Public Document Pack

HEALTH OVERVIEW AND SCRUTINY PANEL

Wednesday, 18th January, 2017
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 and 4 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor P Baillie
Councillor Houghton
Councillor Mintoff
Councillor Noon
Councillor Savage
Councillor White

Contacts

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Democratic Support Officer
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Scrutiny Manager
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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six 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 Health 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 and 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.

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. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council’s Guidance on the recording of meetings is available on the Council’s website.

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.

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 2016/2017

2016	2017
30 June	18 January
25 August	23 February
27 October	27 April
22 December	

AGENDA

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)

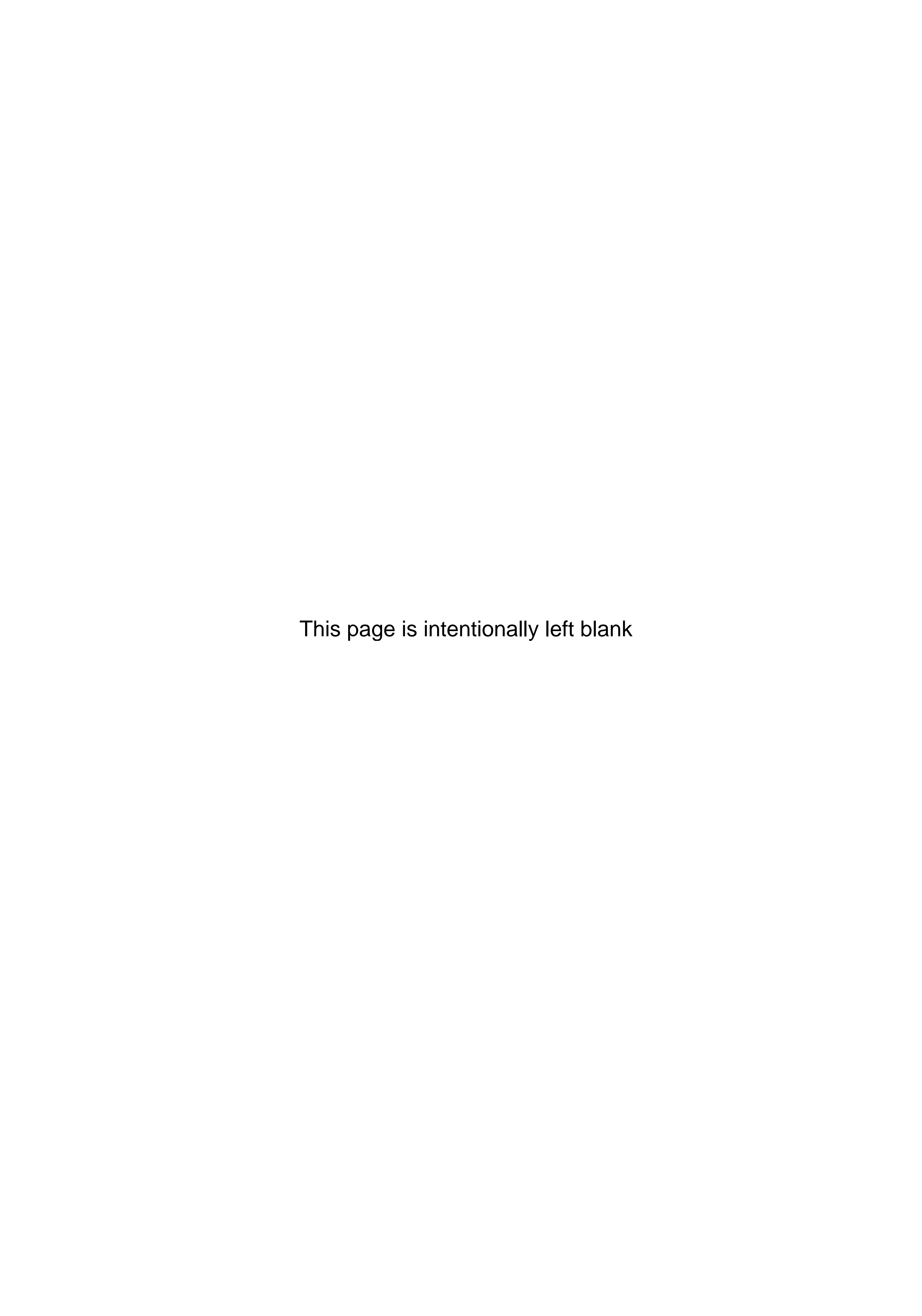
To approve and sign as a correct record the minutes of the meeting held on 19 December 2016 and to deal with any matters arising, attached.

7 HEALTH AND CARE BUDGET PROPOSALS - 2017/2018

(Pages 5 - 120)

Report of the Chair of the Health Overview and Scrutiny Panel detailing the health and care proposal for the 2017-2018 municipal year, for discussion.

Tuesday, 10 January 2017 SERVICE DIRECTOR, LEGAL AND GOVERNANCE



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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 19 DECEMBER 2016

Present: Councillors Bogle (Chair), P Baillie, Houghton, Mintoff, Noon, Savage and White

Also In Attendance Councillor Shields - Cabinet Member for Health and Sustainable Living

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

RESOLVED: that the minutes for the Panel meeting on 27 October 2016 be approved and signed as a correct record.

14. **HAMPSHIRE AND ISLE OF WIGHT SUSTAINABILITY AND TRANSFORMATION PLAN: DELIVERY PLAN**

The Panel considered a report detailing the delivery plan for the Hampshire and the Isle of Wight (HIOW) Sustainability and Transformation Plan (STP) that was submitted to NHS England and NHS Improvement for consideration.

Richard Samuel (Chief Officer of the Fareham and Gosport Clinical Commissioning Group (CCG) and lead on the development of the Sustainable Transformation Plan), John Richards (Chief Executive Officer, NHS Southampton City CCG) and Councillor Shields (Cabinet Member for Health and Sustainable Living) Jane Freeland (Southampton Keep Our NHS Public) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters and concerns including:

- the range and scope of the plan;
    - it was noted that the Plan was a for a period of five years and had been brought together with all of the partners within the local health system. The Plan would build upon best practice developed across the area such as Better Care Southampton.
- the developing consultation process;
    - it was recognised that as the plan was still being developed and that there would be a need for consultation with a range of groups and organisations such as health and wellbeing boards and local healthwatch groups.
- the decision making process;
    - in response to questions it was noted that there were no formal decision making powers being assigned to one body in the development of Sustainable Transformation Plan. It was noted that the aims and goals of the Plan were being developed in dialogue with the stakeholders and that each of the individual organisations. It was noted that each of the organisations involved had been asked to develop their own local operating plan that would feed into the aims and goals of the Plan as a whole.

- the flexibility of the Plan to cope with future demands on the local health system;
    - it was noted that the Plan was aimed to alleviate pressures that were growing both nationally and locally within the health system. However, it was acknowledged that there were considerable demands on both the recruitment of staff and in relation to the demands on adult social care.

RESOLVED that the Panel noted the challenges and aspirations of the Sustainable Transformation Plan set out in the report and would continue review and monitor the development of the Plan.

15. **SOLENT NHS TRUST CQC REPORT**

The Panel considered the report of Chief Executive – Solent NHS Trust providing a summary of the key findings from the inspection and outlines the approach the Trust will follow to address the issues raised in the Care Quality Commission reports.

Mandy Rayani (Chief Nurse) and Alex Whitfield (Chief Operating Officer) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters and concerns including:

- that the Trust had been rated as requiring improvement by the Care Quality Commission (CQC);
    - it was noted that the CQC report had indicated that there were areas of the Trust, including some of the services in Southampton, that had been rated as outstanding. That the result was an overall judgement of the Trust. It was also noted that action had commenced to address the concerns raised by the CQC following the inspection.
- why some services in the Portsmouth area had outperformed the same services in the Southampton area;
    - It was noted that the management of the children and adolescent mental health services (CAMHS) had been structured in different ways and that this led to information being recorded differently. It was explained that steps had been implemented to resolve this including the redesign of various templates to more clearly indicate that the required information had been considered and recorded. In addition it was noted that the Trust had also reviewed its staff structure within this area in order to ensure consistency of care.
- concern was raised that the Trust was not learning from serious incidents;
    - assurance was given by the Trust that the CQC had found no issues in the Trust's ability to learn from serious incident or its leadership.

RESOLVED that the Panel noted the report and would continue to monitor the performance of the Trust and that the item would return at a future meeting.

16. **MENTAL HEALTH MATTERS**

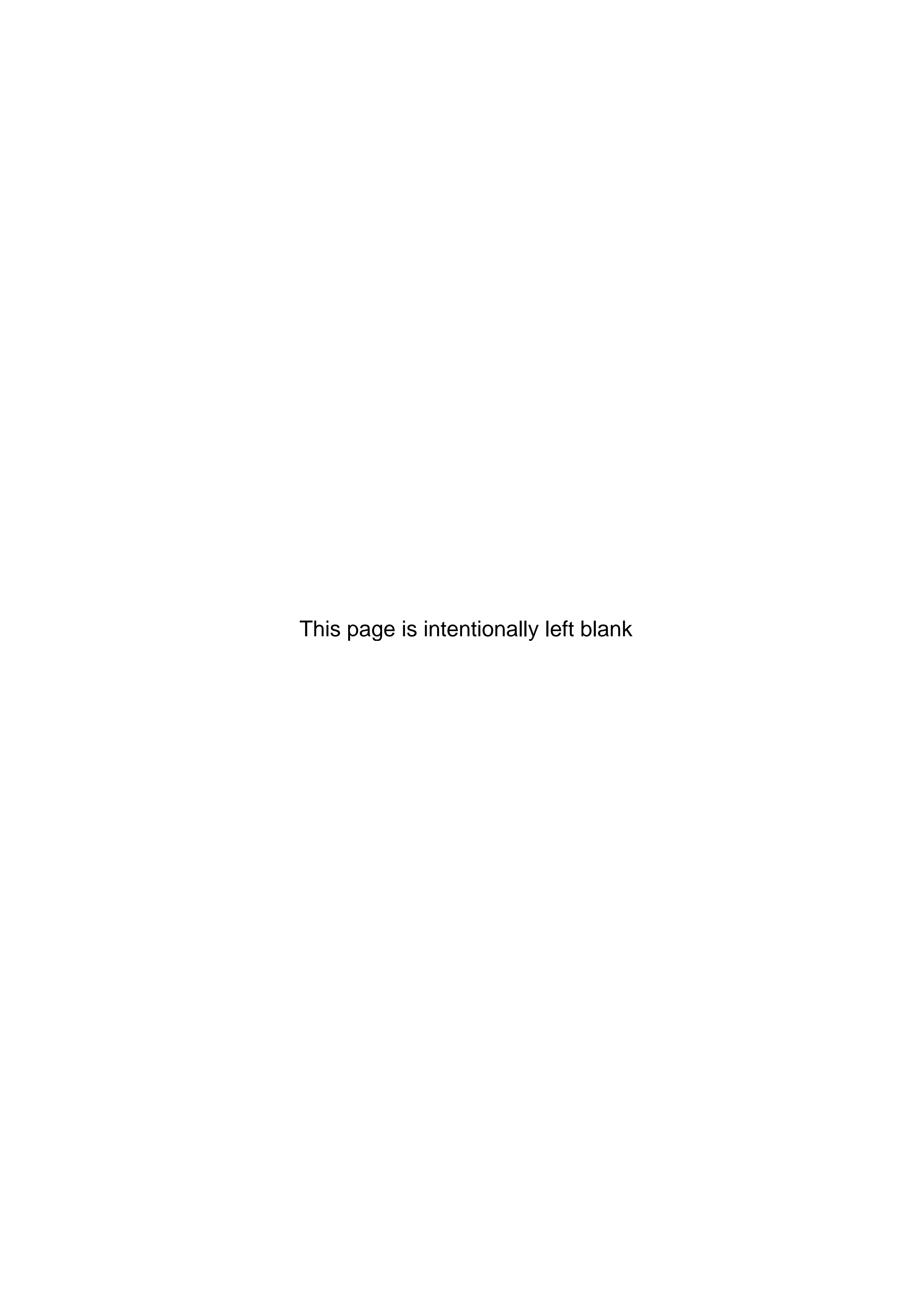
The Panel considered the report of Chief Executive – Solent NHS Trust providing a summary of the key findings from the inspection and outlines the approach the Trust will follow to address the issues raised in the Care Quality Commission reports.

Mandy Rayani (Chief Nurse) and Alex Whitfield (Chief Operating Officer) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters and concerns including:

- that the Trust had been rated as requiring improvement by the Care Quality Commission (CQC);
    - it was noted that the CQC report had indicated that there were areas of the Trust, including some of the services in Southampton, that had been rated as outstanding. That the result was an overall judgement of the Trust. It was also noted that action had commenced to address the concerns raised by the CQC following the inspection.
- why some services in the Portsmouth area had outperformed the same services in the Southampton area;
    - It was noted that the management of the children and adolescent mental health services (CAMHS) had been structured in different ways and that this led to information being recorded differently. It was explained that steps had been implemented to resolve this including the redesign of various templates to more clearly indicate that the required information had been considered and recorded. In addition it was noted that the Trust had also reviewed its staff structure within this area in order to ensure consistency of care.
- concern was raised that the Trust was not learning from serious incidents;
    - assurance was given by the Trust that the CQC had found no issues in the Trust's ability to learn from serious incident or its leadership.

RESOLVED that the Panel noted the report and would continue to monitor the performance of the Trust and that the item would return at a future meeting.



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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		HEALTH AND CARE BUDGET PROPOSALS - 2017/18		
DATE OF DECISION:		18 JANUARY 2017		
REPORT OF:		CHAIR OF THE HEALTH OVERVIEW AND SCRUTINY PANEL		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

None.

BRIEF SUMMARY

At the 15 November 2016 meeting Cabinet approved the Executive's General Fund Revenue Account 2017/18 to 2020/21 budget proposals for consultation. The Cabinet report includes a number of proposals that have implications for Adult Social Care, Public Health and Commissioning.

In addition to the relevant City Council's budget proposals, attached for information is the draft NHS Southampton CCG Two Year Operational Plan that is subject to approval by the CCG Board on 25th January 2017.

The Panel are requested to consider the attached budget proposals, reflecting upon the draft CCG Plan and wider pressures on the health and care system, with the Cabinet Member for Health and Sustainable Living, and invited officers, and, if the Panel agree, formally respond to the budget proposals.

RECOMMENDATIONS:

	(i)	That, within the context of the Hampshire and Isle of Wight Sustainability and Transformation Plan (H&IOW STP), the attached draft NHS Southampton CCG Two Year Operational Plan and the attached 2017/18 budget proposals relating to the Council Priority - 'People in Southampton lead safe, healthy and independent lives', the Panel discuss with the invited attendees the potential impact of the financial proposals under consideration by the Southampton health and care system on the health and wellbeing of Southampton residents.
	(ii)	That the Panel discuss the appended 2017/18 budget proposals relating to the 'People in Southampton lead safe, healthy and independent lives' Council priority and, if agreed by the Panel, formally responds to the Council's budget consultation process.

REASONS FOR REPORT RECOMMENDATIONS

1.	To enable the Panel to consider the Council's budget proposals relating to the 'People in Southampton lead safe, healthy and independent lives' priority within the context of the pressures on the wider health and care system in Southampton.

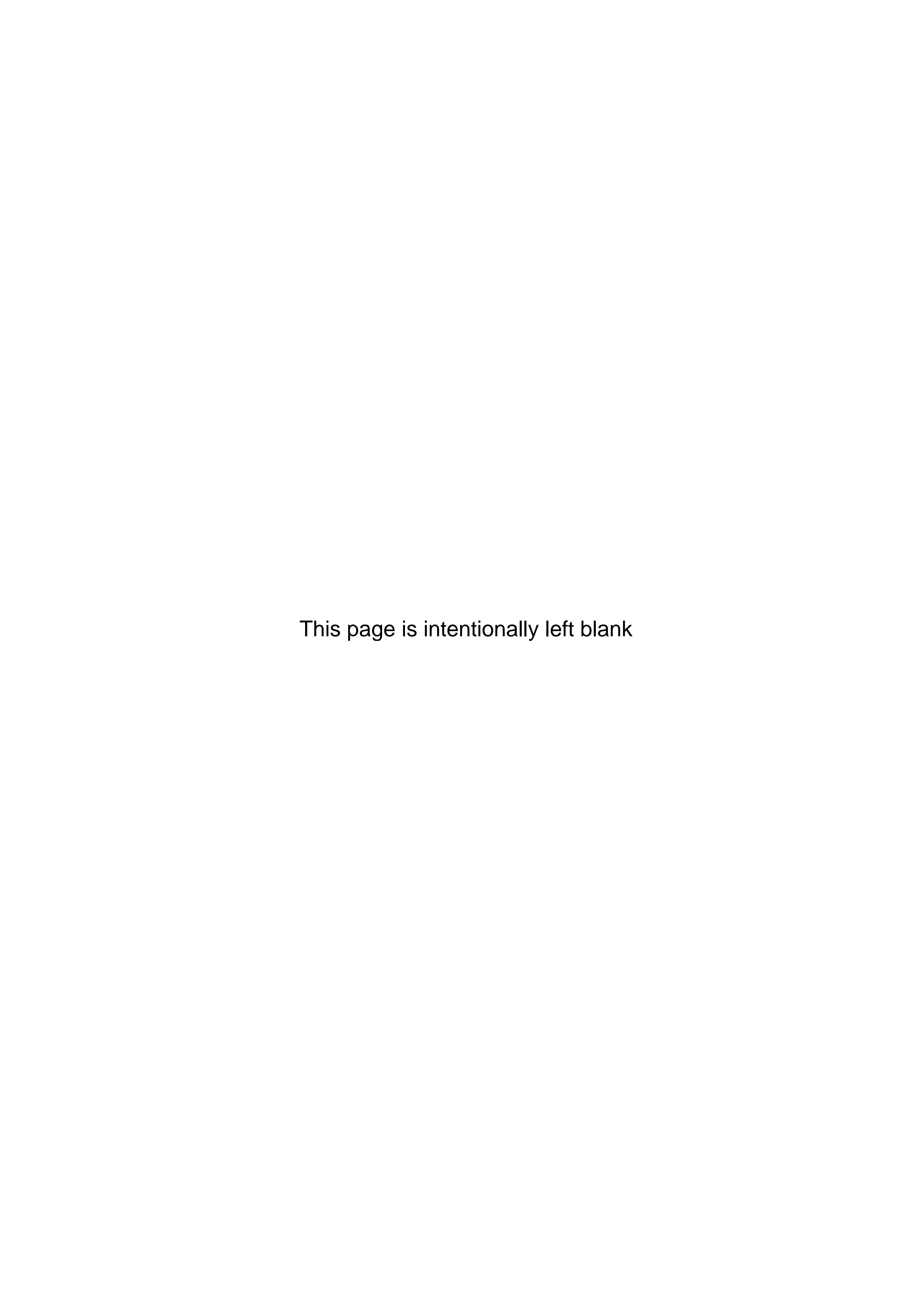
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None.
DETAIL (Including consultation carried out)	
3.	Cabinet, at their meeting on 15th November 2016, approved the Executive's General Fund Revenue Account 2017/18 to 2020/21 budget proposals for consultation. The period of consultation will continue until the final decision is made by Cabinet on 15th February 2017.
4.	The Cabinet report includes a number of proposals that have budgetary implications for Adult Social Care, Public Health and Commissioning. The Chair of the HOSP has requested that the proposals, attached as Appendix 1, are considered by the Panel.
5.	To enable an informed discussion that reflects the context within which the City Council's budget proposals relating to health and adult care are being taken, the published Budget Information Sheets and Equality and Safety Impact Assessments (ESIAs) are attached as Appendices 2 to 11, and the draft NHS Southampton CCG Two Year Operational Plan is attached as Appendix 12. This draft report translates the H&IOW STP into practical action within the city and outlines key actions to be taken and the CCG's financial pressures. The Operational Plan is scheduled to be discussed at the CCG Board meeting on 25th January 2017.
6.	The Panel are requested to consider and discuss the proposals and the information contained within the appendices with the Cabinet Member for Health and Sustainable Living and invited officers from Adult Social Care, Public Health, the Integrated Commissioning Unit and NHS Southampton CCG. The Panel may opt to submit a formal response to the budget consultation with regards to these proposals.
RESOURCE IMPLICATIONS	
Capital/Revenue	
7.	The 15th November 2016 Cabinet report identifies savings proposals under the 'People in Southampton lead safe, healthy and independent lives' council priority totalling £6.213m in 2017/18, rising to £9.731m in 2020/21. The capital and revenue implications of the budget proposals are fully detailed within the Cabinet report.
Property/Other	
8.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
9.	The legal implications of the budget proposals are fully detailed within the 15th November 2016 Cabinet report.
Other Legal Implications:	
10.	None.
POLICY FRAMEWORK IMPLICATIONS	
11.	The Medium Term Financial Strategy and the Budget are key parts of the

	Policy Framework of the Council.
KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All wards

SUPPORTING DOCUMENTATION	
Appendices	
1.	Budget Proposals – People in Southampton live safe, healthy, independent lives
2.	Information Sheet – Adult Social Care
3.	Information Sheet – Public Health and Commissioning
4.	ESIA – Public Health Grant
5.	ESIA – SHIL 1
6.	ESIA – SHIL 2
7.	ESIA – SHIL 4(i)
8.	ESIA – SHIL 4(ii)
9.	ESIA – SHIL 8 (i)
10.	ESIA – SHIL 9
11.	ESIA – SHIL 10
12.	Draft - NHS Southampton CCG Two Year Operational Plan
Documents In Members' Rooms	
1.	None

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	Yes
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No

Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None.	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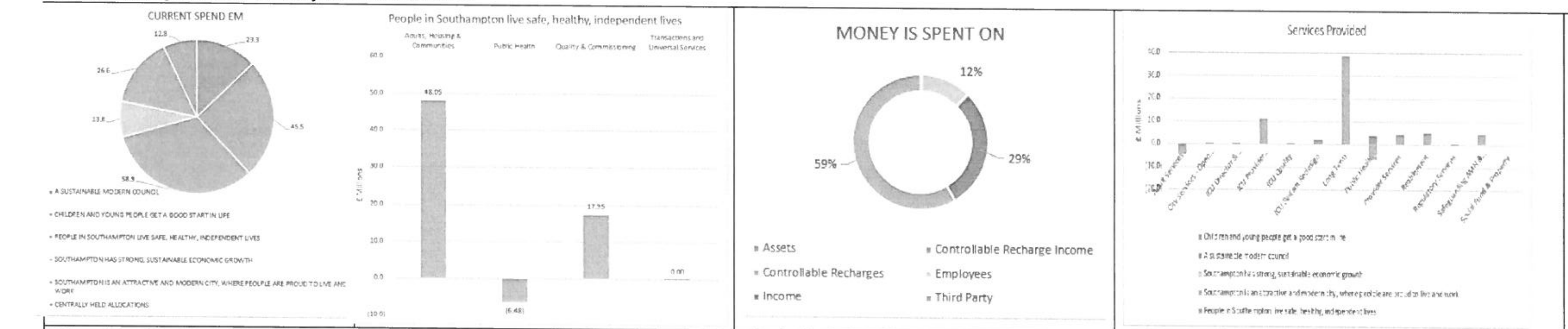
People in Southampton live safe, healthy, independent lives

Our Goal	We want Southampton to be a city that is recognised for its approach to preventing problems and intervening early. We want our residents to have the information and support they need to live safe, active, healthy lives and to be able to live independently for longer.

How do we spend our money at the moment?



Budget Envelope (£M)	
2016/17	58.9
2017/18	53.9
2018/19	50.6
2019/20	46.0
2020/21	46.0

This represents a reduction of **22%** over the four year period of the Medium Term Financial Straategy.

What do we know?

