them through the process.		
Safeguarding	Safeguarding	The Act places the safeguarding of adults on a statutory footing for the first time (currently this is governed by the 2000 No Secrets guidance, and although councils must follow this unless they have a reasonable excuse, legislation will strengthen their safeguarding requirements). The Act establishes duties for adult safeguarding including: • responsibility to ensure enquiries into cases of abuse and neglect • establishment of Safeguarding Adults Boards on a statutory footing (sets out membership and funding of SABs, along with duty to publish yearly strategic plan and annual report) • Information sharing • Updates duty to protect the property of adults who have been admitted to hospital or residential care	• The new Safeguarding Adults Board has gone live (1st December). • The majority of current practice will be compliant with new requirements. • Initial scoping of training has been undertaken to fall in line with the 4LSAB learning and development strategy. Tier 1 which is based at increasing awareness and understand that 'Safeguarding is everyone's business' will be rolled out via a number of two hour workshops to be held February to March. These will reach all members of the LSAB. • SCC are also introducing an e-learning package to all SCC employees to enable all staff to understand what abuse to vulnerable adults may look like and how they can report such incidents.		**Green**
Integration & Partnership	Integration, Co-Operation & Partnership	The act requires that local organisations work together in a more 'joined-up way' to ensure people receive high quality care and support. The vision created by the Act is for care and support to be person-centred and tailored to the needs and preferences of the individual as well as their carers and families.	• Better Care Plan has been signed off by both SCC and CCG. • A single manager has been appointed for integrated discharge bureau aiming to develop joint and integrated work practices across all organisations. • Discharge to assess beds have been set up and functioning as of December 2014.	Potential impacts upon patients may exist if no clear arrangements are in place regarding whether SCC or CCG maintain overall responsibility.	**Amber**
	Transition	The Act establishes new legal duties regarding transition arrangements: • duty for LA to assess a child, young carer or child's carer before they turn 18, to establish if they will have needs after turning 18, what these are and what can be done to prevent or delay development of these needs • allows LA to meet the needs of an adult caring for a child (regulations to be developed regarding exercise of this	• Agreement has been made for joint working in the 0-25 service with Adults Social Care. An Adults Social Worker will be placed in the service to aid with smooth transitions. They will specifically work with children who are about to transfer to ASC. • Policies will be updated to reflect the changes required by the Act as to how and when individuals transfer from Children's Services to Adult Services.		**Green**

Area of Act	Item	Description	Progress	Risks/Area of Concern	RAG Rating
		power) provides continuity so young people receiving children's services must continue until adult services have a plan in place.			
	Continuity of Care	The Act establishes duties when an individual moves from one area to another. The first LA must provide specified information. The second LA must provide information; assess the adult and their carer. If the second LA hasn't carried out an assessment before the person moves, they are required to provide services based on the care and support plan provided by the first LA until it has done its own assessment. These are new legal duties to ensure notification and information-sharing, as well as continuity of care when a person moves.	• To be managed as business as usual. Consideration given to updated policy to ensure consistent practice. • PARIS / CIVICA development regarding the ability to produce a full client report containing all information regarding a single client is being undertaken. This will enable a simple process to hand over to a new authority when a client moves. Additionally it may support some local functions which currently are resource heavy.		**Red**
	Delegation of LA Functions	Councils will be able to consider other forms of delivery for social care functions, including assessment services. Under current legislation, the statutory assessment function can only be carried out by a local authority or by an NHS organisation (through a Section 75 agreement). The Act introduces a power for local authorities to delegate these and other functions to bodies other than an NHS organisation. In effect, this allows local authorities the freedom to market test and outsource most adult social care functions other than safeguarding, integration with health and charging for services.	• Due to timescales the only current option regarding delegation of functions which is being considered is that of Carer's assessments. It is currently anticipated that a phased approach will be undertaken which will work towards ensuring all carers assessments are delegated to voluntary organisation(s). The phased approach has been adopted as a method of mitigating risk is areas such as current contracts held, uncertainty regarding demand and timescales for the demand. • Further areas may be considered in due course however they will not be considered and implemented prior to April 2015. There is no requirement for such delegations to be in place prior to April 2015 (delegations are all optional), therefore SCC will remain compliant with the Care Act.		**Amber**
	Appeals	For the first time, there will be a process through which appeals may be made against decisions taken by a local authority in terms of eligibility and funding. There will be an element of independence from the local authority.	• SCC already provides an appeals process for those who fit an appeals criteria. This process will be developed and updated alongside legal advice to align with the new Care Act requirements. • The Legal workstream has been asked to consider the implications of this requirement – this may not be possible until the final form of regulations and guidance is available	Delays in national regulations and guidance will mean that timescales will be shorter than anticipated and work will have to be carefully prioritised.	**Amber**

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Option Appraisal for Proportionate Assessments.

This paper outlines possible options for future delivery of Adult Social Care assessments under the Care Act 2014 ("the Act") which is being considered by Southampton City Council Officers.

Background/Current Situation

The Act is a significant piece of legislation, which bring the complex web of adult social care law into a single statute. It aims to transform both the social care system and its funding. The Act comes into force in April 2015 however a number of funding reforms come into force in April 2016.

Under Section 9 of the Act the Local Authority must carry out an assessment of an adult if it appears they have needs for care and support and identify what these needs are.

Under the Act's statutory guidance and the Regulations it confirms that any assessment must be carried out in an appropriate and proportionate manner to the needs and circumstances of the individual and ensure that the individual is able to participate in the process and the LA must take into account the wishes and preferences of the individual, the outcome they seek and the severity and overall extent of the individual's needs.