- By 2022 the city population in the city is expected to grow by nearly 5% and the population of those over the age of 65 are expected to grow by 12%.
- 20% of the population are Black and Minority Ethnic, with a further 13% of residents being white non-British.
- There are around 98,000 households in the city, with 51% owner occupiers and 25% living in privately rented homes.
- There are around 7,000 Houses in Multiple Occupancy (HMOs) in the city.
- We support around 3,000 adults with care needs.
- We have around 17,000 tenants and leaseholders, equating to about 65,000 individuals.
- We currently own 18 community buildings, including community centres.
- Life expectancy in the city is 83.1 years for women and 78.2 years for men – lower than the national average for men.
- Since 2012, the potential years of life lost due to premature mortality has fallen from 496.8 to 484.6 (2012-14).
- Mortality rates are generally falling in Southampton. However, although people are living longer, it is often with long term conditions and an extended period of poor health/disability.
- Between 2008/9 and 2012/13, Southampton has become relatively more deprived – of the 326 Local Authorities in England, Southampton is now ranked 54th (previously 72nd) most deprived.

What do we do well?

- The Council and Health have:
  - successfully implemented plans to offer integrated health and social care services through Better Care Southampton, pooling £60M of health and care budgets to deliver key outcomes.
  - integrated rehab and reablement services into an Integrated Community Independence Service, to help people retain or maintain their independence in their own homes.
- The Approved Mental Health Professional (AMHP) team has improved quality and reduced costs of the service.
- Since 2011 the council has delivered 1,475 new affordable and sustainable homes, including 73 properties designed specifically for wheelchair users.
- We have delivered improvements to reduce the impact of fuel poverty and increase energy efficiency to over 2,000 Council-owned homes since 2013.
- We have delivered new 'housing with care' properties at Erskine Court and Weston Court.
- We have delivered over 5,600 adaptations to homes since 2011.
- The Emergency Planning Team have been recognised nationally for their work integrating flood management and Public Health emergency planning into their work, making the city safe and more prepared.
- The 'In Case of Emergency' (ICE) bus provides a safe haven for people in need of help at on a night out – it was operational for 51 nights over 2015/16 and dealt with 244 clients.

What feedback do we have?

Customer feedback: According to the City Survey 2016:

- 74% of Southampton residents consider themselves in good health, compared to the national average of 81%
- 91% of residents feel safe in their local area during the day and 3% feel unsafe, while 62% feel safe and 22% feel unsafe after dark.
- 69% of residents feel they have a say in decisions that affect their own healthcare.

In the 2015 Priorities Survey the highest ranked outcome (out of 14) was 'People in Southampton are safe and protected from harm'. In the same survey, residents also ranked 'providing help and support services for older and disabled people was fifth highest.

In the Tenants Survey in 2014, 64% of council housing tenants were satisfied with the service provided to them by Southampton City Council.

Horizon Scanning

Regional

- If approved, Devolution/Solent Mayoral Combined Authority will provide an opportunity to jointly deliver services and develop regional solutions.
- Sustainability and Transformation Plan (STP) – work is underway on the Hampshire and Isle of Wight NHS 5 year plan.

National

- Department of Health/Social Care Institute for Excellent (SCIE) – Integration 2020: a local plan needs to be in place by 2017.
- 'Pay to Stay', Welfare Benefit Changes (e.g. Universal Credit changes), the Benefit Cap, Flexible Tenancies
- Joint Inspection fpucsing on domestic abuse

Local

- Development of a city Alcohol Strategy
- Unified approach to the council's investment in the voluntary sector

Our Challenges

External

- Increasing number of older people and changes in the population profile leading to increased demand on services.
- Increase in people living with multiple long term conditions.
- Poor air quality – Southampton was identified as exceeding annual limits for NO_2 levels in 2013 and modelling suggests that this exceedance could persist beyond 2020.
- Community tensions across have risen across the UK in recent months, Black and Minority Ethnic and European communities have expressed concerns about hate crime following the decision to leave the EU.

Partnership/citywide

- Higher than national average levels of obesity, smoking and binge drinking.
- Domestic Violence and Abuse: second highest Multi Agency Risk Assessment Conference (MARAC) referral rate amongst comparator areas and over twice the national average.
- Developing capacity in the home care market.
- Over 9,000 households in the city were identified as living in fuel poverty in 2012.
- Over 8,000 households are on the Council's Housing Register.
- 25% of Southampton residents live in privately rented accommodation – higher than the average for comparator cities at 18.2% and the England average of 17%.

Council

- Backlog of cases Adult Social Care assessments needing review.
- Low percentage take-up of direct payments.
- 7.98% of the Council's housing stock is 'non decent' as a result of the aging profile of stock and the deteriorating condition of components.

Addressing the Challenges: We are

- Improving joint commissioning across health and Council services, with a focus on safety, quality, and prevention and early internation.
- Taking action to manage and develop the market for provision of residential and domicilliary care to meet demand the match the needs of our residents.
- Supporting local communities to look after their neighbourhoods and become more resilient, helping to reduce demand and make services more sustainable.
- Increasing independence, moving away from residential and replacement care to 'housing with care'.
- Making best use of care technology including increasing the number of telecare users and making use of emerging technology options that can help support people to stay independent in their own homes.
- Developing a new Clean Air Strategy and implementing a Clean Air Zone (CAZ).
- Working with Portsmouth City Council through a shared Director of Public Health (DPH) deliver joined up approaches across the two cities.
- We are working with with community, voluntary and faith organisations on community asset transfer resulting in sustainable community managed assets.

KEY MEASURE BY PRIORITY	Performance Bench - mark (2015/ 16)	2011/12	2012/13	2013/14	2014/15	2015/16	Targets 2016/17	2017/18	2018/19	2019/20
We will increase the proportion of social care service users receiving direct payments, so that service users have more choice and control										
People using social care who receive direct payments	22.6%				17.2%	18.2%	22.6%	27.1%	32.5%	39.0%
We will improve housing quality and reduce fuel poverty										
% local Council housing stock that is decent	93.6%	97.0%	94.9%	93.5%	92.4%	92.0%	93.0%	94.0%	95.0%	97.0%
No of households in receipt of ECO measures (per 1,000 households)	53		18	41	53	62				
We will improve air quality										
Recorded levels of nitrogen dioxide in the city's Air Quality Management Areas (ug/m3)			39.1	41.6	39.5	35.5	35.1	34.9	34.8	34.7
We will protect vulnerable people and enable more people to live independently										
Number of 'extra care' homes built to provide housing for people with support needs			32	28	0	0	50	50	50	50
No of Social Care service users receiving an element of technology enabled services as part of their care package						0	1220	1272	1306	1330

HOW ARE WE PERFORMING 2015/16 base	HOW WILL WE PERFORM in 2019/20
18.2%	39.0%
92%	97%
62	
35.5	34.7
0	50
0	1330

PEOPLE IN SOUTHAMPTON LEAD SAFE, HEALTHY, INDEPENDENT LIVES

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000
Base Estimate 2016/17	58,930.2	58,930.2	58,930.2	58,930.2
Previously Agreed Savings & Pressures	1,467.0	1,242.0	(1,498.0)	(1,498.0)
New Pressures				
Non Achievement of Adult Social Care Approved Savings Proposals	800.0	800.0	800.0	800.0
Identified Budget Savings Proposals				
Further Procurement Savings	0.0	0.0	0.0	0.0
Further Digital Savings	0.0	(313.0)	(313.0)	(313.0)
Business As Usual Savings	(1,091.0)	(1,523.0)	(2,193.0)	(2,193.0)
Service Delivery and Redesign Proposals	(6,213.4)	(8,522.4)	(9,731.4)	(9,731.4)
Current Budget Requirement Based on existing proposals	**53,892.8**	**50,613.8**	**45,994.8**	**45,994.8**

	Service Delivery and Redesign Proposals	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000
	Adult Social Care				
1	Manage demand by offering alternatives to home care for new clients by providing advice and information, supporting self management and signposting to partner services	(270.0)	(400.0)	(540.0)	(540.0)
2	Changing the way that adult social work teams operate to ensure that the right processes are in place to assess people for the right care, in the right place, at the right time and making full use of community support, telecare and extra care housing to help people live independently.	(3,054.0)	(3,129.0)	(3,629.0)	(3,629.0)
3	Using less residential care and more extra care housing supporting people to be discharged home from hospital wherever possible before a decision about their long term care and support arrangements are made.	(300.0)	(700.0)	(1,420.0)	(1,420.0)
4	Increase benefits from integration of council and health learning disability teams; removing a subsidy from people who can afford to pay for their own care following a means test and a review of mental health services	(500.0)	(500.0)	(500.0)	(500.0)
5	Joint Prevention Service with Hampshire Fire & Rescue Service	0.0	(50.0)	(50.0)	(50.0)

6	Integration and development of community health and social care clusters. Developing local teams to reduce hospital admissions and reduce packages of care for clients with complex and multiple needs.	(200.0)	(500.0)	(1,250.0)	(1,250.0)
7	Integrate adults and housing services to maintain independent living for longer in supported housing	(780.0)	(1,560.0)	(780.0)	(780.0)
	Quality & Commissioning				
8	Cease appropriate adult scheme and Positive Lives HIV/AIDS contract, and reduce alcohol specialist nurse service	(131.0)	(184.0)	(184.0)	(184.0)
9	Increase employment, skills, volunteering and other opportunities which promote and maintain independence as an alternative to day services	(400.0)	(1,000.0)	(1,000.0)	(1,000.0)
10	Review substance misuse provision (see also Public Health Grant Reduction Appendix 5) total saving £734k	(368.4)	(368.4)	(368.4)	(368.4)
	Public Health				
11	Transfer responsibility for funding health services to the NHS	(200.0)	(121.0)	0.0	0.0
12	Cease contribution to Hepatology nurse	(10.0)	(10.0)	(10.0)	(10.0)
	Total Service Delivery & Redesign Proposals	**(6,213.4)**	**(8,522.4)**	**(9,731.4)**	**(9,731.4)**

People in Southampton lead safe, healthy, independent lives

Adult Social Care

SOUTHAMPTON CITY COUNCIL

What does this information sheet cover?

One of the Council's four priority outcomes is 'People in Southampton lead safe, healthy, independent lives'. In developing our Medium Term Financial Strategy and to close our budget gap, we have reviewed all our services and considered what changes we can make in order to deliver our priority outcomes within the resources we have available. Under this outcome, we have grouped our proposals into two areas: this information sheet covers proposals about Adult Social Care; a separate one explains our proposals for Public Health and Commissioning.

The Council provides a range of services for adults with long and short term care and support needs. This includes services for adults with learning disabilities, physical disabilities, sensory impairments, mental health issues, older people, vulnerable adults who are, or may be, at risk of abuse, and carers for residents in any of these groups. In Southampton, the care and support provided to over 3,000 adults is funded by the Council, and many more are supported in other ways by Adult Social Care services.

The population of the city is growing and it is expected to increase by nearly 5% by 2022 to 259,615 and by 12.1% for the over 65s. People are generally living longer, but it is often with long term conditions and an extended period of poor health/disability. This means that demand for health and social care services is increasing, at a time when funding is reducing. We are committed to working together with local people, communities, the NHS and the voluntary sector to improve people's wellbeing, and want to make sure that services are delivered as efficiently as possible, and targeted towards those people who need the most help.

£ Budget envelope (£m)

2016/17	58.9
2017/18	53.9
2018/19	50.6
2019/20	46.0
2020/21	46.0

This represents a reduction of **22%** over 4 years.

Resident feedback

In the 2015 Priorities Survey, residents rated 'People in Southampton are safe and protected from harm' as the most important outcome, of a total of 14 outcomes. 50% of respondents rated this outcome 'Very important', and 40% as 'Important'. In addition, 'providing help and support services for older and disabled people' was rated as the sixth most important Council service (out of 21) in the same survey. Given the importance of these services to our residents, our focus in developing budget proposals has been to ensure we make the best use of our resources, and work closely with our partners, so we can provide support to everyone who really needs a service.

Budget proposals for 2017-18

This year, the Council has taken a different approach to budget planning. We have focused on the most important outcomes we want to achieve, and for the first time we have developed plans for the next four years rather than just one year. Under each outcome, we then identified proposals to reduce costs in the following areas:

- Business as usual – being more efficient in how we manage and deliver our services on a day-to-day basis
- Digital savings – changing and improving how we deliver services, making better use of online channels
- Service delivery changes – redesigning, sharing, stopping, reducing or changing services.

Under the outcome of 'People in Southampton lead safe, healthy, independent lives', we are proposing the following savings:

	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000
Further Digital Savings	0.0	(313.0)	(313.0)	(313.0)
Business As Usual Savings	(1,091.0)	(1,523.0)	(2,193.0)	(2,193.0)
Service Delivery and Redesign Proposals	(6,213.4)	(8,522.4)	(9,731.4)	(9,731.4)

Service delivery and redesign proposals

Reducing costs by providing better information, guidance and signposting

We are proposing to reduce the cost to the Council, in particular for home care, by providing comprehensive information, guidance and signposting. We want to help more people to help themselves, or access alternative services when they approach the Council with an Adult Social Care enquiry. We will do this by:

- Making sure good quality information and online self-assessment is available via a single point of access so people (or their families, carers or friends) can identify what support is available, what it might cost and whether or not they need any further help to plan their support.
- Ensuring experienced staff are available at the single point of access, to help people who feel they need to make direct contact, and signpost them to the most appropriate means of meeting their needs.
- Putting proactive, preventative measures in place at this early stage, to support people to be independent for longer and prevent or delay the point at which they need further involvement with Adult Social Care services.

For those people whose needs cannot be met through the provision of information, advice and signposting, staff in the single point of access will work with them to establish eligibility, develop a plan to meet their immediate needs and manage any risk, and refer them to the reablement service, where appropriate. Where this occurs the Care Assessment will be paused whilst the person accesses reablement or other services. The Council will complete the assessment once the provision of the service has been completed.

In cases where it is not appropriate to refer to reablement or other beneficial activities, a referral will be made to the Adult Social Care service to carry out a care assessment. In cases where people require ongoing care, direct payments will be the first option considered, so that the person is able to choose the right care in the right place for them.

Changing the way adult social care teams operate

We need to make sure that individuals have the right level of care, in the right place, at the right time – and that this is provided in a way that helps them stay as independent as possible for as long as possible in their own homes. We will do this by:

- Implementing the new Adult Social Care policy which we consulted on in summer 2016. This sets out how we will deliver our responsibilities, including in terms of establishing eligibility, undertaking assessments, care and support planning, allocating funds and meeting eligible unmet needs, and will ensure there is a fair and consistent approach to care and support planning.
- Ensuring individuals receive more regular and timely reviews of their social care needs.
- Giving more people Direct Payments, instead of the Council arranging care on their behalf, so that they have more choice and control over how their needs are met.
- Supporting people to move into ‘housing with care’ (‘extra care housing’), instead of residential care homes.
- Making more use of care technology, in particular where people are at risk of falling, wandering, seizures, immobilisation, extreme temperatures, smoke in the home or feelings of insecurity. This can help maintain independence by reducing the need for home care, residential care or a nursing home.
- Where appropriate, helping people to get support that they need from their family, neighbours and the wider community, reducing their reliance on support provided by the Council.

No changes will be made without thorough, person-centred assessments or reviews being undertaken, which will take into account the views and preferences of the person as well as their families, carers and where appropriate their independent advocates.

Developing more housing with care schemes and changes to hospital discharge

We are proposing to develop additional ‘housing with care’ (‘extra care housing’) homes to provide housing for people with support needs. These schemes increase independence and choice, which results in less need for residential care; they are also more cost-effective. We also want to ensure that people are discharged home from hospital, with appropriate support, wherever possible before a decision about their long term care and support arrangements are made. This will mean that they do not have to stay in hospital longer than necessary, reducing costs to the Health Service. It will also mean we can make a more accurate assessment of their needs and put the right level of care in place.

Service delivery and redesign proposals continued

Reducing subsidies, reviewing mental health contracts and integrated learning disability teams

We are proposing to reduce subsidies for people who can afford to pay for their own care following a statutory means test, making sure that we can use the money we have to support those people who really need our help. This proposal will affect people receiving homecare services, who have over £23,250 in capital (money in bank accounts, building societies, premium bonds, shares and second properties). At the moment, these people are not charged an arrangement fee to cover the cost of the Council arranging their care. The proposal is, in future, to charge £632 in the first year and £520 in subsequent years to cover these costs. This was subject to a separate consultation which concluded in April 2016, and in which no significant issues or impacts were raised.

We are also proposing to review our Mental Health contracts. Currently, the Council works in partnership with Southern Health Foundation Trust to provide mental health care in Southampton. We are proposing to review this partnership and develop a new fit for purpose contract, to ensure the agreement continues to offer value for money and the best care possible for service users. There will be no interruption in care provision as a result of this change, and it is anticipated that services will improve.

We are also proposing to build on the work that has already been taken to join up health and social care Learning Disability teams, and develop a fully integrated service across the Council, Health (Southampton City Clinical Commissioning Group) and Southern Health Foundation Trust. This will deliver a targeted service offer that improves outcomes, delivers high quality and cost effective care and support, and enables people to maintain or regain their independence; it will also reduce duplication and therefore be more cost-effective.

Joint prevention service with Hampshire Fire and Rescue

Hampshire Fire and Rescue already undertake risk assessments in homes across the city. We are proposing to work with them to develop and extend this service, so that assessments cover a broader range of issues, and identify where people may benefit from some proactive, preventative support to prevent or delay their requirement for Adult Social Care services.

Redesigning current day time support services

We are proposing to redesign a number of currently commissioned services that provide day time support for older people, which are currently provided by external organisations. These contracts are coming to an end, and we are proposing to undertake a fundamental review. We want to ensure that there is a range of support available for older people, which helps individuals to maintain their independence. We propose to look at needs across the city, and develop recommendations about how we can better use our resources to meet those needs – for example increasing the use of direct payments so they have more choice and control over their care and support. Once more detailed proposals are developed, further consultation will be undertaken should this be required.

We are also proposing to increase employment, skills development, volunteering and other opportunities which promote and maintain independence as an alternative to day services for people with Learning Disabilities, as well as a small group of individuals with mental health and physical disabilities. This proposal covers day care provided by external providers, as well as Council services at Sembal House and Woolston Community centre. The intention is to review what is currently in place, and for external providers to focus support around individuals with more complex needs, while Council services focus their support on helping people into employment. Individuals will also be encouraged to consider direct payments as an alternative to day services so they are able to choose the right care in the right place for them.

Joining up community health and social care teams

We are proposing to continue to develop and expand community teams to make services more localised and able to respond to meet the needs of the local community. These teams will be made of health, social care, voluntary groups, housing, primary care and the community. By working together, the teams will be able to undertake more holistic planning for individuals, to make sure they have the right services in place and are supported to access community resources and activities as well as statutory Health and Social Care services. The aim is for each individual to have a 'lead professional' who will oversee all of their care and support so they receive a more joined up service and reduce duplication.

Service delivery and redesign proposals continued

Joining up adults and housing teams

We are proposing to reshape and integrate our adults and housing teams, to provide a more joined up service. This will mean we are able to consider how best to meet people's housing and social care needs, in ways that maximise their independence – for example, enabling people to move into (or stay in) Supported Housing with some additional support from housing staff, rather than having to move into 'housing with care' ('extra care housing').

Business as usual

We are proposing to make a number of efficiencies in the way that we manage and deliver our day to day services, for example by restructuring our workforce and making sure we recover the cost of providing training and other services to providers.

Potential impact of the proposals for this area

Residents

Some residents may see a change in the type or amount of care and support they receive, or the amount they need to contribute towards the cost of their care. All service users will continue to receive support that meets all of their eligible needs, and this will be delivered in the most effective and efficient way possible. Equality and Safety Impact Assessments (ESIAs) are available online for the proposals in this area, and further more detailed consultation will be undertaken where appropriate.

Staff

In order to make sure the Council is fit for the future and as efficient as possible, we will be restructuring our teams and services over the coming years. Staff will be consulted on proposals as they are developed in line with agreed Council processes.

Alternative options

In order to make sure that we continue to provide good quality services to residents, it is important that we identify efficiencies wherever possible. If we did not make these proposals, alternative options would be to reduce or stop delivering other front line services, increase fees or introduce charges for some services that are currently offered free to the user.

People in Southampton lead safe, healthy, independent lives

Public Health and Commissioning

What does the information sheet cover?

One of the Council's four priority outcomes is 'People in Southampton lead safe, healthy, independent lives'. In developing our Medium Term Financial Strategy and to close our budget gap, we have reviewed all our services and considered what changes we can make in order to deliver our priority outcomes within the resources we have available.

Under this outcome, we have grouped our proposals into two areas: this information sheet covers proposals about Public Health and Commissioning; the other information sheet covers our proposals for Adult Social Care.

The Council, working with our partners particularly in Health, supports, commissions and delivers a wide range of Public Health services in the city, with the aim of improving the health and wellbeing of all residents and reducing inequalities. Some of these services provide support to people with long-term illnesses, disabilities or specific conditions such as alcohol/drug abuse. Others focus on prevention and early intervention, and changing behaviours so that the risks of developing health problems later in life are reduced for our residents.

We are committed to working together with local people to improve their health and wellbeing, and want to make sure that services are delivered as efficiently as possible, and targeted towards those people who need the most help.

£ Budget envelope (£m)

Year	£m
2016/17	58.9
2017/18	53.9
2018/19	50.6
2019/20	46.0
2020/21	46.0

This represents a reduction of **22%** over 4 years.

Resident feedback

In the 2015 Priorities Survey, 'People in Southampton are safe and protected from harm' was the highest rated priority outcome. 'People in Southampton live active, healthy lives for as long as possible' was the eighth highest outcome. In the 2016 City Survey, 74% of residents stated that they were in good health and 65% that they engage in physical activity at least three times a week. Given the importance of these services to our residents, our focus in developing budget proposals has been to ensure we make the best use of our resources, so we and our partners can provide support to everyone who really needs a service.

Budget proposals for 2017-18

This year, the Council has taken a different approach to budget planning. We have focused on the most important outcomes we want to achieve, and for the first time we have developed plans for the next four years rather than just one year. Under each outcome, we then identified proposals to reduce costs in the following areas:

- Business as usual – being more efficient in how we manage and deliver our services on a day-to-day basis
- Digital savings – changing and improving how we deliver services, making better use of online channels
- Service delivery changes – redesigning, sharing, stopping, reducing or changing services.

Under the outcome of 'Safe, Healthy, Independent lives', we are proposing the following savings:

	2017/18	**2018/19**	**2019/20**	**2020/21**
	£000	**£000**	**£000**	**£000**
Further digital savings	0.0	(313.0)	(313.0)	(313.0)
Business as usual savings	(1,091.0)	(1,523.0)	(2,193.0)	(2,193.0)
Service delivery and redesign proposals	(6,213.4)	(8,522.4)	(9,731.4)	(9,731.4)

Public Health and Commissioning

Service delivery and redesign proposals

Cease appropriate adult scheme and Positive Lives HIV/AIDS contract, and reduce alcohol specialist nurse service

We are proposing:

- To cease our funding contribution to the appropriate adult scheme, which provides people to act as an 'appropriate adult' for children and young people or mentally vulnerable adults in the absence of a parent or guardian whilst they are in custody, a victim or a witness at a police station. The service also supports unaccompanied asylum seeking children requiring an age assessment. Alternative approaches to funding the service will be developed with partners.
- Not to renew the outreach and support service commissioned from Positive Lives for people living with HIV/AIDS; this service currently supports approximately 120 service users at any one time. People living with HIV who meet our eligibility criteria will be able to obtain Social Care services. We will also support local voluntary sector and community organisations which address the stigma and discrimination associated with HIV/AIDS with fundraising and grant applications.
- To redesign the Alcohol Specialist Nurse Service, based in the University Hospital, and seek an alternative funding source.

Review substance misuse provision

We are proposing to review drug and alcohol treatment services, to reduce costs and develop a more integrated approach. At present, a number of contracts are in place to deliver drug and alcohol treatment services, including via the Southampton Drug and Alcohol Recovery Service, Shared Care Support, Alcohol Care Team at Southampton General Hospital, the Hepatology Outreach Nurse and the Pharmacy Needle Exchange. The proposal is to reduce investment across all services, which have been protected from previous reductions, and review the whole model in the longer term to focus on earlier intervention and create further efficiencies. This includes incorporating national reductions in the Public Health grant.

Business as usual

We are also proposing to reduce our costs in a number of ways which include:

- Introducing spending controls to meet the cost pressure caused by increased provision of emergency contraception.
- Reviewing our contracts to identify efficiencies.
- Restructuring our workforce.

Potential impact of the proposals for this area

Residents

Some individuals will be impacted by a reduction in services, including those who currently receive support through the Positive Lives HIV/AIDS contract. The review of substance misuse services may also have an impact on some service users. The introduction of spending controls in relation to the provision emergency contraception will have the greatest impact on women, and could have an impact of increased unplanned pregnancies and generating demand on other areas of service provision.

The proposals will reduce or cease funding to other programmes, such as the Appropriate Adults scheme and Alcohol Specialist Nurse. However, we propose to work with partner organisations to identify alternative funding sources, ensure that statutory duties are met, and minimise the impacts on service users.

Where proposals affect a contract the service provider will engage with the services users on our behalf and inform us if there are any impacts we need to consider.

Staff

In order to make sure the Council is fit for the future and as efficient as possible, we will be restructuring our teams and services over the coming years. Staff will be consulted on proposals as they are developed in line with agreed Council processes.

Alternative options

In order to make sure that we continue to provide good quality services to residents, it is important that we identify efficiencies wherever possible. If we did not make these proposals, alternative options would be to reduce or stop delivering other front line services, increase fees or introduce charges for some services that are currently offered free to the user.

Equality and Safety Impact Assessment

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

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

Outcome	**People in Southampton Live Safe, Healthy, Independent Lives**
Code	**Public Health Grant**
Name or Brief Description of Proposal	Controlling spend on Emergency Hormonal Contraception.
Brief Service Profile (including number of customers)	
Emergency Hormonal Contraception (EHC) is a form of contraception that can be used by women to prevent an unwanted pregnancy after unprotected sexual intercourse, including when they have reason to believe that their regular form of contraception may have been compromised, or following an unwanted / unplanned sexual encounter, such as a sexual assault. Southampton City Council commissions community pharmacies to provide access to EHC, plus information and advice, free of charge, to women in Southampton. Women can also access EHC free of charge from GPs or from the integrated sexual health service, or buy it over the counter from a Pharmacy if they wish. In Southampton, women sought access to EHC through the council funded pharmacy service on 4,200 occasions in 2015-16. The Council is proposing a reduction in spend on EHC from 2017-18 of approximately £30,000 through the introduction of targeting the Council commissioned element to more vulnerable groups.	
Summary of Impact and Issues	
Reducing access to EHC for any given group could result in an increase in levels of unplanned pregnancy, though this will be mitigated in part by: • An increase in the number of women buying EHC privately. • An increase in the number of women accessing EHC via GP surgeries. • An increase in the number of women accessing EHC following attendance at a Sexual Assault Referral Centre.	

There could be an increase in the number of women accessing EHC through the integrated sexual health service but this would be at a higher unit cost to the Council (as this would be part of a comprehensive Level 3 service). There could be an increase in unplanned and unwanted pregnancy among those who would previously have used this service which may have a range of financial, relationship, employment and mental health impacts upon the woman/family. There would also be impacts on other services. As the impact of these is most likely to be greater for younger women, it is most likely that age restricted access would be the simplest way of minimising the negative impact of this change upon population health and wellbeing outcomes.	
Potential Positive Impacts	
Promoting the take-up of other forms of contraception. Possible increase in the recognition, reporting and treatment of sexual assault.	
Responsible Service Manager	Tim Davis, Senior Commissioner
Date	18 October 2016
Approved by Senior Manager	Dr RA Coates, Interim Director of Public Health
Date	2 November 2016

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	This is a service that benefits women of child bearing age (13-49), though in practice 3 out of 4 service users are aged 25 or less.	Increased access to long acting reversible contraceptives (LARC) methods that are less subject to failure than oral contraceptives and/or condoms. Improvements in education about sexual and reproductive health.
Disability	No specific impact anticipated for this group.	Not applicable.
Gender Reassignment	No specific impact anticipated for this group.	Not applicable.
Marriage and Civil Partnership	May be used on occasion in stable relationships in the instance of contraception failure.	Increased access to LARC methods that are less subject to failure than oral contraceptives and/or condoms. Improvements in education about sexual and reproductive health.

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Pregnancy and Maternity	Some increase in unplanned pregnancies is likely, and this is likely to lead to a disproportionate rise in complex pregnancy and maternity episodes, since those subject to unplanned pregnancy are less likely to have been adhering to positive pre-pregnancy lifestyle changes in nutrition, alcohol intake or smoking behaviours An increase in unplanned pregnancy levels among more vulnerable women is also likely to result in an increase in terminations of pregnancy, and in the number of children being placed at birth into care for adoption or protection.	Increased access to LARC methods that are less subject to failure than oral contraceptives and/or condoms. Improvements in education about sexual and reproductive health.
Race	No specific impact anticipated for different ethnic groups.	
Religion or Belief	No specific impact anticipated for different faith groups, though devout followers of some faiths may be less likely to make use of this service.	
Sex	The immediate impact of restrictions on this service would fall exclusively on women. The wider impact may affect men and women, but most directly women.	
Sexual Orientation	This will affect women who have sex with men.	Increased access to LARC methods that are less subject to failure than oral contraceptives and/or condoms. Improvements in education about sexual and reproductive health.
Community Safety	Whilst there is no immediate link there is evidence that sexual assault against women is significantly under-reported in England. Some proportion of those that access this service may be among those who have been subjected to a sexual assault, but who do not wish to	Women who state that they have been subject to a sexual assault during a pharmacy consultation might be exempted from any broader age related restrictions. Increased education about sexual assault and the wider

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	report this to police, other authorities or access Sexual Assault Referral Centre (SARC) services.	health, wellbeing and emotional support that a SARC service can offer victims of sexual assault and other unwanted sexual experiences.
Poverty	Whilst there is not good local information about the socio-economic profile of women using EHC, the impact of unplanned pregnancy, particularly where it progresses to a live birth is more profound upon people already living in poverty given the space, accommodation and financial pressures associated with raising children. A rise in unplanned pregnancy would tend to result in a rise in the number of children living in poverty.	It might be possible, in addition to relaxing restrictions by age and sexual assault, to relax rationing of free EHC access by deprivation by looking at the postcode of women. However, a mechanism for facilitating this for pharmacists at the point of service delivery has not been identified.
Other Significant Impacts	There is a risk that, having stimulated an expectation that women can access EHC for free that a proportion will seek it from the integrated specialist sexual health service commissioned by the Council. EHC provided through this method cannot be capped, and activity would cost more as it would be part of a more comprehensive service offer. There is therefore a risk that a saving on EHC in pharmacy may be partially wiped out through driving channel shift to a more expensive intervention. Making this a restricted service (rationed) will make it more costly for pharmacy providers to provide the service, whilst reducing associated income. Reputationally, changing this so soon into the Council's new contract may damage its reputation as an organisation to do business with for other public	Making it clear how those no longer able to access this service would still be able to access EHC would mitigate the impact. Moving to a longer term track record will help to establish the council's reputation as a commissioner of services from pharmacies.

	health activities. For the majority the increase in numbers could result in an increase in demand and spending for universal children's services (early years' places, school places, children's centres etc.) Among women who are vulnerable due to housing, domestic abuse, poverty, youth, learning difficulty or disability or substance misuse there would also be an increase in demand for more specialist health, wellbeing and safeguarding services that would need to be planned for as a result of additional births in these groups. This has potential to increase number of children looked after in the city. Whilst condoms are not recommended as a reliable form of contraception in the long term. An increase in condom use might have some additional benefits for public health by reducing levels of sexually transmitted infection.	Overall it is also likely that this will result in a small net increase in the birth rate, all in relation to unplanned pregnancies which would need to be planned for in relation to planning for additional future demand and spending in relation to universal, targeted and specialist children's services and future demand for children's safeguarding services as a result of rises in these populations. Increased condom use would not require mitigation as it would be part of the wider mitigation.

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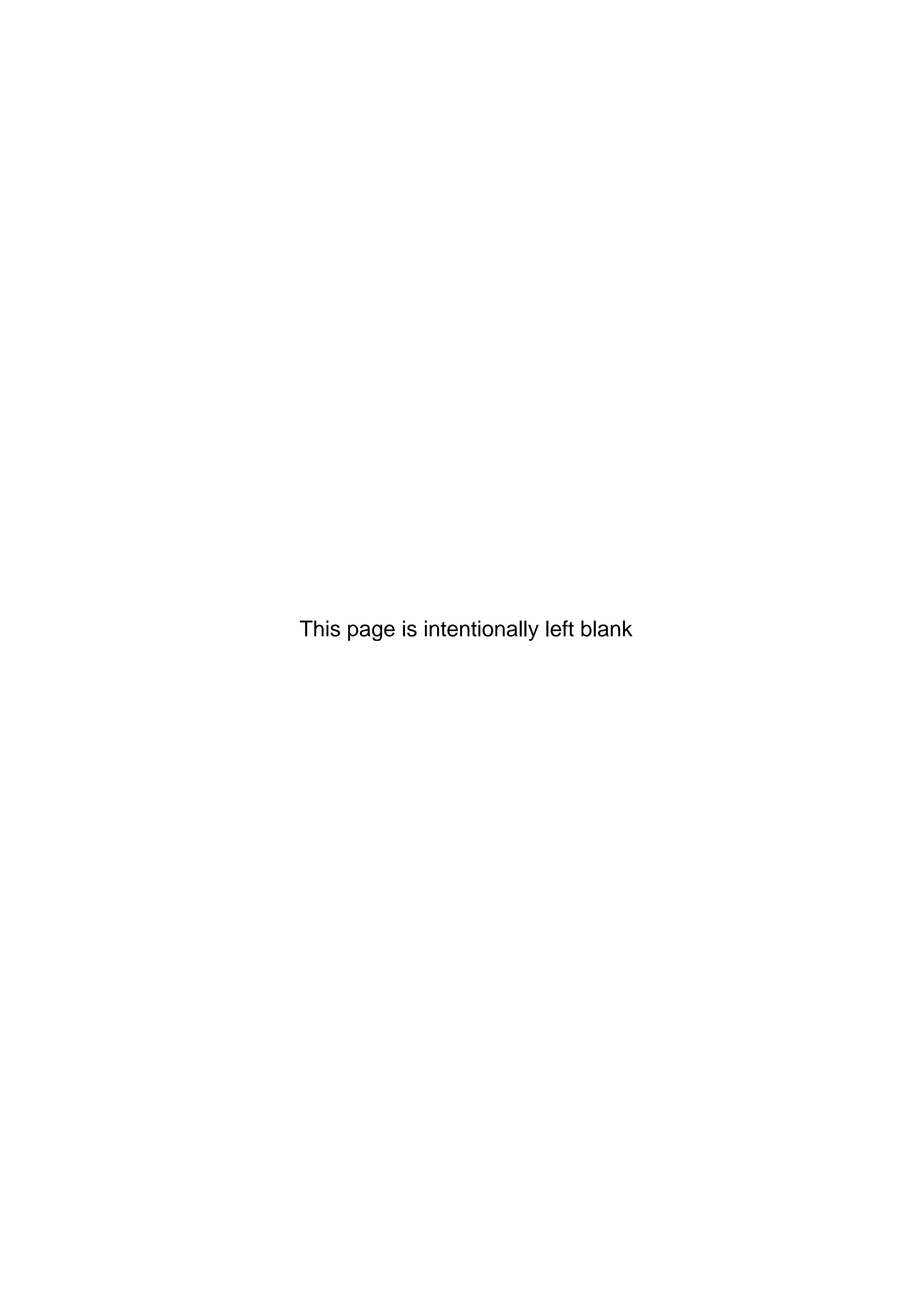
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Equality and Safety Impact Assessment

The **Public Sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.
The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the Council to better understand the potential impact of the budget proposals and consider mitigating action.

Outcome	**People in Southampton live safe, healthy, independent lives**
Code	**SHIL1**
Name or Brief Description of Proposal	Manage demand by offering alternative to home care for new clients by providing care for new clients by providing advice and information, supporting self-management and signposting to partner services.
Brief Service Profile (including number of customers)	
With good quality information, made available via a single point of contact, many people will be able to use their own resources to identify what support is available, how much it might cost and whether or not they need any further help to plan the means of meeting their or their relative or friend's needs. By providing online self-assessment to identify needs and financial assessment, again many people will able to make their own decisions with no further support. However, should people feel they need to make direct contact either as a referrer or as a person who may need support, the staff at the single point of access will be experienced and will be able to signpost the majority of people to the most appropriate means of meeting their own needs themselves. It is expected that proactive preventative measures can be provided at this point to support people to be independent for longer and so prevent or delay the point at which they need further involvement with Adult Social Care Services. By providing this advice, a holistic and family focussed service can be given. In Southampton, community teams (clusters) are being developed to make services more localised and being able to respond to meet the needs of the local community. These teams will be made of health, social care, voluntary groups and the community. It is anticipated these clusters will be able to support people to find alternative services to those traditionally provided by social care and health. Community Navigator roles are being piloted in clusters. For those people whose needs cannot be met through the provision of information, advice and signposting, staff in the single point of access will work with them to establish eligibility, develop a plan to meet their immediate needs and manage any risk, and refer them to the reablement service, where appropriate. Where this occurs the Care Assessment will be paused whilst the person accesses reablement or other services. The Council will complete the assessment once the provision of	

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the service has been completed. In cases where it is not appropriate to refer to reablement or to other beneficial activities a referral will be made to the Adult Social Care service to carry out a care assessment. In cases where people require ongoing care, direct payments will be the first option considered, so that the person is able to choose the right care in the right place for them.
Summary of Impact and Issues
The points below summarise the findings from observations of the Single Point of Access (SPA) team who manage referrals into Adults Services: • 80% of referrals are from existing clients Key Volumes: • Capita Contact Centre calls (33%) 147 per week • Alerts for welfare (22%) 98 per week • Direct email (44%) 195 per week • Winter months show a 30% increase in referrals than a standard week. There are likely to be additional savings, for example in the cost of providing long-term care, associated with the proposed new ways of working.
Potential Positive Impacts
The potential positive impacts identified are: • Individuals being supported in and by local communities in local settings. • Support at an earlier stage to reduce crisis. • Being able to better identify and respond to needs of the most vulnerable adults in Southampton. Further work needs to be completed to ascertain the source of referral, and if duplication can be reduced. The vision is for an efficient and effective social care support service which takes an "asset based" approach, building on individual skills, strengths and the family and community networks to support individuals to be active participants in tackling the issues they face. The service will be focused on the safety and wellbeing of individuals. This means that it will help people maintain an "ordinary life" continuing to do the things that give them enjoyment, have the opportunity for social involvement, to contribute to society and to use existing networks to cope with change and crisis.

Responsible Service Manager	Sharon Stewart Prioritisation, Safeguarding and Initial Response Service Lead
Date	13 October 2016
Approved by Senior Manager	Paul Juan Acting Service Director – Adults, Housing and Communities
Date	13 October 2016

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Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	This may affect older people who are vulnerable or isolated. Some older people may require support to access new teams, in a different way than they have traditionally done. Some service users have older carers who have their own support needs or who may develop needs in the future.	Needs of all service users will be addressed and individual needs including age, complexity and access issues. However, they may be provided in a different way than usually provided. Working with multi agency team in clusters so that potential problems are identified at an earlier stage. Carers are entitled to assessments in their own right and would be able to access this where necessary.
Disability	The recommendation will impact on people with learning disabilities, physical disabilities, sensory impairment and mental health needs. The recommendation may have either a positive or negative impact depending on the individual and the extent to which they prefer current models of service. A positive impact for some will be the freedom and flexibility to use their personal budget to meet their individual need, and utilise their local community.	Needs of all service users will be addressed and individual needs including age, complexity and access issues. However, they may be provided in a different way than usually provided. Alongside the changes individuals may be able to have a personal budget/take a Direct Payment, and be supported to do so, which will enable people to make arrangements to meet their individual need.
Gender Reassignment	No identified negative impacts.	N/A
Marriage and Civil Partnership	No identified negative impacts.	N/A
Pregnancy and Maternity	No identified negative impacts.	N/A
Race	No identified negative impacts.	N/A
Religion or Belief	A positive impact would be service users may have the opportunity to use the faith groups or communities to provide additional care and support they may not have used in the adult social care provision.	Needs of all service users will be addressed and individual needs including age, complexity and access issues. However, they may be provided I a different way

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		than usually provided.
Sex	No identified negative impacts.	N/A
Sexual Orientation	No identified negative impacts.	N/A
Community Safety	Positive impact – service users will be aware of their local communities and what are within these communities. As they are familiar with their areas they will take control of their own safety.	Needs of all service users will be addressed and individual needs including age, complexity and access issues. However, they may be provided in a different way than usually provided.
Poverty	Some low income households may not have direct access to the internet.	Promote public access and digital inclusion in places like libraries.
Other Significant Impacts	People with learning disabilities experience a range of health problems earlier than the general population which needs to be factored into the design of alternatives services.	Needs of all service users will be addressed and individual needs including age, complexity and access issues. However, they may be provided in a different way than usually provided.

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Equality and Safety Impact Assessment

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

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

Outcome	**People in Southampton live safe, healthy, independent lives**
Code	**SHIL 2**
Name or Brief Description of Proposal	Changing the way that adult social work teams operate. This is to ensure that the right processes are in place to assess people for the right care, in the right place, at the right time and making full use of community support, telecare and extra care housing to help people live independently. Social workers and care managers will routinely ensure that people are supported to achieve independence and the best outcomes for them through the use of support available in their networks and communities; telecare; direct payments; regular and timely assessments and reviews; and existing housing with care and Shared Lives schemes. This new approach will be underpinned by a comprehensive training and development programme for staff, a new structure and fresh approaches to managing performance and monitoring outcomes and spend.
Brief Service Profile (including number of customers)	
As at 30 September 2016, the service supported 3,011 adults with packages of care and support to meet their social care needs. This care and support can be broadly divided into two categories: • 2,172 (72%) people receive "non-residential care", which includes home care (also known as domiciliary care).	

- 839 (28%) people receive “residential care”, which includes people living in residential and nursing homes.

All people receive a thorough assessment, centred on their individual social care needs, in line with the Care Act 2014, and this is kept under regular review.

Summary of Impact and Issues

This proposals aims to ensuring that individuals have the right level of care, in the right place, at the right time in a way that maintains their independence. The average cost of each care package is expected to reduce, because:

- Individuals who currently receive a care package may receive support in a different way in the future, following a holistic review of their social care needs.
- New individuals coming forward for an assessment for the first time may receive support in a different way than would have traditionally have been provided in the past.

No changes will be made without a thorough, person-centred assessment or review that would take into account an individual’s views and preferences, along with those of their families, carers and, where appropriate, their independent advocates.

Examples of how care and support could be provided differently in the future include:

- Giving someone a Direct Payment instead of the Council arranging care on their behalf, so that they have more choice and control over how their needs are met.
- Supporting someone to move to a suitable accommodation with care scheme (also known as Extra Care Housing) instead of a residential care home, to help maintain their independence.
- Making more use of care technology, in particular where people are at risk of falling, wandering, seizures, immobilisation, extreme temperatures, smoke in the home or feelings of insecurity. This can help maintain independence by reducing the need for home care, delaying or preventing a need to move to a residential care or nursing home and can help prevent carer burnout.
- Where appropriate, helping people to get the support that they need from their neighbours and the wider community, reducing the need to rely on home care and other support arranged by the Council.

Potential Positive Impacts

Individuals will receive more regular and timely reviews of their social care needs.

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Providing care and support in different ways often leads to greater independence and a fuller life for individuals, families and carers. By focussing on training and developing Social Workers and Care Managers, there will be a fairer and more consistent approach to care and support planning.	
Responsible Service Manager	Liz Slater, Service Lead, Assessment, Support Planning and Options
Date	18 October 2016
Approved by Senior Manager	Paul Juan Acting Service Director – Adults, Housing and Communities
Date	18 October 2016

Potential Impact

<table>
<tr><th>Impact Assessment</th><th>Details of Impact</th><th>Possible Solutions & Mitigating Actions</th></tr>
<tr><td>Age</td><td>Older people are more likely to be impacted by this proposal, as there are more older people who receive care and support to meet their social care needs.

The table below shows the age breakdown:

<table>
<tr><th>Age</th><th>Home care</th><th>Res care</th><th>Total</th></tr>
<tr><td>18-64</td><td>1,016</td><td>182</td><td>1,198</td></tr>
<tr><td>65-74</td><td>312</td><td>126</td><td>438</td></tr>
<tr><td>75+</td><td>844</td><td>531</td><td>1,375</td></tr>
<tr><td>Total</td><td>2,172</td><td>839</td><td>3,011</td></tr>
</table></td><td>Each person who is affected by this proposal will receive a thorough, person-centred assessment or review of their social care needs, taking into account their preferences along with those of their family and carers, in line with the requirements in the Care Act 2014. A support plan will be agreed in accordance with the Council's Adult Social Care and Support Planning Policy. The council will continue to ensure that suitable arrangements are in place to meet all eligible social care needs that would otherwise not be met. People who lack mental capacity to make decisions about their care and support will be protected by legal safeguards. An appropriate person or independent advocate will</td></tr>
</table>

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		help ensure the person's views are taken into account during the assessment or review. The Council will consult partners and stakeholders to identify any adverse impacts and this plan will be updated to incorporate any further mitigating actions agreed.
Disability	People who have a physical or learning disability are more likely to be impacted by this proposal, as there are more people with a physical or learning disability who receive care and support to meet their social care needs.	As above.
Gender Reassignment	No identified negative impacts.	N/A.
Marriage and Civil Partnership	No identified negative impacts.	N/A.
Pregnancy and Maternity	No identified negative impacts.	N/A.
Race	No adverse impact identified, although Black and Minority Ethnic communities are currently under-represented in the group of people who currently receive care and support.	Some further analysis is needed to better understand why Black and Minority Ethnic communities are generally under-represented in the group of people who currently receive care and support to determine whether additional steps need to be taken to ensure that adequate arrangements are in place to meet individuals' social care needs.
Religion or Belief	No identified negative impacts.	N/A.

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<table>
<tr><th>Impact Assessment</th><th>Details of Impact</th><th>Possible Solutions & Mitigating Actions</th></tr>
<tr><td>Sex</td><td>Women are more likely to be impacted by this proposal, as there are more women who receive care and support to meet their social care needs.

The table below shows the gender breakdown:

<table>
<tr><th>Gender</th><th>Home care</th><th>Res care</th><th>Total</th></tr>
<tr><td>Female</td><td>1,309</td><td>488</td><td>1,797</td></tr>
<tr><td>Male</td><td>863</td><td>351</td><td>1,214</td></tr>
<tr><td>Total</td><td>2,172</td><td>839</td><td>3,011</td></tr>
</table>
</td><td>Each person who is affected by this proposal will receive a thorough, person-centred assessment or review of their social care needs, taking into account their preferences along with those of their family and carers, in line with the requirements in the Care Act 2014. A support plan will be agreed in accordance with the council's Care and Support Planning Policy. The council will continue to ensure that suitable arrangements are in place to meet all eligible social care needs that would otherwise not be met. People who lack mental capacity to make decisions about their care and support will be protected by legal safeguards. An appropriate person or independent advocate will help ensure the person's views are taken into account during the assessment or review. The council will consult partners and stakeholders to identify any adverse impacts and this plan will be updated to incorporate any further mitigating actions agreed.</td></tr>
<tr><td>Sexual Orientation</td><td>No identified negative impacts.</td><td>N/A.</td></tr>
<tr><td>Community Safety</td><td>No identified negative impacts.</td><td>N/A.</td></tr>
<tr><td>Poverty</td><td>No impact identified. Eligibility for funding for Adult Social Care is</td><td>N/A.</td></tr>
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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	subject to a statutory means test, which takes into account income, savings and assets.	
Other Significant Impacts	No identified negative impacts.	N/A.