Although the Act places a statutory duty on the LA to carry out these assessment it is in the discretion of the LA as to how it meets this duty depending on the individual circumstances so long as the LA takes into account the Act, Guidance and Regulations and also has due regard to certain key principles which are:

- The principle of well-being. Any decision that the local authority makes must now promote an adult's wellbeing.
- Preventative services must be provided to prevent, delay and reduce the development of care and support needs.
- Integration must be focused upon to ensure that any Local Authority integrate with Health Services; particularly where the integration promotes wellbeing, prevents or delays the development of need and improves the quality of support.
- Providing adults with choice over the support they receive. Different providers must be available to provide choice, quality, diversity and sustainability over the support that is provided. The choice available should be shaped by the demands of individuals, families and carers.

The statutory guidance makes it clear that the assessment may be carried out in a variety of different formats but the LA must not limit the formats as it must be appropriate and proportionate the individual.

Options

Option 1

To not provide any proportionate assessments (the only assessment being offered would therefore be face to face).

Positives

- Staff training would be simpler as only one requirement needs to be understood.
- Less development for IT systems such as PARIS as only one form need be developed.

Negatives

- The act requires all assessments to be 'appropriate and proportionate'; should we not provide proportionate assessments SCC will not be compliant with legislation in April 2015 and the Council could face a legal challenge.
- Should all assessments provided be carried out in the most in-depth detail unnecessary resources (staff capacity and money) will needlessly be used up.
- Full assessments may polarise adults in need of care and support if we force them to forgo an entire assessment and don't tailor to meet their needs.

Issues

- As a requirement of the Care Act is to provide proportionate assessments, following this option would result in non-compliance with the Act.

Option 2

To provide proportionate assessments via means of phone in addition face to face assessments currently provided.

Positives

- This provision would link to current staff's skill sets and aligns with SCC's current provision.
- Some adults may prefer this format of assessment.
- Provision to provide assessments via phone are a cheaper alternative to face to face assessments.
- Phone assessments have the ability to be flexible to an individual's needs.

Negatives

- While the Care Act supports phone assessments, it suggest that assessments should not be limited to this format
- Certain types of assessments (e.g. phone assessments) may pose risks for certain groups of adults. This may mean the assessment risk not fully exploring all the needs of an individual. A higher degree of training would be required to implement this method of assessment.
- Some people may not believe that phone assessments are an appropriate form of assessment.
- If the LA limit the assessment to only this format it is likely the Council could face a legal challenge as it would not be in the spirit of the Act.

Issues

- Careful training is required to understand underlying conditions/requirement that may need care and support but do not appear obvious during a phone assessment.

Option 3

To provide proportionate assessments via means of online assessments in addition face to face assessments currently provided.

Positives

- This provision would provide another alternative format of assessment that may be preferred by some adults.
- Online assessment would help streamline resources as by its nature as it is a screening process.
- Staff resource for carrying out the assessment is low/not required. (Note: the follow up from the online screening/assessment requires more staff resource).

Negatives

- This provision may provide an alternative format of assessment which some adults may not believe is appropriate. Additionally a large percentage of the adults with whom we work may not be computer literate and will find an online system difficult to use.
- While the Care Act supports on-line assessments, it suggest that assessments should not be limited to this format
- Some individuals may find that due to the difficulty they face with online assessments they require help and assistance in filling the form. Consideration must be given to resource implication of those who may not have an appropriate individual to help with the task.
- A robust and secure IT system is required to allow assessments to be undertaken and stored safely.
- Online assessments do not provide the flexibility that other forms of assessments provide.

Issues

- The reliability and security of an online provision needs to be given careful consideration. The method of how information is used to inform future care and support also needs careful consideration.

Option 4

Provide proportionate assessments via a combination of online, telephone and face to face assessments.

It should be noted that the provision of these assessments are not intended to be a hierarchy where adults are expected to progress from one assessment to another, but that each point of entry will be able to highlight the level of need and appropriate actions taken from whatever the finding of the assessment is.

Positives

- The combination of assessments will mean that a higher proportion of adults will be able to undergo an assessment which meets their needs to the highest degree.

- This approach is supportive of the customer pathway desired by Adult Social Care at Southampton City Council. The outcome is a streamlined process which reduced wastage of staff resource and time.
- Assessments which can be described as 'resource heavy' are able to only be used and provided in suitable situations.
- The Statutory guidance suggests all assessments must be appropriate and proportionate and so a number of different formats should be available depending on the needs of the individual.

Negatives

- Communication regarding the types of assessments which are available needs careful management. We must be clear that individuals need not undergo a number of assessments and hierarchy of assessments does not exist.
- Recording of different types of assessments needs consideration. Should different PARIS forms be required this would create further work for other teams.
- To enable all types of assessment to be carried out successfully, a higher degree of staff training would be required. This needs to be built into the training schedule.

Recommendations

In conclusion, it is recommended that SCC pursue the fourth and final option provided by this option appraisal. The recommended option is therefore that SCC: **Provide proportionate assessments via a combination of online, telephone and face to face assessments.** This means that the current approach within Adult Social Care can be maintained. Furthermore this approach meets the statutory requirement within the Act. A number of considerations have been made as to how to mitigate risk and negative drawbacks which are raised through this option appraisal. The most significant drawback of implementing this approach would be the requirement for more in-depth training as a variety of different assessment skills would need to be covered in training for staff. However as this approach is already being implemented within Adult Social Care, training packages have already been considered and the majority of staff within Adult Social Care will already have the required skills to pursue this option.