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Equality and Safety Impact Assessment

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

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

<table>
<tr><td>Outcome</td><td>People in Southampton live safe, healthy, independent lives</td></tr>
<tr><td>Code</td><td>SHIL 4 (i)</td></tr>
<tr><td>Name or Brief Description of Proposal</td><td>Removing a subsidy from people who can afford to pay for their own care following a means test.</td></tr>
<tr><td colspan="2">Brief Service Profile (including number of customers)</td></tr>
<tr><td colspan="2">This proposal will affect people receiving home care services who are financially assessed as having over £23,250 in capital (money in bank accounts, building societies, Premium Bonds, shares and second properties) - who are not charged an arrangement fee to cover the cost of the Council arranging their care.

This currently applies to 122 people. The proposal is to charge £632 in the first year and then £520 per year in subsequent years. The charges will also apply to new clients.</td></tr>
<tr><td colspan="2">Summary of Impact and Issues</td></tr>
<tr><td colspan="2">Individuals with over £23,250 in capital, will be charged an arrangement fee for the first time. People may choose to enter into a contract with a home care provider privately, but would typically pay a higher hourly rate.

This was subject to a separate consultation carried out under the Care Act 2014 that concluded in April 2016, to which no significant issues or impacts were raised.</td></tr>
<tr><td colspan="2">Potential Positive Impacts</td></tr>
<tr><td colspan="2">None.</td></tr>
<tr><td>Responsible Service Leads</td><td>Liz Slater – Assessment, Support Planning and Options
Sharon Stewart – Prioritisation, Safeguarding & Initial Response</td></tr>
<tr><td>Date</td><td>13 October 2016</td></tr>
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Approved by Senior Manager	Paul Juan –Acting Service Director, Adults, Housing and Communities
Date	14 October 2016

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	There are a higher number of people aged over 65 who would be impacted by this proposal. Of the 122 people currently identified, 109 people are aged over 65 and 13 people are aged between18-64 have been identified who would be affected.	Financial assessment carried out to confirm that person can afford to pay. Clients have the option of making the arrangements themselves with information on care agencies that we would provide. For those people who are unable to make a decision because they lack mental capacity, the council could offer Appointeeship or Deputyship Services to help them manage their finances.
Disability	There is higher use of home care services by disabled people. Of the 122 people currently identified, here are 7 people with a learning disability, 13 people with a mental health need and 102 with a physical disability who would be affected.	Not required.
Gender Reassignment	No identified negative impacts.	N/A
Marriage and Civil Partnership	No identified negative impacts.	N/A
Pregnancy and Maternity	No identified negative	N/A

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	impacts.	
Race	No identified negative impacts.	N/A
Religion or Belief	No identified negative impacts.	N/A
Sex	There are more women than men who will be impacted by this proposal. Of the 122 people currently identified, there are 93 women and 29 men who would be affected.	Financial assessment carried out to confirm that person can afford to pay. Clients have the option of making the arrangements themselves with information on care agencies that we would provide.
Sexual Orientation	No identified negative impacts.	N/A
Community Safety	No identified negative impacts.	N/A
Poverty	No identified negative impacts.	N/A
Other Significant Impacts	No identified negative impacts.	N/A

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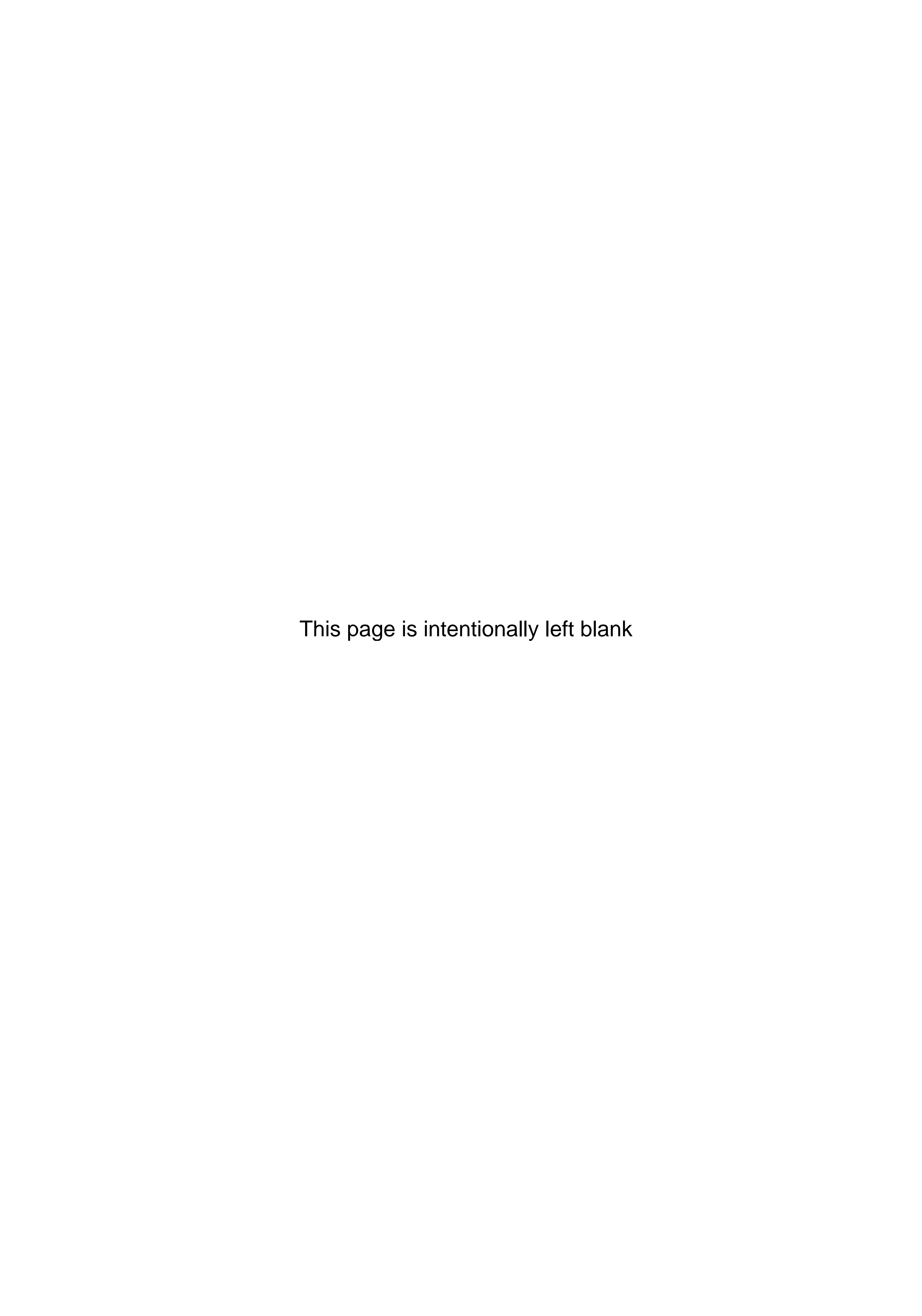
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Equality and Safety Impact Assessment

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

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

Outcome	**People in Southampton live safe, healthy, independent lives**
Code	**SHIL 4 (ii)**
Name or Brief Description of Proposal	A review of Mental Health services.
Brief Service Profile (including number of customers	
Currently Southampton City Council are in partnership with Southern Health Foundation Trust to provide Mental Health Care in Southampton. The Council provide and fund social workers and support staff to the Community Mental Health Teams and crisis services. These are line managed by Southern Health Foundation Trust.	
Summary of Impact and Issues	
The Council proposes to review its relationship with Southern Health Foundation Trust to ensure the agreement continues to offer value for money and the best care possible for services users. This includes to: • Consider the joint arrangements in place to ensure they are meeting current level of demand. • Work in partnership with health to review all Mental Health care packages to ensure value for money. • Review and update policies and procedure and ensure that the provision of aftercare services is appropriate. • Review current training to ensure we are meeting legislative requirements. In Southampton, we have approximately 3,500 service users. It is anticipated that the service provision will improve and there will be no interruption in care provision.	
Potential Positive Impacts	
• A fit for purpose contract, which is current and up to date. • Service is flexible and able to meet current level of demand.	

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• The service will have the right amount of staff to complete the complexity of cases. • The service will have monitoring arrangements to manage budgets effectively. • To use accommodation/office buildings in the most effective way. • Reduce duplication between teams.

Responsible Service Manager	Sharon Stewart Prioritisation, Safeguarding and Initial Response Service Lead
Date	14 October 2016
Approved by Senior Manager	Paul Juan Acting Service Director – Adults, Housing and Communities
Date	14 October 2016

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	The recommendation should make no fundamental impact on the service users in regard to age. Some service users have older carers who have their own support needs or who may develop needs in the future.	All service users will be considered in view of their individual needs including complexity and access issues. Carers are entitled to assessments in their own right and would be able to access this where necessary.
Disability	The recommendation aims to have a positive impact on people with mental health needs but may have negative impact depending on the individual. A positive impact for some will be the freedom and flexibility to use their personal budget to meet their individual need.	All service users will be considered in view of their individual needs including complexity and access issues.
Gender Reassignment	Services can provide a safe environment for people who face multiple discrimination. Accessing mainstream activities may be more	This can be mitigated by support to access alternative, appropriate services such as peer support and by working

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	challenging for some individuals.	with other agencies to ensure al purchased and community services are accessible to all communities.
Marriage and Civil Partnership	No identified negative impacts.	N/A
Pregnancy and Maternity	No identified negative impacts.	N/A
Race	The impact on Black and Minority Ethnic (BME) groups will be in line with current evidence to support the need to facilitate better access to services for this group.	All service users will be considered in view of their individual needs including complexity and access issues.
Religion or Belief	No identified negative impacts.	N/A
Sex	No identified negative impacts.	N/A
Sexual Orientation	In house services can provide a safe environment for people who face discrimination. Accessing mainstream services for some individuals may be more challenging.	This can be mitigated by support to access alternative, appropriate services such as peer support and by working with other agencies to ensure all purchased and community services are accessible to all communities.
Community Safety	No identified negative impacts.	N/A
Poverty	There are potential impacts if people have to travel further at extra cost to access their support. Alternatively people can chose to access more local services.	All service users will be considered in view of their individual needs including age, complexity and access issues.
Other Significant Impacts	No identified negative impacts.	N/A

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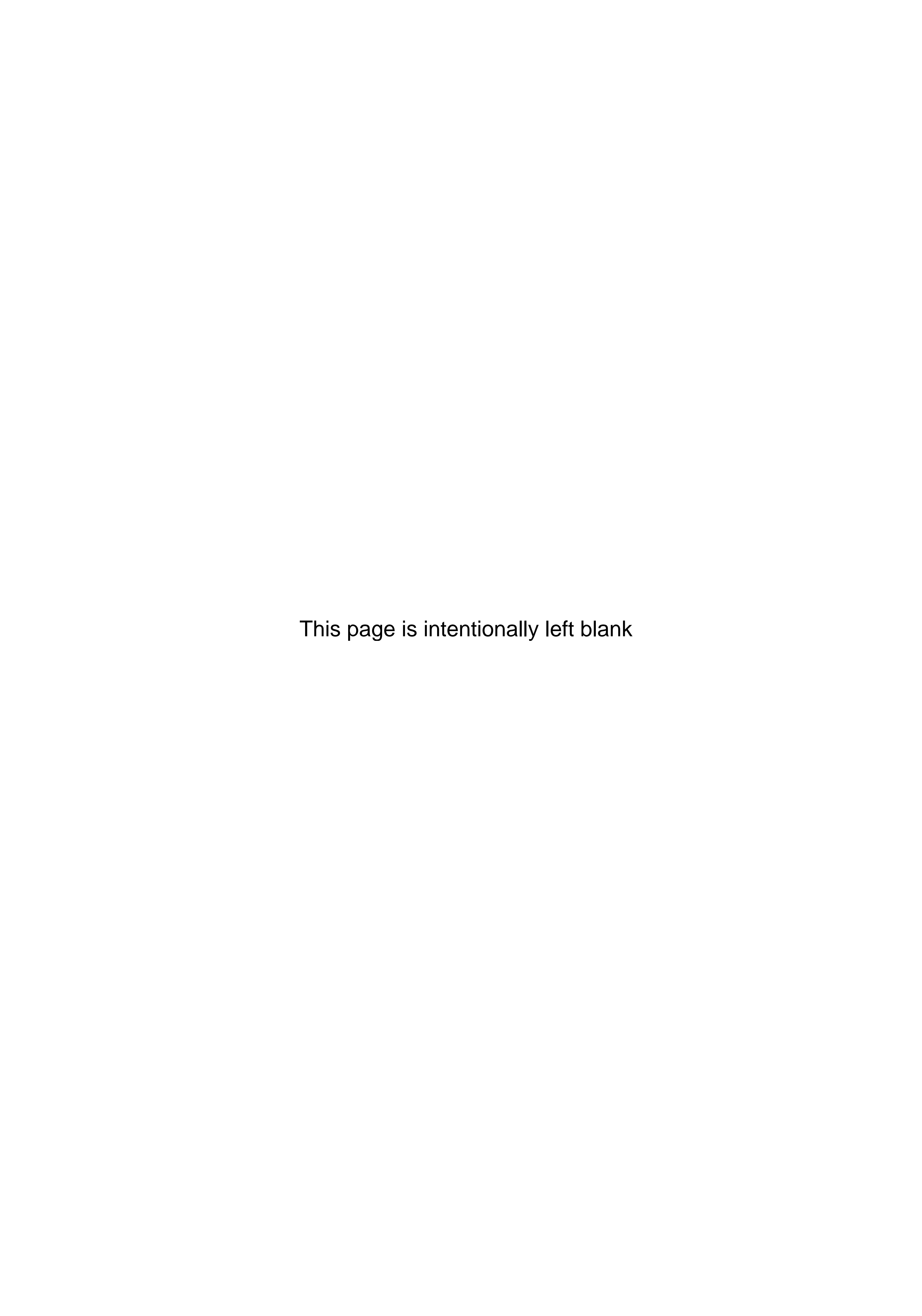
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Equality and Safety Impact Assessment

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

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

Outcome	**People in Southampton Live Safe, Healthy, Independent Lives.**
Code	**SHIL 8 (i)**
Name or Brief Description of Proposal	Cease funding contribution for appropriate adult scheme.
Brief Service Profile	
The service provides persons acting as an Appropriate Adult (AA) for children and young people (in the absence of the parent, guardian or, if the juvenile is in the care of a local authority or voluntary organisation, a person representing that authority or organisation, or a Social Worker) and mentally vulnerable adults (in the absence of a relative, guardian or other person responsible for their care) held in custody at a police station. The service will also provide AA for children or vulnerable adults who are victims or witnesses required at the police station; and to provide AA support for Unaccompanied Asylum Seeking Children who are requiring an age assessment to be undertaken by Children's Services in situations where the age of the child is in dispute. The service was re-commissioned in collaboration with Hampshire County Council, Southampton City Council, Portsmouth City Council, Isle of Wight Council and Hampshire Constabulary following a recent procurement process. The contract start date was 01/07/2016 and end date 30/06/2019. The annual contract value is £300,000 with Southampton contribution from Children's Services £23,000 (indicative) and Adult Services £39,960 (maximum).	
Summary of Impact and Issues	
The provision of an Appropriate Adult service is non statutory for adults aged 18 and over.	

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There is a statutory requirement upon Youth Offending Teams to provide Appropriate Adults for those up to the age of 18.
Hampshire Constabulary have so far declined to provide a contribution towards the adult element of this service due to predicted financial reductions and a view that the vulnerable individuals within custody fall within the responsibility of Local Authorities.

Risks identified prior to procurement included:

1. Despite no statutory requirement on any organisation this area of work must be picked up. If the council cease to fund then the current model within the Southampton suite will not be financially viable. The current commissioning allows a person to be present in the custody suite during core hours and has reduced the cost of the model compared to the alternative of spot purchasing the support when needed. Withdrawal of this post will require Hampshire County Council to spot purchase for their residents within the suite and also for us to spot purchase the statutory element for Southampton (children's resource) this may impact on our budget for the children's element as the spot purchase rate is significantly higher than the current model. Hampshire Constabulary will need a resource and so may have to fund provision within Southampton either through their operational budgets or with Office of Police and Crime Commissioners (OPCC) monies. This will present a cost or resource pressure within their custody teams which has the potential to increase the amount of time officers spend sourcing AAs. In order to meet this shortfall it is possible, in line with the current approach, that the Constabulary and OPCC will top slice or reduce the various grants which they currently contribute towards functions of the council.
2. There is a potential risk that this pressure will be passed on to the council's operational teams as this work must be covered and many people will fall within the councils eligibility criteria and already be allocated.
3. At present Hampshire Constabulary would like to make changes to the service but are unable as they are not party to the contract. Through funding in part or entirely the Constabulary will be able to have more say over the service they want, potentially reducing delays in custody, which may give them benefits to commissioning directly that cannot be achieved through local authorities. If Southampton withdraw completely and the Police or OPCC fund in its entirety then other local authorities might follow and this would increase the cost to Hampshire Constabulary and they might be less likely to fund in Southampton; asking for part funding might be a more achievable option.
4. Having no commissioned AA service is likely to lead to delays in the sourcing of AAs by police officers, increasing the length of time vulnerable adults spend detained within Southampton. It is highly likely that there will be associated risks with extended detention and reduced outcomes relating to health and wellbeing. This is at a time when there are well documented issues nationally in relation to vulnerable people being held in police cells and some high profile serious incidents.

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5. Damage in relationship between SCC, Hampshire Constabulary, the other local authorities and the OPCC and reputational damage.
6. Hampshire Constabulary may potentially withdraw other funding streams, from the council in order to meet demand of AA provision.
7. A report commissioned by home office and completed by the National Appropriate Adult Network is likely to suggest AAs becoming a statutory requirement however, after talking to reports author, it is highly unlikely this request will be supported by Home Office due to the cost involved.

Potential Positive Impacts

Recommence negotiations with OPCC and Hampshire Constabulary to seek a contribution towards these services.

Responsible Service Manager	Katy Bartolomeo
Date	13 November 2016
Approved by Senior Manager	Carole Binns
Date	13 November 2016

Impact Assessment	Details of Impact	Possible Solutions
Age	No service would be available for adults aged 18 years and over. This will result in people of working age spending longer in police cells. Children would have to wait longer in custody for an appropriate adult to arrive as currently there is one permanently situated in the custody suite in core hours to work with all ages and this would be withdrawn. The spot purchased route will cause delays	Work with Hampshire Constabulary (HC) to develop joint solutions.
Disability	The service safeguards the rights and needs of vulnerable individuals, which may impact individuals across all of the protected characteristics, including those with learning and mental disabilities. This is likely to lead to a reduction in	Work with HC to develop joint solutions.

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	the wellbeing of vulnerable adults.	
Gender Reassignment	As above - no additional negative impacts identified.	
Marriage and Civil Partnership	As above - no additional negative impacts identified.	
Pregnancy and Maternity	As above - no additional negative impacts identified.	
Race	As above, in addition there is some evidence that people from Black and Minority Ethnic (BME) communities are more heavily represented in arrest figures and therefore vulnerable people from BME communities could be disproportionately affected.	Work with HC to develop joint solutions.
Religion or Belief	As above - no additional negative impacts identified.	
Sex	As above - no additional negative impacts identified.	
Sexual Orientation	As above - no additional negative impacts identified.	
Community Safety	As above - no additional negative impacts identified.	
Poverty	As above - no additional negative impacts identified.	
Other Significant Impacts	Individuals may fall within the eligibility criteria of the council and responsibility for covering some of this work may fall to the council's operational teams, increasing pressure on those services. The current model of having a worker based in the custody suite for core hours, works out significantly cheaper than the spot purchase rate and so the statutory function for children's could be higher than the current budget and cause a cost pressure there.	

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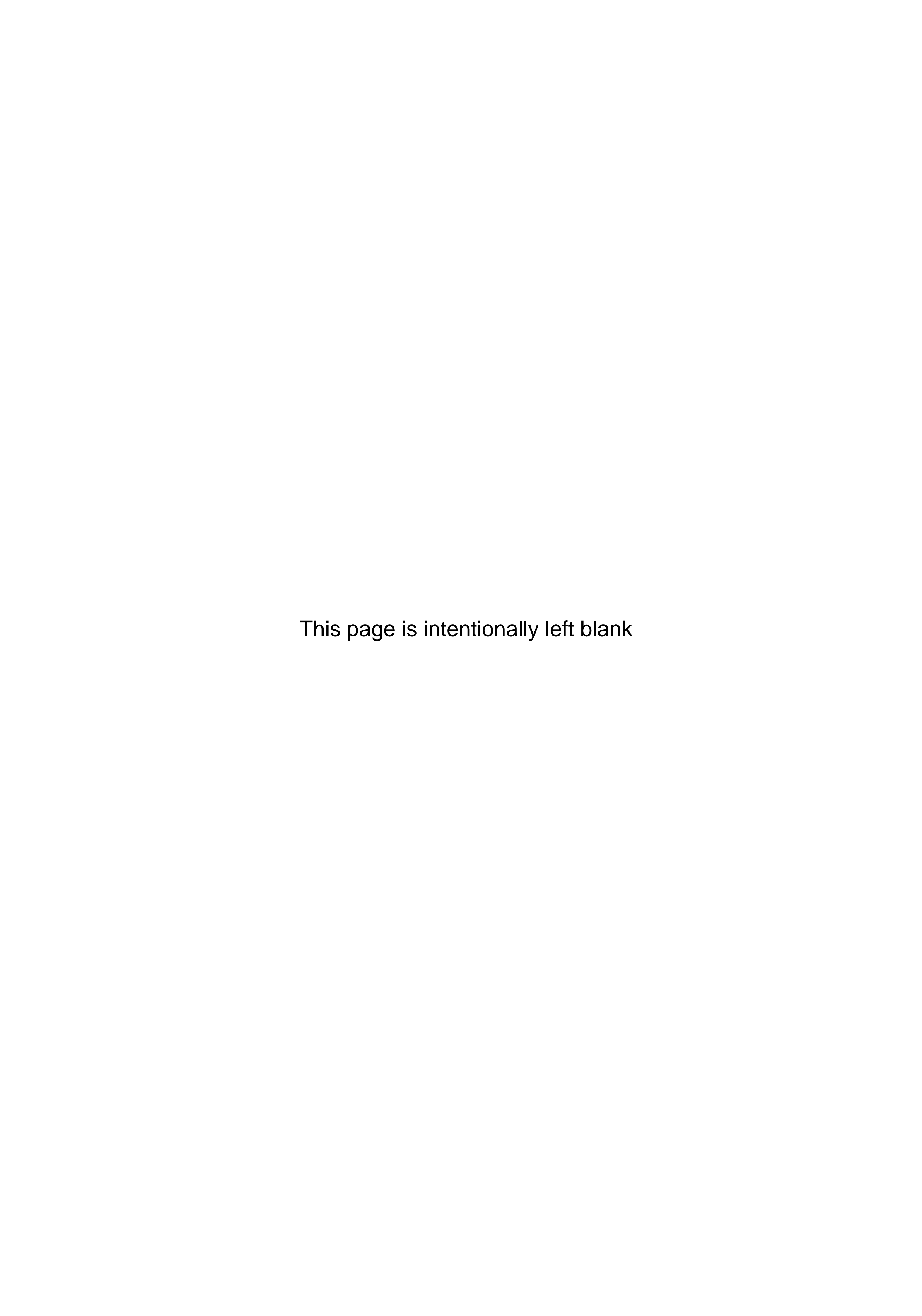
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Equality and Safety Impact Assessment

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

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

Outcome	**People in Southampton live safe, healthy, independent lives**
Code	**SHIL 9**
Name or Brief Description of Proposal	Increase employment, skills development, volunteering and other opportunities which promote and maintain independence as an alternative to day services. This covers all day care including those provided by external providers and Council services at Sembal House and Woolston Community Centre. This proposal incorporates a review of how the council funds transport to and from day services for people predominantly aged 18 to 65 years (excludes transport provided for the older person day service which is subject to a separate review).
Brief Service Profile (including number of customers)	
This proposal aims to address inequalities experienced by people, predominantly those with learning disabilities, but includes a small group of individuals with mental health and physical disabilities, who use the day services, from getting and keeping paid employment. The full impact will not be clear until implemented and outcomes can be monitored. The Care Act 2014 promotes individual wellbeing, and for some this may be about finding employment or voluntary work to build confidence and skills. This, coupled with the financial climate provides the basis for exploring an alternative approach to the way we support individuals currently using day services. Data from Adult Social Care Outcomes Framework (ASCOF) shows that 6.3% of individuals with a reported Severe Learning Disability in Southampton are in employment is higher than the national average of 6% but lower than the previous year of 9.4% and lower than the regional	

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average 8%.

Further ASCOF data for this group reveals that 3.6% of this client group would like to work. The percentage was higher at 6% for those clients within Southampton Day Services, Southampton City Council internal provision who were asked recently if they would like employment support. In Valuing People Now (2009) it was estimated that 65% of people with learning disabilities (moderate & severe) would like a paid job.

Current provision of day services for people with a learning disability (LD) equates to 281 individuals of which the Council provides 41% of the total market. The level of employment among other users of day services is expected to be comparable to those with LD.

Southampton Day Service (SDS) is a day service provision running out of two buildings, across the city providing service users with different types and levels of need. SDS operates from 2 locations:

- Sembal House
- Woolston Community Centre

Across both services provision is offered to 114 individuals a week. These individuals access the services for one to five days a week. 60 individuals who require a support ratio of 6-1 (clients to staff) attend for 157 sessions a week. These individuals would be more likely to be supported into a work opportunity in partnership with a supported employment team.

36 individuals who require periods of 1-2-1 or smaller group work attend 69 sessions a week. 17 individuals who require 1-2-1 support at all times access 71 sessions a week. It is likely these individuals would still require access to a standard day services provision which could be provided via the external market.

SDS offers a range of activities such as sports, arts and crafts, life skills and educational programmes and in some cases offers specialist therapy services. The in house services provide transport, support for trips and activities in the community. The service is used predominantly by individuals with learning disabilities and has a higher number of individuals with more profound and multiple learning disabilities than individuals using external services.

Work often plays a pivotal role in defining an individual's quality of life, sense of independence and may be an integral part of a person's overall life experience. Employment should be an achievable goal for people including those with disabilities (LD, mental health and physical disabilities) as much as it is for non-disabled people in our society.

The current Day Service offer across both internal and external costs on average £40,833 per week for 281 individuals making the annual cost

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£2,123,316.

The proposed savings would reduce the budget portfolio by 33% in year two onwards. The overall reduction would be across all day services providers but where alternative employment, skills development and comparable opportunities are sourced within the wider external market, it would enable the effective closure of internal services. During the period of development and change, the in house services would focus their support delivery around employment, while external services would focus their development towards the higher more complex needs.

Summary of Impact and Issues

Access to employment or comparable opportunities is likely to provide a significant positive impact. However, a potentially negative impact of this will be the prospective closure of the internal provision of day services, as well as a reduction or change in the use of the external provision to meet the needs of the individuals with complex needs.

There would need to be extensive consultation and co-production work carried out with external providers in order to gain successful buy-in and ensure that the needs of those clients with more complex needs are appropriately supported within external service provision.

There is likely to be a requirement for the Council to support appropriate skills development within external provider workforce.

Attention will need to be made regarding suitability of accommodation of external providers to meet accessibility requirements of the new cohort of clients. This could require capital investment from the Council.

Individuals, carers and their families may experience both positive and negative impacts depending on their individual circumstances and how they perceive the changes. For around 60 -100 individuals who are expected to move closer to the employment setting, the initial impact may feel more negative, especially for individuals with learning disability who find change more challenging. However, the long term impact is expected to be positive.

The impacts are described for the current population using day services. However, there will be a positive impact for a larger number of individuals in the long term as the younger population gains increased access to positive experiences of employment and comparable activities.

Carers may experience both a positive and negative impact as they see their loved ones gain increased choice and independence; equally they may find the change impacts negatively on their caring responsibilities.

Transport is often an important part of someone’s independence. Where this is transferred to suitable alternatives the impact is likely to be

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positive. However, with all changes, the process of change and the move to using different transport options may have a negative impact on individuals.	
Potential Positive Impacts	
Accessing employment, skills development and comparable opportunities is known to be a positive improvement in the lives of most people. This will be extended to those individuals who are supported through this change as well as the cohort of younger people who will be provided with a more independent and flexible approach. Alongside the changes, individuals may choose to have a Personal budget and / or take a Direct Payment and be supported to do so though appropriate services. This will enable people to make arrangements to meet their individual needs themselves thus increasing personal control and independence in managing their own care and support.	
Responsible Service Manager	Ricky Rossiter Service Manager - People
Date	14 October 2016
Approved by Senior Manager	Paul Juan Acting Service Director – Adults, Housing and Communities
Date	17 October 2016

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Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	People with learning disabilities experience a range of health problems earlier than the general population which needs to be factored into the design of alternatives services. Some service users have older carers who have their own support needs or who may develop needs in the future.	All service users will have an assessment prior to any consideration of service closure. This will address individual needs including age, complexity and access issues. Carers are entitled to assessments in their own right and would be able to access this where necessary.
Disability	The recommendation will impact on people with learning disabilities, physical disabilities, sensory	All service users will have an assessment prior to any consideration of service

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	impairment and mental health needs. The recommendation may have either a positive or negative impact depending on the individual and the extent to which they prefer current models of service. A negative impact for some will be the change in service location This could impact specifically on people with physical disabilities who need to use services and buildings which are accessible. Some of the buildings currently providing SDS have good access arrangements but other community resources may not be as suitable.	changes. This will address individual needs including age, complexity and access issues. In addition to individual assessments the phased closure of SDS will consider which buildings should be retained in the initial phase in order to address any potential impact. This will also provide the time to seek suitable alternatives for people. Capital investment form the Council may be required to ensure alternative accommodation of service provision for Clients with complex needs meet accessibility requirements and personal care needs.
Gender Reassignment	No identified negative impacts.	N/A
Marriage and Civil Partnership	No identified negative impacts.	N/A
Pregnancy and Maternity	No identified negative impacts.	N/A
Race	The recommendation may have either a positive or negative impact depending on the individual. Building based services have not traditionally attracted people from Black and	All service users will have an assessment prior to any service change which will include cultural issues.

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	Minority Ethnic (BME) communities suggesting in-house services are not attractive to these communities and shift of focus may improve service take up.	
Religion or Belief	The recommendation may have either a positive or negative impact depending on the individual, although increased use of personal budgets is usually experienced as a positive impact, allowing individuals with different requirements to be addressed individually.	All service users will have an assessment prior to prior to any of service change which will address matters of religion and belief.
Sex	No identified negative impacts.	N/A
Sexual Orientation	No identified negative impacts.	N/A
Community Safety	National research identifies disabled people are more likely to experience crime and anti-social behaviour, than non-disabled people. This may be harder to identify in a wider, employment based setting. There could be a negative impact on Individuals who feel safer accessing city council buildings in areas that they know and feel comfortable in.	Assessments will consider community safety issues for individuals including service location. The Community Safety team works with a wide range of partners to address and provide a more resilient response to community safety issues.
Poverty	Access to employment and other comparable opportunities usually leads to improved economic situations. However, there are potential impacts if people have to travel further at extra cost to access their support or need to access	All services users will have an assessment prior to any service change which will address these issues. Good information and advice about employment based benefits will be provided

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	the benefit system. A change of service for those not accessing employment skills could cause financial difficulties. Alternatively people can chose to access more local services.	through the changes. Individual financial circumstances will be considered in any new arrangements that are agreed with the individuals. Costs of transport can be included in a personal budget/direct payment.
Other Significant Impacts	No identified negative impacts.	N/A

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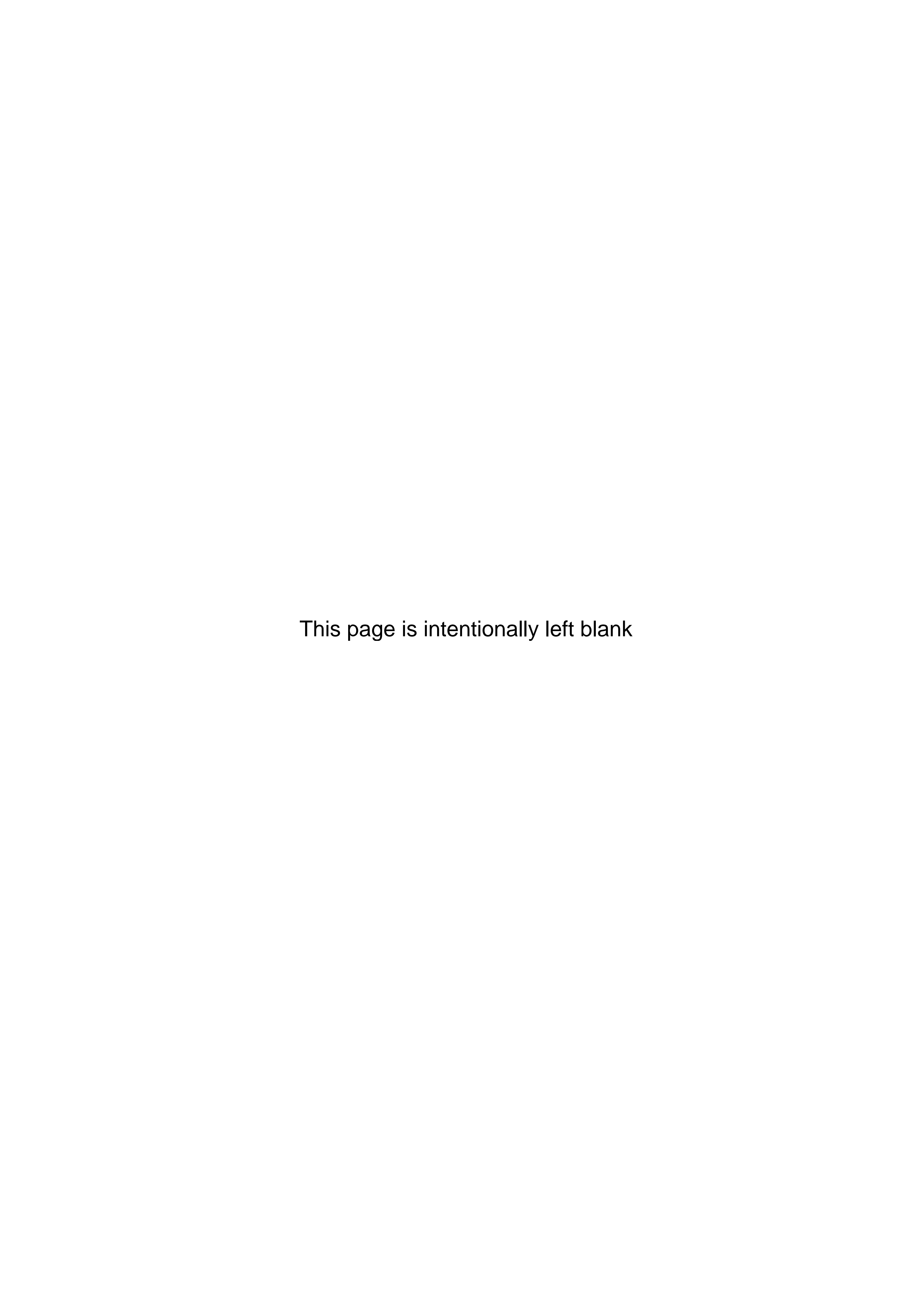
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Equality and Safety Impact Assessment

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Outcome	**People in Southampton live safe, healthy, independent lives**
Code	**SHIL 10**
Name or Brief Description of Proposal	Review substance misuse provision. To reduce investment in drug and alcohol treatment services by working with providers to change the model of support in the short term and in the longer term to review services alongside other areas, including homelessness services, to develop a more integrated approach.

Brief Service Profile

The Council took over the ongoing commissioning of alcohol and substance misuse services when the responsibility for Public Health transferred from health. The Public Health Grant is used to deliver a number of contracts for drug and alcohol treatment services:

- Southampton Drug and Alcohol Recovery Service (SDARS) with a current contract value of £2.9m which is comprised of :
    - DASH Young Persons Substance Misuse Service (No Limits)
    - ARM Assessment Review and Monitoring Service (CGI)
    - Structured Interventions Service (Solent NHS – Society of St James – No Limits)
- Shared Care Support delivered by 8 GP Practices in the city in partnership with SDARS (current contract value £45k)
- Alcohol Care Team at Southampton General Hospital (UHS) (current contract value £93k)
- Hepatology Outreach Nurse Service (current contract value £10k)
- Pharmacy Needle Exchange (current contract value £10k)

Outcomes from the services include :

- provision of early prevention and interventions to young people and brief interventions and early treatment for adults with a substance misuse problem to reduce the number of adults needing to seek help for more serious, entrenched drug and alcohol problems in later life, including those requiring

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treatment for serious health conditions such as liver disease.
- Reduction of harm and recovery from problematic substance use.

The Southampton Drug and Alcohol Recovery Service provides the majority of interventions to facilitate individual reduction of harm and recovery from problematic substance use. In 2015/16 this partnership of services:

- Engaged 1,040 people in Structured Treatment consisting of;
  - Alcohol and Non Opiate drug use - 67
  - Alcohol Only - 196
  - Non Opiate drug use - 68
  - Opiate drug use - 709

The partnership have struggled to achieve desired outcomes since the beginning of this contract in Dec 2014, however performance is improving but non opiate recovery rates are still of concern. Recovery rates are:

	Baseline 1/4/15 – 31/3/16	Latest 1/7/15 – 30/6/16	National Top Quartile
Opiate	6.6%	7.5%	7.5 – 10.3%
Non Opiate	28.3%	32%	49.5 – 63.4%
Alcohol	30.6%	41.3%	39.48%
Alcohol and Non-Opiate	25.8%	25.8%	37.7 – 60.92%

DASH provides help and support for young people up to the age of 25 who would like support with their drugs or alcohol use
In 2015/16:

- 1,906 young people received a brief intervention for drug and/or alcohol problem use.
- 8,930 young people were contacted through targeted outreach. Seventy six (11-17 year olds) were seen for specialist substance misuse treatment (tier 3) and 128, 18–24 year olds.
- 86% of young people who were treated for substance misuse problems exited the service in an agreed and planned way.
- Every secondary school within Southampton and home educated children received awareness sessions last academic year. Workshops for young people needing support are also offered.

Shared Care is provided by 8 GP Practices in Southampton. The service oversees care for approximately 80 drug clients on maintenance treatment at any one time. 70-80% are men, most in middle age, with a very long addiction history. It relies on specially trained GPs who work with the clients in their GP practices. This removes the clients from the specialist service setting in which more active drug users are treated more intensively. This model of care provides care nearer home, and in a more mainstream setting.

The Alcohol Care Team (ACT) at UHS works 5 days a week and is joint funded by

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Hampshire County Council. Recent activity data shows:

- Assessed 227 people (135 - 60% were Southampton residents).
- Majority (75%) = high risk drinkers scoring 15 or more on AUDIT (people drinking at this level would be likely to have physical dependency and significant impact on health and wellbeing outcomes). Majority aged 45 +.
- Delivered Alcohol training sessions to 86 clinicians in alcohol awareness, referral routes & brief advice.
- Developed anticipatory care plans for high impact users.

Hepatology Nurses offer an outreach service to drug clients with liver disease (mainly Hepatitis C and B, some alcohol related disease). There are 400 clients screened each year. The nurses also provide education for staff and clients, and treatment supervision for a caseload of 20-30 each year.

The pharmacy needle exchange scheme operates across pharmacies in the city. The scheme distributes injecting equipment to a range of users, including intravenous drug users (IVDU), body enhancement and steroid users in the city. There are between 6,000-8,000 needle exchanges per year. The purpose of the service is to contain/prevent spread of blood borne viruses (BBVs), such as HIV, and hepatitis B and C, and to prevent abscesses and septicaemias in those who inject drugs.

Health and Social Care Act 2012 gives local authorities the duty to reduce health inequalities and improve the health of their local population by ensuring that there are public health services aimed at reducing drug and alcohol misuse. The 2015/16 public health ring-fenced grant included a new condition that requires that local authority must, in using the grant, "…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…".

The proposal is to reduce investment across all services, which have been protected from previous reductions and review the whole model in the longer term to focus on earlier intervention and create further efficiencies. This includes incorporating national reductions in the Public Health grant.

Summary of Impact and Issues

A reduction in service availability will have an impact upon the provision of harm reduction and recovery interventions to the citizens of Southampton. This could mean an increase in drug use and associated drug litter, crime, anti-social behaviour, domestic abuse and violence, adult and children's safeguarding issues, housing problems and homelessness, as well mental and physical ill health, blood borne virus prevalence and drug related deaths.

Southampton struggles with above national average alcohol related hospital admissions. At least 10% of UHS emergency department attendances are alcohol related and there could be an increase.

Needle exchange and hepatology outreach services are known to contribute to managing the prevalence of Blood Bourne viruses and the likelihood is that there will be an increase in Blood Borne Virus infections such as Hepatitis B or C. Prevalence of Hep C in the IV drug users is currently 40-60%. Recent HIV outbreaks have again

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been associated with IV drug use, but locally our main issue is Hepatitis B and Hepatitis C. An increased rate of blood borne virus infection which will lead to increased cost to other services including health and social care. There could be an impact for key stakeholders such as police, probation, ambulance service and the public) if the number of people who can access treatment and the range of interventions that are available were to be reduced resulting in the consequences described above. It is also likely that local performance will reduce against national indicators. Individuals with significant substance misuse problems also meet the eligibility criteria for care and present need both individually and in relation to carer and family impact. There is a significant overlap between substance misuse, domestic violence, safeguarding, homelessness, poverty and the development of long term conditions requiring care package support. It is therefore possible that there will be a transfer of costs to other services including other social care teams. Through service redesign savings could be made within the entire substance misuse resource and considering the role of combining other service areas however there is a higher risk of adverse consequences if services are reduced before this piece of work can be completed as redesign and recommissioning takes time.
Potential Positive Impacts
Complete service redesign will provide an opportunity to review the substance misuse services and develop a more integrated approach which takes an holistic approach that goes beyond looking at single lifestyle issues and instead aims to take a whole-person, whole-family and community approach. This could include combining services with others such as housing support services to achieve a more integrated approach that focuses on the cause of issues rather than managing the consequences. However this will take time to achieve a detailed review, consultation and service specification development process. Lower level outcomes could be achieved through encouraging and facilitating individual behaviour change and interventions that build personal resilience though this will not address impact in specialist services for people who already have significant problems.

Responsible Service Manager	Carole Binns, Acting Director Adult Social Services Sarah Weld, Consultant in Public Health
Date	17 October 2016
Approved by Senior Manager	Stephanie Ramsey, Director of Quality and Integration Dr RA Coates, Interim Director of Public Health
Date	17 October 2016

Potential Impacts

Impact Assessment	Details of Impact	Possible Solutions
Age	Negative impact across all age groups. It is usually more effective to provide intervention to people with substance misuse problems as early as possible and reducing service provision to young people could result in problems becoming more severe and entrenched. Outreach into schools and the community are likely to be reduced leading to fewer young people at risk of developing problems being identified and limited our ambitions for early intervention. Shared care proposals likely to impact disproportionately on middle age/mature drug users with long-term addiction who are a group at high risk of drug related death. Outreach into the community may be reduced leading to fewer people at risk of developing problems at a younger age being identified and limiting our ambitions for early intervention.	Service redesign could specify that brief/early intervention is prioritised. As part of the CAMHS (Child and Adolescent Mental Health Services) transformation plan, it is likely that counselling services may be improved. This may help to identify young people experiencing substance misuse problems and refer them accordingly. Consider higher reductions in adult services to protect young person's services (though this would increase impact in these services).
Disability	Negative impact. Long term drug use is associated with a range of other chronic health problems and people with disabilities are likely to be over represented in this group. Interventions can and do prevent disability. Current services take a universal but targeted approach. Whilst impact will be population wide there is a risk that groups that find it harder to engage with universal services are disproportionately affected when resources are reduced.	Service redesign could specify that providers will be required to prioritise certain groups including adults with long term physical and / or mental health conditions.
Gender Reassignment	Negative impact. Current services target adults who are	Ensure commissioned services are able to work with diverse

Impact Assessment	Details of Impact	Possible Solutions
	experiencing problems with substance misuse. There is a risk that people that find it harder to engage are disproportionately affected when resources are reduced.	need. Contract monitoring to ensure take up of service reflects population and local need.
Marriage and Civil Partnership	Negative impact. People's problematic use of alcohol has a direct impact on relationships. In particular the relationship between Alcohol and Domestic Abuse is well evidenced. Any reduction in funding will have an impact on our city's ability to address the strains and difficulties caused by alcohol and drugs on relationship breakup.	Partnership work with other stakeholders and children and families teams to address negative consequences where possible. The DAPP (domestic abuse) scheme is currently working with substance misuse services to address the issues of identifying perpetrators and domestic abuse victims engaging in treatment.
Pregnancy and Maternity	Negative impact. Drug and Alcohol use have direct and detrimental implications to conception and foetal development. Any reduction in funding would impact on ability to prevent and reduce harm thus increasing numbers experiencing complications in pregnancy, still birth and low birth weight and children born with Foetal Alcohol Spectrum Disorders, which can result in lifelong health and social care need. This could drive up the need for adoption or fostering and cost transfer to other services. Women who are pregnant or who have children are often reluctant to approach statutory services due to the fear of child protection proceedings. The current funding arrangements include a joint post across children and adult services	Increase the responsibility of Pre and post-natal services to address need, subject to capacity within those services. Consider upskilling children and family workers to incorporate into core work.

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Impact Assessment	Details of Impact	Possible Solutions
	in order to proactively engage women in these situations. Reduced investment may put specialist posts like this at risk, as a considerable amount of the post time is taken in networking and promotional activities and remaining funding will need to be targeted on case holding activities in order to meet national targets. Reductions in these services are likely to have an impact on safeguarding.	
Race	Negative impact. No specific impact on individual ethnicities. Current services take a universal but targeted approach. Whilst impact will be population wide there is a risk that groups that find it harder to engage with universal services are disproportionately affected when resources are reduced. There is some evidence that people from BME communities are under-represented in accessing services in the city – additional barriers to access such as longer waiting times may more negatively impact on people who already face barriers.	Service redesign could require providers to prioritise certain groups including Black and Minority Ethnic (BME) groups and to provide active outreach to minority ethnic communities. Contract monitoring and data capture which ensures all parts of the community can access services.
Religion or Belief	Negative impact. As above – may impact disproportionately on groups with diverse need.	
Sex	Negative impact. The service engages with whole populations focussing on harm rather than gender. More men are impacted by problematic drug and alcohol use and therefore are likely to experience greater impact. Health of men in Southampton is significantly worse than women with	Maximum use of personalisation/Direct Budgets and referral to community care funding where Fair Access to Care (FACS) applies. Contract monitoring and data capture which ensures all parts of the community can

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Impact Assessment	Details of Impact	Possible Solutions
	lower life expectancy and higher premature mortality. Alcohol is a key driver of morbidity and mortality thus reducing investment in these services may increase inequalities between men and women. Men are more likely to die a drug related death. Men are known to be less likely to engage with health services. There is a risk that groups that find it harder to engage with universal services are disproportionately affected when resources are reduced.	access services. Joint work with children and families. Specification to ensure gender specific issues are considered in style of provision.
Sexual Orientation	Negative impact. LGBTQ (Lesbian, Gay, Bisexual, Trans and Queer) groups have a higher incidence of substance misuse yet these communities are underrepresented in substance misuse services. Current services take a universal but targeted approach. Whilst impact will be population wide there is a risk that groups that find it harder to engage with universal services are disproportionately affected when resources are reduced.	Joint work with partners to address negative consequences. Maximum use of personalisation/Direct Budgets and referral to community care funding where Fair Access to Care (FACS) applies.
Community Safety	Negative impact. The impact of problematic drug and alcohol use on community safety is well documented A reduction of investment in this service would risk a reduction in our ability to reduce harms related to drug and alcohol use on individuals, their friends, families and communities Increase in Anti-Social Behaviour, Drug Litter, Street Drinking and begging. Crime may increase to pay for drug habits.	Joint work with partners to address negative consequences.

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Impact Assessment	Details of Impact	Possible Solutions
Poverty	Negative impact. There is a direct relationship between deprivation and substance misuse. Any reduction in investment could negatively impact on our more deprived populations, exacerbating poverty and associated health inequalities.	Joint work with partners to address negative consequences.
Other Significant Impacts	There is overwhelming evidence that addressing substance misuse issues can have a major impact on mortality and morbidity and thus reduce demand for health and care services. Unhealthy behaviours such as long term drug or alcohol use are known to cluster in populations and are a key driver of health inequalities. A reduced substance misuse treatment offer is likely to lead to higher demand on future health and social care services and may increase health inequalities. All emergency services – Police, Ambulance and acute care experience the burden of people's problematic drug and alcohol consumption. Reduction in services is likely to lead to increased pressure on these services. The Southampton Safe City Partnership has committed to developing new Drug and Alcohol Strategies for the city. Discussions have identified the need to increase capacity in treatment services as a key action. The proposed disinvestment in services presents a reputational risk to the Council. Substance misuse services based in Southampton represent a preventative opportunity which would be significantly reduced.	Review all substance misuse budgets together to identify how to design services in a new way to maximise the outcomes that we can achieve from the entire resource. Registrar starting soon who will focus on needs assessment for our population which will assist with service redesign.

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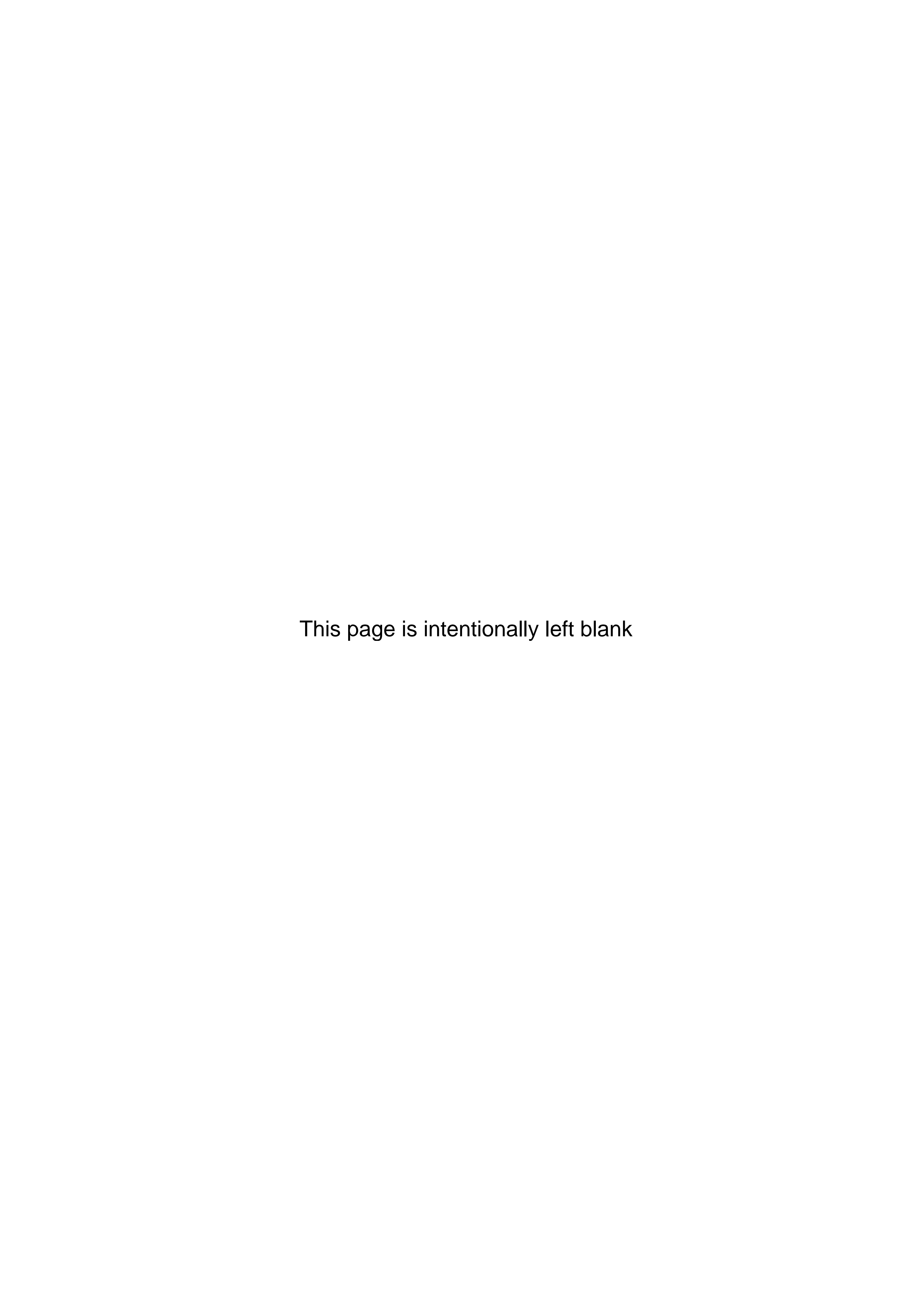
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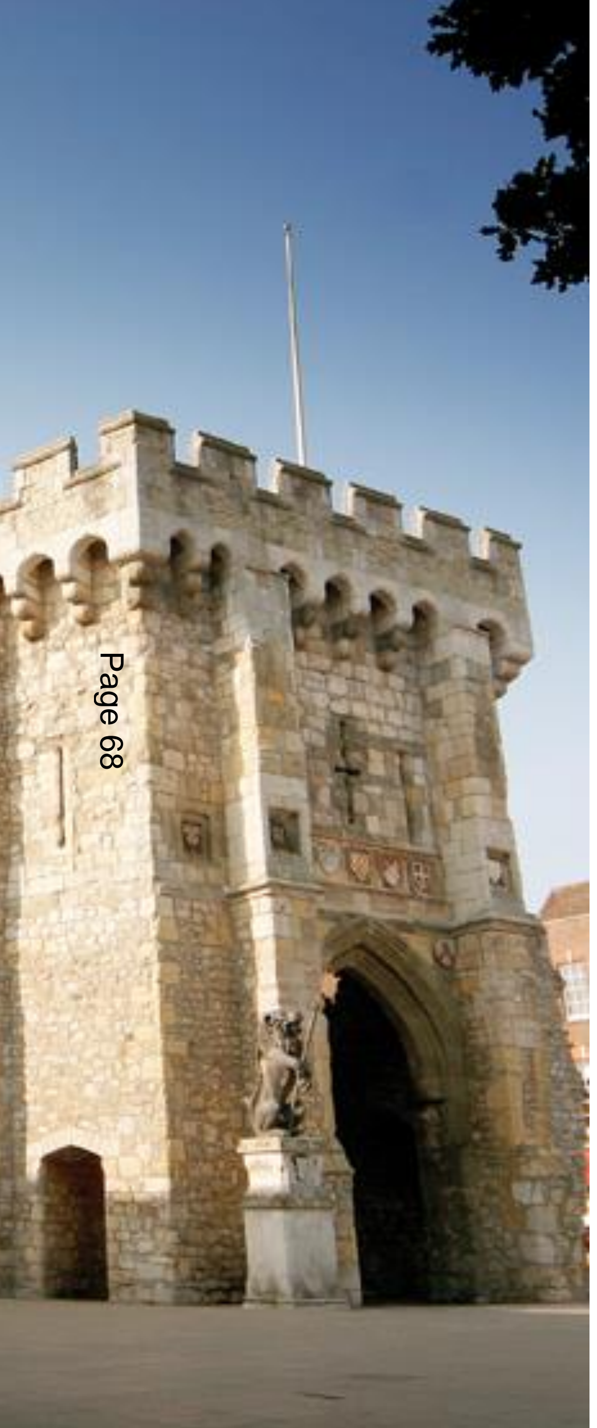
NHS Southampton City CCG Two Year Operational Plan (2017-19)

Making Southampton a healthy city for all and supporting delivery of the Hampshire & Isle of Wight Sustainability & Transformation Plan (STP)



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Foreword

In December 2015, NHS England and NHS Improvement set out a series of mandatory national priorities and requirements in the planning guidance. For the first time, every organisation across the health and care system was asked to come together to create a shared plan, called the Sustainability and Transformation Plan (STP), for tackling the three 'gaps' of the Five Year Forward View:

- Health and wellbeing – requiring a radical upgrade in prevention;
- Care and quality – requiring integrated, person-centred care;
- Funding and efficiency – closing the affordability gap.

The local 'footprint' we chose for this STP is Hampshire & Isle of Wight (HIOW) and Southampton City Clinical Commissioning Group (CCG) will play its full part in this, building on the approach we have developed with our partners in the City. Across this system, we face a number of significant shared challenges which means that the way services are provided needs to change:

- Demand for health and care is growing at an unaffordable rate whilst people are living longer, they are increasingly spending longer in poor health;
- Too many people are admitted to hospital and stay in hospital longer than they need to;
- In most sectors we struggle to recruit and retain sufficient numbers of staff;
- As a result, many of our critical health and social care services are under severe pressure.

Throughout 2016, leaders across Hampshire & Isle of Wight health and care organisations have come together to develop a plan of how we will work together to tackle our shared challenges. In October 2016, a delivery plan was produced which outlines the core priorities for the HIOW STP over the next few years. These include:

- Deliver prevention, early intervention and self care at scale and with the support of new technologies;
- Accelerate new models of integrated local care and ensure sustainability of general practice;
- Address the issues that delay patients being discharged from hospital, learning from recent achievements in Southampton;
- Deliver the highest quality, safe and sustainable and efficient acute services to Southern Hampshire and the Isle of Wight, and;
- Improve the quality, capacity and accessibility of specialised mental health services whilst joining up care with other local community services.

The STP enables a proportionate, tiered approach: successful collaboration at scale on the issues that need it, whilst maintaining a focus on local action connected to communities.

The Southampton City CCG Operational Plan is fully aligned with the wider aims of the STP and translates them into practical action. It continues our local journey, working with our partners in Southampton City Council and providers in the City to deliver our Better Care Southampton programme. Our plan details how, over the next two years, together we will achieve reconfiguration of health, social care, housing and other services into integrated teams based around populations (clusters) of 30-50,000 people building on the GP practice registered list that is the backbone of primary care. It shows how, working with the voluntary sector and building strong supportive communities, patients and service users will benefit from easier access to information and have more control and support over their care. GPs will be collaborating with housing, social workers, community nurses and therapists to discuss and understand the whole needs of individuals and their communities. Pooling knowledge and experience means we bring a more joined up and considered approach to care.

Our Operational Plan also meets the requirements of the NHS England planning guidance for 2017-2019, specifically:

- To deliver national standards
- To deliver business rules
- To deliver the Five Year Forward View nine "must do's"
- To demonstrate how our Operational Plan will support the delivery of the HIOW STP

The action plans in this document have been developed by our CCG leads and outline our work programmes over the next two years to deliver significant changes required to achieve both the CCG objectives and the delivery of the HIOW STP.

In particular, our plan demonstrates how we will meet national commitments to invest in mental health and in primary care, whilst also following the principles of the STP in terms of shifting the balance of investment away from hospital services supported by evidence of realistic and quantified actions. The stable platform of control that has been the result of diligent work over the past three years will now be converted into lasting positive change.

We will monitor our plan on a quarterly basis with a half year review at our CCG Governing Body. Overall, our plan will take us much closer towards our vision of making Southampton a healthy city for all.

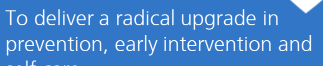
John Richards
Chief Executive Officer
NHS Southampton City CCG

Dr Sue Robinson
Clinical Chair and GP
NHS Southampton City CCG

Our 2-Year Operational Plan on a Page (2017/18 – 2018/19)

Hampshire & Isle of Wight STP priorities

Prevention at Scale



To deliver a radical upgrade in prevention, early intervention and self care

Better Care Southampton

To accelerate new models of integrated local care and ensure sustainability of general practice

Effective Patient Flow & Discharge

To address the issues that delay patients being discharged from hospital

Acute Care System

To ensure the provision of sustainable acute services across Hampshire & Isle of Wight

Mental Health

To improve the quality, capacity and access to mental health services

Enablers: Digital, Estates, Workforce and New Commissioning Models

Southampton City Clinical Commissioning Group (CCG) vision & objectives – "A healthy Southampton for all"

- Behaviour change: Improve health outcomes through behaviour change initiatives that support healthy choices.
- Cancer: Improve cancer screening uptake, earlier cancer diagnosis, survival rates and deliver NHS Constitution standards.
- Diabetes prevention: Reduce the risk of patients developing Type 2 diabetes through education, support to lose weight and physical exercise programmes.
- Falls prevention: Improve falls prevention services to ensure people who have had a fall or are at risk of a fall have access to effective prevention services.
- Care technology (telehealth): Increase the independence and quality of life for vulnerable older people, individuals with a learning disability and others.

- Integrated health & social care (Better Care Southampton): Develop integrated health and social care which provides community based person-centred care closer to home and develops integrated provision for 0-19 year olds.
- Long term conditions: Develop care pathways in the community for people with long term conditions to improve case finding, management and support.
- Primary Care: Develop a strong, effective and sustainable model of primary care which improves access, quality, infrastructure, workforce and collaboration.
- Learning disabilities: Deliver actions to transform care for people with learning disabilities.
- End of life & complex care: Improve the experience of care in the last year and months of life.

- Discharge planning: Ensure that every patient has a discharge plan which is understood by professionals, the patient, their relatives and carers, and includes plans for any future care needs.
- Effective management of patient flow: Manage the capacity, demand and utilisation of every bed across the Acute, Community and Mental Health sectors.
- Complex discharge and hard to place patients: Identify patients with complex needs and design appropriate support that prevents readmission, long lengths of stay and patient decompensation.
- Development of onward care services: Develop and provide cost effective onward health and social care services that maximise patient outcomes.

- Urgent & emergency care: Develop NHS 111 to be the gateway to the urgent care system, ensure our population knows what services are available so A&E is no longer the default choice, in a life threatening emergency people will be rapidly transported to hospital and will receive the highest quality of care from expert consultants, and services will meet national standards.
- Elective care: Getting people to the right place first time, eliminating waste and duplication across all stages of treatment e.g. eliminating face to face follow ups, and faster access to diagnostics and treatment.
- 7 day standards for urgent care in hospital: Implementation of the four priority standards that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

- Acute & community mental health: Review and redesign current acute pathways and community service provision and develop a network of services across the whole age range.
- Mental health rehab pathway & out of area placements: Ensure people supported in out of area placements and repatriated and supported in locally provided services.
- Mental health crisis care: Develop pathways to ensure people presenting in mental health crisis have access to timely, appropriate care.
- Dementia: Improve dementia diagnosis, care and support.

- Quality: Ensure people are provided with a safe, high quality, positive experience of care in all providers.
- Sustainable finances: Creating a financially sustainable health system for the future.

Our Key Outcomes

- ✓ People are better supported to **stay well and independent**, with greater confidence to manage their own health and wellbeing
- ✓ More people have a **positive experience of care** which is joined up and tailored to meet the needs of individuals
- ✓ Reduced inequalities in **life expectancy**
- ✓ Better **health outcomes** for people with long term conditions and mental health issues
- ✓ Better **access to primary care**, with appointments 7 days a week
- ✓ Reduced **delayed transfers of care** and length of stay following a hospital admission
- ✓ People are able to access **safe, acute services**, 7 days a week
- ✓ Reduced **hospital demand** (elective, A&E and non elective admissions)
- ✓ Consistently **good, coordinated and timely mental health services** experienced by people in a mental health crisis

Prevention at Scale

OVERALL OBJECTIVE

To improve healthy life expectancy and reduce dependency on health and care services through a radical upgrade in prevention, early intervention and self care

Prevention at Scale

Behaviour Change

Objective: Improve health outcomes through behaviour change initiatives that support healthy choices

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

Broad Actions

- Implementation of the newly commissioned Behaviour Change service (in conjunction with Public Health at Southampton City Council)
- Build "stop before the op" into acute contracts and embed the current CQUIN programme around Making Every Contact Count (MECC), to ensure that all patients receive prevention messages about lifestyle choices in all care settings.
- Promote eye health
- Participation in the second wave of the Diabetes Prevention Programme
- Support primary care and Public Health with the NHS Health Check programme

Smoking

- Work with providers to identify and target people who smoke with a long term condition
- Commission mental health services that prioritise reducing the very high prevalence of smoking in this group.

Obesity

- New Tier 2 weight management programme tendered in conjunction with behaviour change programme
- Review the weight management pathway in the city and prioritise weight loss as an intervention to reduce long term conditions and health inequalities.

Alcohol

- Working with Southampton City Council & Public Health to develop an alcohol strategy for the City

Mental Health

- Increase of physical health screening for patients with serious mental illness (SMI) in line with or greater than the population without SMI, offering parity of esteem for all individuals.
- Work with secondary care mental health provider to develop a training programme which enable staff to support behaviour change in clients with regards to their physical health, including smoking cessation, exercise, weight and diet and alcohol consumption.

Our Key Actions in 2018/19

- To monitor progress and work with providers to develop services to achieve the overarching objectives and outcomes for the city
- To further roll-out healthy conversation/motivational interviewing training

Key Outcomes by the end of 2018/19

- ✓ Reduction in the number of residents who smoke (4,900 fewer adults, 115 fewer pregnant women)
- ✓ Increase in the number of residents who are physically active (5,650 fewer being physically inactive)
- ✓ Increase in the number of residents who eat a healthy diet
- ✓ Increase in the number of residents who achieve and maintain a healthy weight (200 fewer adults classified as obese)
- ✓ Reduction in the number of residents drinking alcohol at risky levels (8,500 fewer adults binge drinking)
- ✓ MECC is an adopted and embedded culture for stakeholders
- ✓ Reduction in co-morbidities

Cancer

Objective: Improve cancer screening uptake, earlier cancer diagnosis, improve survival rates and deliver NHS constitution waiting time standards.

Leads: Peter Horne, Lisa Sheron

Our Key Actions in 2017/18

- Ensure our Cancer Plan aligns with the National Cancer Strategy, FYFV and the STP priorities, supports collaborative working with all stakeholders across Wessex, takes a RightCare approach and has prevention and patient experience at its heart.
- Work with University Hospital Southampton to ensure that constitutional standards are delivered through ensuring that pathways are as efficient as possible.
- Carry out audit of lung cancer pathways to understand their pathway and what improvements can be made and to improve the staging of cancer.
- Implement direct access to CT for GPs for the lung pathway. The lung pathway is the primary focus as Southampton has poor outcomes for this tumour site.
- Work with primary care and Public Health England to ensure that screening rates are maximised and promote uptake of cancer screening programmes, particularly in minority ethnic groups and those with learning disabilities and mental health problems.
- Investigate the introduction of a vague symptom pathway as part of the two week wait pathway. This is to prevent patients from being on multiple pathways and help with the early detection of cancer.
- Implement Significant Event Analysis for patients diagnosed with cancer as a result of an emergency admission. This is to understand whether there are any gaps in the provision of services.
- Use the locally developed Cancer Dashboard to target those practices/areas that need particular assistance.
- Review diagnostic capacity (in particular CT) to ensure that the GP 28 days to diagnosis pathway can be delivered by 2020.
- Implement our End of Life Strategy Action Plan.
- Implement an integrated health improvement and behaviour change service for the city that will promote healthy lifestyles and support healthy behaviour change.
- Roll out elements of the Recovery Package.
- Develop and support the roll out of personal health budgets and promoting personalisation for patients/individuals who could benefit from the flexibility of a personal health budget or joint health and social care budget.

Our Key Actions in 2018/19

- Commission all elements of the Recovery Package. Including the holistic needs assessment, a treatment summary sent to the GP at the end of treatment.
- Implementing direct access to CT for GPs for the GI pathway.
- Ensure that stratified pathways are rolled out across all pathways.
- Ensure that sufficient diagnostic capacity is available to implement the 28 days to diagnosis pathway. This will be dependent on the review, carried out in 2017/18.
- Work with providers to ensure all mental health patients have Health Passports and increase take-up of screening with Serious Mental Health Illness.
- Work with providers to progress an End of Life Hospice at Home/Rapid Response service.
- Work with acute providers to map out the cancer pathways (in relation to 28 days to diagnosis pathway).
- Carry out cancer training on new pathways for primary care.
- Ensure that local cancer pathways are embedded into the clinical decision support tool, in advance of the two week wait pathway being phased out.
- Audit cancers diagnosed at Emergency Presentation locally.

Key Outcomes by the end of 2018/19

- ✓ Delivery of the NHS Constitution 62 day cancer standard
- ✓ Improvement in the one year survival rates
- ✓ Diagnosing earlier – improving the proportion of cancers diagnosed at stages one or two
- ✓ Reduce the proportion of cancers diagnosed following an emergency presentation
- ✓ Stratified care pathways introduced

Prevention at Scale

Diabetes Prevention

Objective: Reduce the risk of patients developing Type 2 diabetes through education, support to lose weight and physical exercise programmes.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Work with collaborative partners across the STP footprint to implement wave 2 of the National Diabetes Prevention Programme (NDPP) from April 2017.
- Continue to progress improved Diabetes management in primary care through the Primary Care Local Improvement Scheme in 2017/18 in support of the new model of care for long term conditions including Diabetes.
- Improve the achievement of the three Diabetes treatment targets for HbA1c, Blood Pressure and Cholesterol by reducing variation in the city and ensuring that the city wide average of 41% achievement remains inline with the national average for Type 2 Diabetes.
- By working with primary care, the community diabetes provider and patients, review barriers which impact on the uptake of structured education for all diabetes education programmes provided in Southampton city (Type 1, Type 2 and refresher education).
- Continue to monitor and improve local foot care pathway and increase patient education programme to support patients with a low risk status to help to maintain this status.
- Enhance self-management programmes targeted at people with a LTC to reduce health inequalities.
- Develop and support the roll out of personal health budgets and promote personalisation for patients with a long term condition.

Our Key Actions in 2018/19

- Build on the first year of the NDPP to further improve local take-up to the scheme .
- Review 2017/18 Primary Care local improvement scheme and develop 2018/19 scheme as part of a continuous improvement programme for long term conditions.
- Continue to work to develop an improvement in average achievement of treatment targets in primary care to prevent complications in diabetes.
- Following review and the evaluation of the barriers which impact on the uptake of structured education work with the local community provider, primary care, to improve uptake locally. Following details of transformational bids, our focus will be to enhance Type 1 education.

Key Outcomes by the end of 2018/19

- ✓ By end 2017/18 5,700 referrals made to the NDPP across STP
- ✓ By end 2018/19 additional 6,000 referrals made to the NDPP
- ✓ Improvement performance in the achievement of treatment targets to reduce the complications of diabetes
- ✓ Increase uptake of structured education in Southampton city

Falls Prevention

Objective: Improve falls prevention services to ensure people who have had a fall or are at risk of a fall have access to effective prevention services.

Leads: Stephanie Ramsey, Donna Chapman,

Our Key Actions in 2017/18

- Continue to increase the number of Falls Champions in community settings, including domiciliary, residential and nursing care providers to promote falls prevention and identify risk factors.
- Continue to increase home safety checks in partnership with Hampshire Fire and Rescue Service (HFRS) so that vulnerable individuals can benefit from a multi-faceted home safety check.
- Establishment of a Fracture Liaison service and database, to ensure that patients with poor bone health and falls risk are identified, followed up and supported with treatment plans.
- Continue to commission targeted exercise classes, whilst seeking to develop exercise classes at whole population levels working with leisure services.
- Work with primary care to improve identification of poor bone health risk factors with clear routes into services.
- Pilot the use of telecare solutions to reduce and manage the risk of patients with falls risks.

Our Key Actions in 2018/19

- Embed, evaluate and further improve developments in 2017/18.
- Roll out exercise and falls prevention awareness at whole population level.

Key Outcomes by the end of 2018/19

- ✓ Reduce the number of falls with injury by 3% year on year 17/18 – 20/21 to achieve the current average of our comparator CCGs

Care Technology (Telehealth)

Objective: Increase the independence and quality of life for vulnerable older people, individuals with a learning disability and others

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

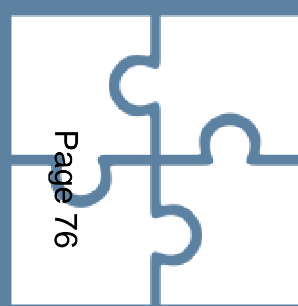
- Implement the Care Technology Strategy (Phase 2).
- Connect and embed the implementation of the Care Technology Strategy within the STP developments.
- Increase the use of care technology as a 'first offer' in both social care and health assessment pathways.
- Support the expansion of local initiatives including:
  - Telehealth vital sign monitoring in nursing homes;
  - Use of GPS to support independent living;
  - Use of Video technology to reduce isolation and improve care at home/independent living, and;
  - Reduce the use of 15 minute home care visits through the use of care technology.

Our Key Actions in 2018/19

- Deliver a fully integrated care technology enabling pathway within Better Care Southampton.
- Continue the expansion of local initiatives including:
  - Video consultations in nursing homes; and
  - Telehealth vital sign monitoring in residential care homes.
- Extend the reach of care technology:
  - To connect with patient records;
  - Provide system wide visibility (within confidentiality parameters) to digital information/ vital sign monitoring, and;
  - To support and assist unpaid carers.

Key Outcomes by the end of 2018/19

- ✓ Year on year 20% increase in the number of adult social care clients with care technology embedded into their care package.
- ✓ Year on year 20% increase in the number of health referrals that take up the use of telecare.
- ✓ 9 city based nursing homes use telehealth for vital sign monitoring
- ✓ Integrated provision of care technology service provision (e.g. installation, monitoring and response service)



Better Care Southampton

(New Models of Integrated Local Care)

OVERALL OBJECTIVE

To accelerate new models of integrated care and ensure sustainability of general practice.

Better Care Southampton

Integrated Health & Social Care (Better Care Southampton)

Objective: Develop integrated health and social care which provides community based person-centred care closer to home and develops integrated provision for 0-19 year olds.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

Continue to roll out our vision to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. This will mean further delivering on our 6 key priorities:

- More rapid expansion of the integration agenda across the full life-course, to include children and families as well as adults and older people.
- A much stronger focus on prevention and early intervention.
- A more radical shift in the balance of care out of hospital and into the community.
- Significant growth in the community and voluntary sector - to achieve the focus on prevention and early intervention required and divert people away from public funded services by building resilience, promoting independence and access to community resources.
- Development of new organisational models which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies.
- New contractual and commissioning models which enable and incentivise the new ways of working described above.

Our key actions for 2017/18 will be:

- Developing place based commissioning focussed around our 6 clusters, principles of integrated person centred care and strong cluster based leadership and accountability.
- Exploring new contractual and payment structures to better support our vision of integrated local care.
- Developing primary care in line with the city's primary care strategy as the bed rock to our vision.
- Embed delivery of 7 day services.
- Roll out discharge pathways and processes, underpinned by discharge to assess and trusted assessment principles.
- Develop community services to support the management of higher levels of acuity in the community.
- Formally integrate prevention and early help services for children 0-19 and their families to deliver a more streamlined pathway of support that enables more families to manage independently, thereby increasing family resilience, promoting the protective factors for children and young people and reducing the need to resort to expensive specialist or statutory intervention.
- Support to develop the community and voluntary sector as equal partners in achieving our vision. To include specific developments such as roll out of care navigation, development of our "older person's offer" and development of advice, information and guidance.
- Continue to develop delivery of care and support centred around integrated care planning through integrated systems and governance.
- People being in control of their care or support – through user led delivery, development of one plan and formalisation of coordination and key worker roles.
- Further development of the proactive approach to identification of those most at risk, expanding the focus from 2 – 5% and across the whole life course.
- Support to carers – work with Southampton City Council to ensure increased identification and signposting of carers.

Our Key Actions in 2018/19

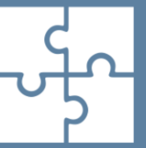
To continue to implement our vision for integrated person centred care, delivered as locally as possible and our 6 priorities.

Our key actions for 18/19 will be:

- To commission at a place based level, centred around the city's 6 clusters, devolving greater responsibility for resources and delivery of city wide targets. This will involve in working closely with providers to embed new forms of delivery which have been tested in 2017/18 to be extended and formalised.
- Implementation of new contractual and payment mechanisms to support this.
- Further strengthening and modernising primary care.
- Seek to formalise the shift the balance of care from acute to community where this is appropriate – through integrated models of delivery.
- Ongoing development of links with health and social care, promoting alignment in commissioning and provision where this is appropriate.

Key Outcomes by the end of 2018/19

- ✓ Reduction in NEL admissions
- ✓ Reduction in delayed discharges and transfers of care (to achieve and maintain the national DTOC target)
- ✓ Reduction in permanent admissions to residential and nursing homes
- ✓ Improved patient experience as measured against the National Voices 'I' Statements



Better Care Southampton

Long Term Conditions

Objective: Develop care pathways in the community for people with long term conditions (Diabetes, Respiratory and Cardiovascular) to improve case finding, management and support.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Continue to progress improved management of long term conditions in primary care through the Primary Care Local Improvement Scheme in 2017/18. This approach supports our new models of care for long term conditions by promoting improved knowledge and skills through training and education, improved practice processes and management of care through audit, implementation of learning and sharing of good practice and the utilisation of specialist community teams in the practice setting.
- Implementation of the 'learning to listen' strategy to improve outcomes for those with more than one long term condition.
- Building upon the work to date, develop integrated models which places care and expertise in the most appropriate setting. Where possible to support collaboration between this pathway and other long term condition areas. Specific focus will be on Cardiology which will include Heart Failure. The other two most common long term conditions this approach will impact on is for those with Diabetes and COPD.
- Continue to review and make recommendation to reduce NEL admissions for those with long term conditions, particularly where resource use is high, including COPD and other respiratory conditions, and those with Diabetes complications.
- Continue to review best practice and emerging new models of care across the STP to help promote improved outcomes within the city, such as Mission ABC and include review of new technologies.
- Work with Mental Health Commissioners to continue to review and develop plans to improve psychological support for those with a long term condition.
- Basing delivery on the key principles of better care and those within the learning to listen guidance.
- Enhance self-management programmes targeted at people with a long term condition to reduce health inequalities, through Collaborative Care and Support Planning.
- Develop and support the roll out of personal health budgets and promote personalisation for patients with a long term condition.
- Prevention - Deliver early detection and management of cardiovascular disease programmes including promoting the NHS Health Check programme and delivery of regular Know Your Blood Pressure events at community events and corporate workplaces and the atrial fibrillation pilot.

Our Key Actions in 2018/19

- Review 2017/18 Primary Care local improvement scheme and develop 2018/19 scheme as part of a continuous improvement programme for long term conditions.
- Improve access rates for psychological support for those with a long term condition in line with the national targets.
- Building upon the work with all commonly occurring long term conditions support primary care to develop integrated person centred approaches to collaborative care and support planning as standard.
- Continue to review and make recommendation to reduce NEL admissions for those with long term conditions, particularly where resource use is high, including COPD and other respiratory conditions, and those with Diabetes complications.
- Continue to review best practice and emerging new models of care across the STP to help promote improved outcomes within the city, such as Mission ABC and include review of new technologies.

Key Outcomes by the end of 2018/19

- ✓ By end 2018/19 improve access target to 19%
- ✓ Promoting person centred delivery – evidenced through qualitative evaluation approaches.
- ✓ Promoting person centred delivery - evidenced through specialist advisory role promoting individuals single care plan.
- ✓ Increase the number of people with long term conditions who access Psychological Support in line with agreed trajectory.

Primary Care (Access)

Objective: People are provided with access to the level of care that they need at the appropriate time, with same day access and services available in the evenings, 7 days a week.

Leads: Stephanie Ramsey, Sue Robinson, Ali Howett

Our Key Actions in 2017/18

- Continue to commission (following handover of contract from NHS England) an Enhanced Access Service to deliver improved access coverage for same day and pre-booked appointments, Monday to Friday 8am to at least 8pm and, Saturdays and Sundays to meet local population needs, against a clear service specification which includes the national core requirements, building on the learning from the Prime Minister's Challenge Fund (PMCF) pilot and feedback from patients, the public and other key stakeholders. Ensure this service is well publicised to maximise uptake/coverage and address inequalities in access.
- Ensure the Enhanced Access Service is providing a minimum additional 30 minutes consultation capacity per 1,000 population, making use of the national new capacity monitoring tool to match capacity to demand, both in-hours and in extended hours.
- Develop and implement commissioning plans for the Enhanced Access Service into 2018/19 and beyond, following appropriate procurement processes.
- The existing Enhanced Access Service already delivers improved access to primary care services. Our plans ensure that we will continue to build on that success.
- Develop the use of digital approaches to support new models of care in general practice, e.g. e-consultations, online assessment (funding for online general practice consultation software systems). E-consultations will be piloted in Q4 2016/17 in collaboration with Southampton Primary Care Limited with a view to full coverage by 1st April 2018.
- Work with current Out of Hours provider to identify and implement opportunities for providing additional capacity for same day appointments within the Enhanced Access Service hubs to relieve pressure on OOH and emergency services and deliver a more coordinated and integrated pathway of support 24 hours a day, 7 days a week, removing duplication.
- Explore, test and develop the roles of other professionals as part of the primary care team, using learning from the PMCF and other pilots, including advanced nurse practitioners (ANPs), clinical pharmacists addressing polypharmacy in elderly people and helping management of long term conditions, mental health therapists, physiotherapists as well as voluntary and community support groups.
- Further develop the model of care and support planning, improving patient activation and education, linking this to the extension of the Local Improvement Scheme (LIS) and work with community and voluntary sector partners e.g. roll out of community navigation and other community solutions (see Collaboration section) and enhanced use of technology, to educate and support patients to manage their own health.
- Develop a self-referral model for patients presenting with Musculoskeletal (MSK) problems who can directly self refer to physiotherapy. Looking at MSK triage in primary care and booking with the appropriate service.
- Continue to develop the scope and reach of the minor ailment scheme in community pharmacies.

Our Key Actions in 2018/19

- Secure future delivery of the Enhanced Access Service, following appropriate procurement processes ensuring continued programme of patient engagement informs the future model of delivery.
- Ensure the Enhanced Access Service is providing a minimum of 45 mins consultation capacity per 1,000 population.
- Continue to develop the use of innovative technological solutions to improve access and self management as part of core primary care.
- Develop programme to promote new ways of accessing primary care.
- Embed new contracts for OOH Service and NHS 111, ensuring strong alignment and collaboration with the Enhanced Access Service and core primary care service delivery to deliver seamless, fully integrated primary care pathways 24 hours a day, 7 days a week.
- Continue to develop the role of other professionals as part of the primary care team, based on the learning from 2017/18 e.g. ANP and clinical pharmacist (one per 30,000 population) available to all surgeries, roll out of mental health therapists, physiotherapists.
- Trained facilitators to support roll out of care and support planning to cover 4% of the population (5% by 2019/20).
- Continue to work with system partners to streamline access to services, ensuring people get to the most appropriate service first time, through development of mechanisms like single point of access.
- Explore self-referral models for other service areas.

Key Outcomes by the end of 2021/22

- ✓ People can telephone or visit their surgery any time between 8am and 6.30pm, Monday to Friday.
- ✓ Pre-booked and same day appointments are structured across 7-days per week to meet peoples' needs.
- ✓ Providers of primary and secondary care services work together to co-ordinate a fully integrated community based primary care pathway for urgent care 24 hours and 7 days a week.
- ✓ Patients are encouraged, educated and empowered to manage their own health and understand when clinical intervention is needed.
- ✓ Innovative and technological solutions to support access, for example e-consultations, apps, home monitoring and telemedicine, are embedded as part of core primary care service delivery.

Primary Care (Quality)

Objective: People are provided with high quality care which is safe and effective, meeting their needs. People have a positive experience, which is person-centred, dignified and compassionate.

Leads: Stephanie Ramsey, Sue Robinson, Ali Howett

Our Key Actions in 2017/18

- Implementation of a Quality Framework for Primary Care (medical) by working closely with general practice and identifying local health care needs.
- Patients and general practice work together to support patient engagement, empowerment, self care and self management; through the use of collaborative working, care planning and the development of new consultation types with all healthcare professionals.
- Development of the multi-disciplinary approach to support physical and mental health working with a range of healthcare professionals including community pharmacists, district nurses, dentists, opticians, etc.
- Work to reduce the variation in quality through the development of key skills and knowledge across the healthcare system, to deliver both public health and healthcare support; providing a single view of the patient's health across the health and social care system.
- Meet patient needs by working with existing partners and developing new partnerships with health and social care providers within the cluster model.
- Support general practice to further develop a learning culture through the review of incidents and event reporting. Engraining in the sharing of information and outcomes to enhance the safety environment.
- Establish a standardised approach to mortality review in primary medical care, building on the work already underway in Solent NHS Trust primary medical care practice.
- Review the TARGET meetings structure to support quality improvement.
- Review inequalities in primary medical care with a particular focus on accessing general practice based on local evidence and agree actions to resolve any inequalities identified.
- The cluster resource centres currently in development will ensure equity of access to primary care in areas of high need.
- We will further strengthen the support available to practices with a poor CQC outcome in collaboration with the GP Federation.
- Building on the work already completed in 2016/17, we will work to identify practices who would benefit from the GP resilience programme and support them to access this.
- Develop plans with Public Health England to increase the uptake of screening and immunisations for identified target groups, inclusive of local resilience planning.

Our Key Actions in 2018/19

- Extend a Quality Framework for Primary Care (medical) through working closely with general practice, the clusters and new models of care to agree and deliver on quality standards.
- Establish a comprehensive support programme for patients who are engaged in self care and self management. To include education and peer support, working closely with voluntary and charity providers.
- Extend the multi-disciplinary approach to involve both out-reach and in-reach services to support the principle of the right time, right place, right professional. Supported by access to a single view of the patient record.
- Work with general practice and other providers of health and social care to deliver a comprehensive learning and development programme for healthcare professionals; learning together to share knowledge and skills and develop professional networks and relationships.

Key Outcomes by the end of 2021/22

- ✓ The quality framework shows evidence of reduced variation in the quality of care delivered across all practices
- ✓ Expected standards for screening and immunisations are achieved across the whole population, using the principle of making every contact count
- ✓ Patient reported outcome measures such as the GP Patient Survey and Friends and Family Test demonstrate improved satisfaction and experience
- ✓ Health professionals have all the clinical knowledge and skills required to deliver safe and effective care to meet the needs of the population
- ✓ There is evidence that providers are engaged in incident/event reporting and peer review to support a culture of ongoing learning and development
- ✓ Practices throughout the city are rated good/outstanding by the CQC

Primary Care (Workforce)

Objective: Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers.

Leads: Stephanie Ramsey, Sue Robinson, Ali Howett

Our Key Actions in 2017/18

- Focus workforce activities on supporting the CCG's future model of primary care with the patient at the centre.
- Update our baseline survey of current workforce in general practice, workload demands and identifying practices that are in greatest need of support; including the development of a "safe working day" in general practice.
- Create a CCG wide workforce development plan which sets out future ways of working, including the development of multi-disciplinary teams, support for practice nursing and establishing primary care at scale; including new roles such as clinical support officers, physicians assistants, visiting practitioners and other healthcare professionals working in primary care.
- Support the development and implementation of initiatives to attract, recruit and retain GPs and other clinical staff, taking advantage of locally designed and nationally available schemes. Consider the development of general practice nurse consultant roles who have even broader expertise than advanced nurse practitioners.
- Build on the new model of primary care in the city to ensure GPs are operating at the top of their license, for example through use of clinical pharmacists and upskilling other healthcare professionals to manage less complex health problems.
- Commitment to develop, fund and implement local workforce plans in line with the GPFV and support delivery of the STP.
- Support practices to access the GP resilience programme to support the development of a sustainable and resilient workforce in the city.
- Build on existing support networks for practice staff such as the practice nurse forum and practice managers forum by developing a menu of support and development for all practice staff including mentorship and coaching.
- Support the development of cluster based practice management including sharing best practice across clusters and across the city.
- Develop relationships with Health Education England (Wessex) to support workforce development and planning in Southampton.
- Explore options with wider CCG partners to support new ways of working / new models of care for primary care in line with the STP.
- Develop extended community navigators (Social Prescribers) someone who is a highly emotionally intelligent fixer with motivational skills, with a close working relationship with the GPs and practice staff.
- Develop multidisciplinary working to support nursing and care homes.

Our Key Actions in 2018/19

- Facilitate an expanded multi-disciplinary team and greater integration across community services to optimise out of hospital care for patients including access to premises, diagnostics, technology and community assets.
- Establish the viability of a city wide "chambers" (staff bank) for flexible working, with a focus on development of roles including clinical leadership, special interests. Apply beyond GPs and include all practice staff.
- Development of new roles and extension of those already in place to practices.
- Development of career pathways for GPs and other practice staff to support recruitment and retention, including supporting staff to work in different practices where possible to gain boarder experience. Including the development of special interests – linking to moving work into primary care.
- Establishment of city wide protocols / charters to support reducing the burden of document and data transfer for GPs, including robust systems for clinical support officer / physicians assistant type roles.

Key Outcomes by the end of 2021/22

- ✓ Practice teams are motivated and engaged, incorporating a range of skilled professionals delivering the appropriate level of care to meet patients' needs.
- ✓ Professional development and succession planning are embedded principles for all providers.
- ✓ GPs and other health and care professionals working in the city are supported to achieve their preferred career pathway and develop special interests, so facilitating recruitment.

Primary Care (Infrastructure)

Objective: Fit for purpose premises which enable access to clinical services out of hospital, 7 days a week. Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care.

Leads: Peter Horne, Paul Benson

Our Key Actions in 2017/18

Primary Care Estates

- Building on work already undertaken during 2016/17, obtain approval for and deliver a comprehensive survey/inventory of the primary care estate across Southampton.
- Identify high-priority issues from the inventory that require rectification insofar as they are obstacles to the delivery of the Primary Care Strategy and/or Better Care Southampton Plan. Develop a costed rectification plan which will take the form of the "modernisation programme".
- Complete a business case development for the establishment of six Cluster Resource Centres (CRCs) across the city. Subject to successful due diligence, one of these – Shirley Health Centre - will be part-funded (66%) via the Estates and Technology Transformation Fund (ETTF) and the procurement process is expected to be completed in the early months of 2017/18 to ensure that this development is completed by the end of 2018/19.
- In respect of the other five CRCs, and assuming the business cases receive necessary approvals and consents, initiate the procurement of the CRCs and commence building works where feasible.
- Work closely with CCG colleagues and members to understand the estate implications of the Primary Care Strategy and specifically the emerging solutions within each cluster.
- Monitor the development of new capital funding options, such as those being developed currently (Autumn 2016) by NHS Property Services/Community Health Partnerships (e.g. "Project Phoenix").
- More information on primary care estates can be found on page 37.

Primary Care Technology

Please refer to the Digital section on pages 35-36

Our Key Actions in 2018/19

Primary Care Estates

- Continue the implementation of the primary care estate modernisation programme.
- Complete the development of the ETTF-funded Cluster Resource Centre at Shirley Health Centre.
- Continue the work on fulfilling our long term aspiration for a Cluster Resource Centre in each of the six clusters. Engagement with partner organisations is a critical part of this development.

Primary Care Technology

Please refer to the Digital section on pages 35-36

Key Outcomes by the end of 2021/22

- ✓ Completion of a modernisation programme ensuring that primary care premises are fit for purpose, provide increased capacity and enable services to be delivered 7 days per week.
- ✓ Flexible, multi-use space is available which is adaptable to service needs and can accommodate innovative and collaborative projects for health and social care provision in partnership with other agencies.
- ✓ A resource centre is located in each of the six clusters across the city providing; a multi-occupancy base for the integrated team supporting all practices in the cluster; multi-use space for training, outreach services and other local initiatives; and information and tools to support people to manage their own health.
- ✓ Premises and technology developments support a culture of learning and education for both staff and patients.
- ✓ Clinical computer systems are interoperable, facilitating communication and information sharing between all parts of the health and care system.
- ✓ Creative and innovative digital solutions which support and empower people to manage their own health are embedded.

Better Care Southampton

Primary Care (Collaboration)

Objective: Sustainable and resilient GP services support delivery of integrated care in the city.

Leads: Stephanie Ramsey, Sue Robinson, Ali Howett

Our Key Actions in 2017/18

- Develop and test collaborative initiatives which support practices working at scale e.g. acute home visiting service, acute same day appointments, online consultations.
- Develop and pilot workforce development initiatives, such as expanding the roles of community pharmacists, introducing medical assistants and signposters into expanded practice teams.
- Maintain the pace for MCP/new model of care development including a structure that is acceptable to the CCG, practices and Southampton City Council. Take first steps in 2017/18 to the establishment of a voluntary shadow MCP/new model of care contract.
- Further develop the leadership of the clusters and strengthen the integration into decision making of the CCG.
- Through clusters, further develop the role of care/community navigators and third sector to support people develop their own plans. Care navigators or third sector supporting GP practices to develop care and support plans for at least 1% (one third of the new Local Improvement Scheme LIS) using an agreed delivery model.
- Develop the LIS to 3% of the population in 2017/18 and 4% in 2018/19 (5% in 2019/20). 80-90% of care plans to be undertaken at surgery level by the core team focused on the registered list but supported by cluster development. Wider cluster development to ensure care plans are supported by police, housing and social services.
- Develop the model for care and support planning as mainstream work and develop operating processes via the primary care development centre. 50% of practices in holding regular MDT's with community and surgery nurses in quality time within the LIS.
- Establish a plan for facilitated learning to implement person centred care.
- Establish clarity of services delivered within clusters laying the foundation for place based commissioning under MCP or equivalent.
- Formally hand over accountability of cluster leadership to clinical and managerial leadership from within each group.
- Establish simple metrics for measuring patient experience and test in shadow form in 2017/18.
- Through the cluster dashboard generate mirror responsibility for performance against key system metrics.

Our Key Actions in 2018/19

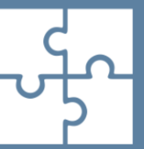
- Shadow MCP/new model of care contract to become real with at least 33% of practices volunteering.
- Implement devolved responsibility for key system performance metrics.
- Formally hand over accountability of cluster leadership to MCP.
- 2% of care and support plans (50% of LIS) begin undertaken with care/community navigators .
- 100% of practices holding regular MDT in core quality time.
- Implement patient experience metrics into the LIS contract.

Key Outcomes by the end of 2021/22

- ✓ GP practices operating within a business framework that ensures sustainable primary care.
- ✓ Practices are working together to build a resilient service in the future which operates at scale but remains focused on the registered population.
- ✓ Primary care is fully engaged with the local integrated provider group to deliver true person centred, integrated care.
- ✓ The operating model delivers improvements to health outcomes, patient experience, access and workforce development.

Two documents are available separately to the Operational Plan which provide more detail on our strategic primary care plan:

- The Transforming Primary Medical Care in Southampton Five Year Strategy sets out our long term vision and objectives to ensure that the people of the city have access to high quality, consistent, sustainable primary care that meets their needs, whilst being attractive to support recruitment and retention of GPs and their allied staff, e.g. nurses or therapists.
- The Delivery Plan looks at the key actions for years one and two of the Transforming Primary Medical Care Five Year Strategy that will need to be implemented to take us a step closer towards achieving our vision of "building a model of general practice in our city that will be the strong, effective and sustainable foundation of our integrated health and social care system".



People with Learning Disabilities

Objective: Deliver actions to transform care for people with learning disabilities.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

The overarching action over the next two years will be implementation of the Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Plan for people with learning disabilities, including those with autism. The plan includes all CCGs and local authorities in the SHIP area as well as NHS England specialist commissioning for the region.

The work areas and action arising from the SHIP Transforming Care Plan and related Southampton specific plans are:

- Roll out of a community forensic service across Hampshire and Southampton to support individuals at risk of becoming inpatients and those who are being discharged.
- Roll out of Learning Disability Friendly GP Practices.
- Increase offer and uptake of annual health checks. This will focus in particular on the quality of health checks, ensuring that there are tangible outcomes written down in a health action plan. The processes involved in organising health checks, GP recording and payments will also be improved. The right to a health check will be promoted to individuals as well as to care/support providers so they can facilitate attendance and active involvement in the health check as well as implementing the actions from the resultant health action plan.
- Review annual health checks pilot work from 2016/17 and develop options appraisal for future service model and commissioning arrangements.
- Working with commissioners and providers of mainstream prevention services such as weight management, cancer screening, sexual health and others to ensure that reasonable adjustments are made so individuals with learning disabilities can access them.
- Continued involvement in the Learning Disability Mortality review 'LeDeR' programme so that premature deaths of individuals with learning disabilities can be learnt from and findings used to directly inform future commissioning practice and service delivery.
- Ensuring the LD workforce, including care providers are equipped to deliver Positive Behavioural Support.
- Identify the full range of housing options for individuals and provide clear easy to read guidance for them and their families.
- Work with local housing departments to expand the portfolio of high quality housing options for individuals including supported living.
- Implementation of an 'At Risk' register to identify individuals at risk of becoming inpatients and mitigating actions. A common criteria for inclusion is to be developed as well as appropriate data protection and information governance processes.
- Initial development of an integrated health and social care Learning Disability team which will support more effective joint working including holistic and person centred assessments, reviews and support plans.

Our Key Actions in 2018/19

Key actions in 2018/19 will primarily be to build on the progress made in 2017/18 towards implementing the SHIP Transforming Care plan. In particular there will be further work on:

- Increasing the availability and quality of annual health checks, including alternative commissioning arrangements (dependent on options appraisal completed in 2017/18).
- Continuing to develop the range of housing options for individuals. Many of the housing development projects will be multi-year so there will likely be ongoing work in this area, particularly in the creation of highly bespoke supported living properties.
- Continuing integration of health and social care Learning Disability teams, including options for colocation.

Key Outcomes by the end of 2018/19

- ✓ By the end of 2019, the SHIP region will have reduced the number of LD inpatients from 68 to 44.
- ✓ 75% of people with learning disabilities on GP registers receive an annual health check
- ✓ The number of people with learning disabilities on the 'At Risk' register decreases

End of Life & Complex Care

Objective: Improve the experience of care in the last year and months of life.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

The model of End of Life care across community and acute provision will provide:

- Equitable access to end of life/palliative care regardless of diagnosis.
- Consistent overnight and out of hours advice and support to allow patients to achieve their preferred place of care (where practicable).
- End of life/palliative care provided through integrated working, aligned with cluster teams with practitioners collaborating to ensure seamless 24/7care.
- Current domiciliary care arrangement for EOL provision managed differently.
- Workforce integration to provide a seamless integrated service where patients can transfer between levels as needs escalate/de-escalate.
- Support to develop End of Life knowledge and skills in the wider Integrated Care workforce.
- Progression of Six Steps EOL training in the wider care home sector.

Our Key Actions in 2018/19

- Build on and embed progress of 2017/18.
- Progress organisational culture to dispel myths and taboos around end of life.
- Progress with developments to establish a Hospice at Home Model
- Re-procurement of hospice function.
- Develop and support the roll out of personal health budgets and promoting personalisation for patients/individuals who could benefit from the flexibility of a personal health budget or joint health and social care budget.

Key Outcomes by the end of 2018/19

- ✓ Reduction in DTOC
- ✓ Increase in number of people achieving preferred place of care (PPC)
- ✓ Reduction in unnecessary admissions
- ✓ Reduction in SCAS call-out
- ✓ Increased capacity in domiciliary care market

Wheelchair Access

Objective: Reduce waiting times for wheelchairs

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Wheelchair service review to be undertaken Jan to March 2017, findings from review to inform service improvements in 2017/18.
- Review data definition with Commissioning Collaborative & Providers to accurately reflect new referrals and clock stops.
- Monthly service review meetings to continue in 2017/18 – commissioning representative from the across the collaborative partnership will continue to review performance of the service against service criteria ensuring that quality indicators are being achieved.
- Develop and support the roll out of personal health budgets as an option instead of the current voucher scheme and promote personalisation for wheel chair service users.

Our Key Actions in 2018/19

- Continue to performance monitor service provision.

Key Outcomes by the end of 2018/19

- ✓ Deliver the National Standard of no children waits over 18 weeks for wheelchairs

Effective Patient Flow & Discharge

OVERALL OBJECTIVE

To address the issues that delay patients being discharged from hospital

Effective Patient Flow & Discharge

Discharge Planning

Objective: Ensure that every patient has a discharge plan which is understood by professionals, the patient, their relatives and carers and includes plans for any future care needs.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

To continue to implement the 8 high impact change model of managing transfers of care. Specifically, we will:

- Implement the 3 standardised pathways that have been designed locally for discharge: 1) simple, 2) supported and 3) enhanced with clear operating procedures and a strong focus on discharge to assess using home first principles and trusted assessment .
- Tighten up the use of EDDs, to ensure that all patients have an expected discharge date and clinical criteria for discharge along with a discharge plan within 14 hours of admission.
- Strengthen the role of the community clusters in discharge planning, underpinned by good communication and sharing of information.
- Remodel the hospital discharge team to focus on more complex discharges.
- Develop the urgent Response Team (Rehabilitation and Reablement) to manage pathway 2, supported discharge, building on the 16/17 discharge to assess pilot.
- Develop the trusted assessment role within the hospital and community teams to support all pathways.

Our Key Actions in 2018/19

- Continue to embed and build on the actions undertaken in 2017/18, evaluating their impact.
- Strengthen communication and sharing of information through developments in the interoperability agenda.

Key Outcomes by the end of 2018/19

- ✓ Reduction in DTOC, working with WHCCG and providers to bring Southampton in line with the 3.5% national target
- ✓ Improved patient satisfaction of the discharge process

Effective Management of Patient Flow

Objective: Manage the capacity, demand, utilisation and efficacy of every bed based care space across the Acute, Community and Mental Health sectors.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Work with the hospital to implement the SAFER effective flow management bundle, to remove internal delay, working together to measure improvements in flow.
- Implement ambulatory care front door turnaround teams.
- Continue development of 7 day standards for urgent care in hospital.
- Continue to work with the market to develop onward care capacity to support timely discharge and flow, in particular domiciliary care.
- Continue to work with care homes to improve communication, encourage greater responsiveness to discharge and implement a model of enhanced healthcare support to care homes based on the NHS England publication and learning from the Vanguards.

Our Key Actions in 2018/19

- Continue to embed and build on the actions undertaken in 2017/18, evaluating their impact.
- Work with Southampton City Council to implement further improvements in onward care to support timely discharge, capitalising on opportunities linked to:
  - Recommissioning of the domiciliary care framework.
  - Commissioning of a nursing and residential care home framework.
  - Development of the Housing with Care Market.

Key Outcomes by the end of 2018/19

- ✓ Improvements in length of stay for patients staying 7-30 days
- ✓ Improvements in length of stay for episodes of 2-7 days
- ✓ Improvements in length of stay for episodes of 0-2 days

Effective Patient Flow & Discharge

Complex Discharge & Hard to Place Patients

Objective: Identify patients with complex needs early in their journey and design appropriate support that prevents readmission, eliminates long lengths of stay and minimises patient decompensation.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Continue to identify patients with complex needs early in their journey through the Integrated Discharge Bureau and take collective action to eliminate elongated acute spells and minimise patient decompensation.
- Implement a clear pathway for complex discharge (pathway 3 – enhanced – see previous section) and remodel the hospital discharge team to specifically focus on this pathway.
- Explore provision and potential for pooled funding arrangements to specifically support discharge to assess for complex patients whilst their health/social care needs are more clearly defined.
- Work across the system to identify key gaps in capacity and provision for particular client groups, e.g. those with dementia related challenging behaviour, non weight bearing, bariatric, and identify joint solutions.

Our Key Actions in 2018/19

- Continue to embed and build on the actions undertaken in 2017/18, evaluating their impact .

Key Outcomes by the end of 2018/19

- ✓ Patients supported in the setting most appropriate to their health and care needs leading to improvements in LOS for patients currently residing in acute and community hospital beds (DTOC)
- ✓ no patient, however complex, should spend more than 14 days in an acute or community care setting, if they are clinically stable for discharge, unless it is deemed by the MDT that hospital is the appropriate care environment

Development of Onward Care Services

Objective: Develop and provide cost effective onward health and social care services that maximise patient outcomes.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

- Improve and maintain quality gains within the sector, including the launch of Home Care Manager Leadership Programme.
- Build greater intelligence of workforce availability and the changing demand – building upon the work of 1617.
- Workforce development features as a key deliverable in the Home Care capacity building plan.
- Promote partnership working between Home Care agencies and employment or education providers.
- Building capacity through innovations and improvements e.g. care technology and dedicated delivery for those at the end of life.
- Work with Southampton City Council to design the new tender for Home Care – building upon the lessons learnt through the implementation of the Framework in 15/16 and 16/17.
- Work with Southampton City Council to expand roles of Home Care providers, building on the lessons learnt from Lot 5 implementation and other initiatives in 16/17.
- Work with Southampton City Council to address blockages at key points in the pathway.

Our Key Actions in 2018/19

- Building upon workforce development lessons in 17/18, including opportunities through partnership with health and other care providers.
- Promote partnerships to embed and sustain. Aiming to build a career pathway which supports.
- Tender the service – through a contracting method which builds upon the lessons learnt.
- Addressing blockages at key point in the pathway.

Key Outcomes by the end of 2018/19

- ✓ Development of a sustainable Home Care Market
- ✓ Home care reputation changed – being seen as a member of the core delivery in the city i.e. as a member of Multidisciplinary Team
- ✓ Change the offer to promote quality and change in provision to meet the changing pattern of demand
- ✓ Care technology seen as a standard enabler for delivering home care.

Acute Care System

OVERALL OBJECTIVE

To ensure the provision of sustainable acute services across Hampshire and Isle of Wight

Urgent & Emergency Care

Objective: Develop NHS 111 to be the gateway to the urgent care system, ensure our population knows what services are available so A&E is no longer the default choice, in a life threatening emergency people will be rapidly transported to hospital and will receive the highest quality of care from expert consultants, and services will meet national standards.

Leads: Peter Horne, Lisa Sheron

Our Key Actions in 2017/18

Our Urgent and Emergency Care priorities in 2017/18 and 2018/19 will focus on delivery of the four hour A&E constitutional standard, and standards for ambulance response times, through implementing the five elements of the A&E Improvement Plan, as well as the other 'Must Dos' to support sustained improvement in Urgent and Emergency Care. This work will be aligned to delivery of the HIOW STP commitments, particularly Southampton City Better Care and the GPFV, and informed by RightCare benchmarking.

Our Top Ten Actions for 2017/18 are:

- Continue to implement the Local A&E Delivery Board Improvement Plan, which includes streamlining at the front door to ambulatory and primary care, increasing the number of 111 calls transferred for clinical advice rather than referred to ambulance or A&E, increasing ambulance 'hear and treat' and see and treat' to reduce conveyances to hospital, improving patient flow through the hospital and embedding 'Discharge to Assess' and 'trusted assessor' models of discharge.
- Support UHS to implement and deliver a new contractual Emergency Pathway RAP to ensure delivery of the agreed 2017/18 A&E performance trajectory and delivery the 4 hour standard by March 2018.
- Continue to work with UHS to ensure focus on improved bed management and flow earlier in the day, simple discharges, 'home before lunch' initiative and 7-day services.
- Ensure that providers have met and sustain the four priority standards for 7-day hospital services.
- Continue to implement the Urgent and Emergency Care Review, working towards a 24/7 integrated care service for physical and mental health.
- Continue to develop a system-wide approach for improving waiting times for urgent care for those in a mental health crisis.
- Further improve and streamline access to local urgent primary care through aligned procurements of a new NHS111 service, enhanced GP access service, out of hours service and home visiting service.
- Further increase capacity in primary and community care for patients with minor conditions to self-manage and/or have care close-to-home, with easy access to advice, support and treatment from Pharmacies, Optical Practices, General Practice and Community Services to reduce demand on A&E.
- Continue to enhance the Directory of Skills and Services to ensure all appropriate dispositions are available for patients.
- Continue the ongoing communication and engagement campaigns to further increase public awareness of alternatives to A&E.

Our Key Actions in 2018/19

Continuing from 2017/18, develop further integration for 24/7 physical and mental healthcare, further streamline services working towards a true single point of access , and increase "out of hospital" access for urgent care.

Our Top Ten Actions for 2018/19 are:

- Sustain the improvements delivered through the five elements of the A&E Improvement Plan.
- Support UHS to sustain delivery of the four hour standard.
- Support the ambulance service to sustain a reduction in hospital conveyances and further improve response time.
- Build on the delivery of 7-day services across the system to further improve patient flow through and out of hospital.
- Ensure forthcoming waiting time standard for urgent care for those with mental health crisis are met.
- Fully implement an improved and streamlined urgent primary care service through mobilisation of the new NHS111 service, enhanced access GP service, out of hours service and home visiting service.
- Maximise use of technology to support delivery of the right care in the right place and the right time first time.
- Continue to implement the Urgent and Emergency Care Review, working towards a 24/7 integrated care service for physical and mental health by March 2020.
- Continue to enhance the Directory of Skills and Services to ensure all appropriate dispositions are available for patients.
- Continue the ongoing communication and engagement campaigns to further increase public awareness of alternatives to A&E.

Key Outcomes by the end of 2018/19

- ✓ Sustained delivery of A&E 4 hour standard (95%)
- ✓ Sustained delivery of ambulance response times
- ✓ Increased access to out of hospital services for urgent care
- ✓ Control over activity in line with STP trajectories
- ✓ Increased use of digital solutions to support self care and signposting to the most appropriate care setting
- ✓ Preparedness to deliver 24/7 integrated care service for physical and mental health by March 2020
- ✓ Single point of access into an urgent and emergency care system with sufficient capacity and without duplication
- ✓ Measurable improvement in clinical outcomes and patient experience

Elective Care & RTT

Objective: Getting people to the right place first time, eliminating waste and duplication across all stages of treatment e.g. eliminating face to face follow ups, and faster access to diagnostics and treatment.

Leads: Peter Horne & Lisa Sheron

Our Key Actions in 2017/18

Our Elective Care priorities in 2017/18 and 2018/19 reflect continuing delivery of the national RTT constitutional standard, choice and electronic booking for all first routine and urgent outpatient appointments and delivery of the HIOW STP commitments through service redesign and efficiencies, including RightCare

Our Top Ten Actions for 2017/18 are:

- Commission sufficient activity across a range of local providers and redesigned clinical pathways to meet demand and waiting time standards.
- Ensure contracts reflect STP activity shifts and efficiencies, e.g. reduced follow ups, Acute Alliance, increasing GPSI activity.
- Continue to promote local Choices and e-referrals to patients and GPs;
- Develop and support the roll out of personal health budgets and promoting personalisation for patients/individuals who could benefit from the flexibility of a personal health budget or joint health and social care budget.
- Support providers to develop sub-contracting arrangements for maximising use of all local capacity to manage seasonal flows.
- Commission more GP and Community direct access diagnostics capacity; reduce duplication between providers through best use of technology.
- Clarify and standardise service specifications to ensure fair competition and best practice delivery, including shared decision making, application of agreed referral criteria, clinical thresholds, management in primary and secondary care, enhanced recovery principles, PROMS and discharge planning.
- Continue to work with UHS to eradicate Appointment Slot Issues (ASIs) on E-referrals so 100% of urgent and routine appointments are electronically-bookable (supported by CQUIN).
- Continue to work with all providers to increase access to, and speed-up response times for, Advice and Guidance on E-referrals; increase opportunities for day to day communication between GPs and Specialists to help manage referral demand.
- Switch to DXS from 1st April as the new GP clinical decision support system of choice, decommissioning Map of Medicine. Monitor referrals with GP practices and resolve outlier issues.

Our Key Actions in 2018/19

Continuing from 2018/19, seek greater integration across clinical pathways by testing prime contractor models, reflect our STP Digital and Prevention programmes in commissioned activity and contracts, and increase "out of hospital" access for routine care.

Our Top Ten Actions for 2018/19 are:

- Implement programmes for prevention and self-care at scale to improve health and reduce referrals for specialist intervention, including stronger links and engagement with voluntary organisations.
- Increase primary care and community specialist services to manage common conditions outside hospital, linked to above.
- Review 17/18 diagnostic access and commission additional if required including potential for self-referral; similar for therapies where low-cost early intervention may benefit.
- Update and promote local pathways and Choices; clarify changes to clinical thresholds including Priorities Committee decisions to stop specific investigations or interventions where these have no proven benefit. Utilise clinical audit as routine to test compliance.
- Reflect the introduction of e-consultation in contracts (STP Channel Shift); test the full potential for 19/20 contracts, activity and access times. Engage with the pilot stage of the Patient Portal.
- Clarify pathways between the extended primary care/community services for common conditions (e.g. GPSIs City-Wide) and the Integrated H&SC teams for chronic conditions and care of the elderly (Clusters) – clear Multi-Specialty Community Provider Model for routine and urgent care in place.
- Reflect STP efficiencies and activity shifts in contracts; ensure capacity matches anticipated demand at the right point the pathway.
- Implement agreed STP Acute Alliance clinical pathway changes, including relevant community services to support these, e.g. single point of access. Monitor reduced clinical variation and improved outcomes.
- Review RightCare benchmarking and progress against 16/17 position; inform further pathway or contractual changes where an outlier on price and/or activity.
- Test prime contractor models for agreed clinical pathways.

Key Outcomes by the end of 2018/19

- ✓ Sustained delivery of RTT standard (92%)
- ✓ Continued provision and use of appropriate local Choices, all via E-Referral
- ✓ Increased access to out of hospital services for common conditions and routine care
- ✓ Control over hospital referrals and activity in line with STP trajectories
- ✓ Increasing use of digital solutions to support self care and self referral
- ✓ Engaged public and voluntary sector
- ✓ Integrated primary and community teams for planned care, linked to urgent response
- ✓ Sufficient diagnostic capacity, without duplication
- ✓ Efficient providers with clear service specifications and pathways,
- ✓ Increased communication between GPs and consultants
- ✓ Clinical audit as routine measure of threshold compliance.
- ✓ Improved position against 16/17 Right Care benchmarking
- ✓ New contractual models going forward.
- ✓ Measurable improvement in clinical and patient reported outcomes

Acute Care System

7 Day Standards for Urgent Care in Hospital

Objective: Implementation of the four priority standards that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

Leads: Peter Horne, Lisa Sheron

Our Key Actions in 2017/18

- In 2017/18, UHSFT will build on improvements in 2016/17 which aimed to deliver the 4 priority clinical standards, including the 5 urgent specialist services:
    - Time to first consultant review;
    - Twice daily consultant review in critical care areas;
    - Seven day access to emergency investigations; and
    - Seven day access to consultant directed interventions.
- Initial priorities are:
    - Pharmacy
    - Therapies
    - Admin and Clerical support on the wards
    - Elderly care
    - Mental Health in ED
    - Stroke Thrombolysis
    - Women and Children's
- Continue key focus on workforce recruitment, retention and skill mix improvements, as well as hospital processes and supporting IT such as the bed management system.
- Continue to review Hospital Standardised Mortality Ratios at Trust Board, with all safety metrics (SIRIS and Never Events) identified in and out of hours.
- Agree further care group priorities with UHSFT to extend to at least a further 25% of hospital patients.

Our Key Actions in 2018/19

- Building on work during 2017/18, in 2018/19 ensure the majority (75%) of hospital patients can receive safe and consistent care across 7 days ahead of full implementation during 2019/20.
- Close working with all partners working to deliver other priority programmes within the HIOW STP, particularly integrated health and social care teams in the community (Southampton Better Care), enhanced access to primary care, 7 day services across all urgent response areas, including access to residential care and domiciliary care.
- Continue to redesign workforce, in tandem with new ways of working to deliver more effective clinical care and better outcomes; aligned to the core commitments in the STP Acute Alliance programme to maximise resources across Solent hospitals, stop ineffective practices such as routine follow ups and ensure scarce skilled staff are best utilised to deliver professional care to those who need it across 7 days.
- Ensure monitoring processes are in place to include detailed UHS plans.

Key Outcomes by the end of 2018/19

- ✓ Reduced length of stay of NEL admissions in outlying areas (Medicine, Elderly Care and Surgery)
- ✓ Improved weekend discharge rates
- ✓ Fewer internal delays – operational standards – no Black alerts during the Winter period.
- ✓ At least maintain Hospital Standardised Mortality Ratio below 100 and aim to show improvement across both weekends and weekdays.

Mental Health

OVERALL OBJECTIVE

To improve the quality, capacity and access to mental health services

Acute & Community Mental Health

Objective: Review and redesign current acute pathways and community service provision and develop a network of services.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

- Increase number of children and young people (CYP) with a diagnosable mental health (MH) condition receiving treatment from an NHS-funded community mental health service to 30% from 2016/17 baseline by developing early intervention mental health team.
- Develop CYP IAPT services (Increasing Access to Psychological Interventions.
- Increase amount of CYP accessing evidence-based community eating disorder services within 4 weeks for a routine appointment and 1 week for an urgent appointment.
- Develop services and support to access early intervention and prevention services for all ages – to include the development of community solutions and navigation roles.
- Reduce waiting times for child and adolescent mental health services (CAMHS) from 18 weeks to 16 weeks, with the aim to reduce to 7 weeks by 2020/21.
- Begin to develop 0-25 years transition service for mental health.
- Continue to meet the early intervention in psychosis (EIP) target for 50% receiving treatment within 2 weeks.
- Increase the number of people accessing individual placement support (IPS) from a baseline of 2016/17.
- Increase the number of people with severe mental illness (SMI) who have received NICE-recommended screening and access to physical care interventions to 30%.
- Increase access to psychological therapies (IAPT) for adults to 17% with a particular focus on long term conditions.
- Eliminate the inappropriate use of acute out of area (OOA) placements by 2020/21.
- Support a reduction of suicides from a 2016/17 baseline by 10% by 2020/21through the development and implementation of a suicide prevention strategy.
- Develop coherent developmental disorders pathway for CYP and adults with ADHD, autism and Asperger's.
- Reporting will continue via Main CQRM, to include evidence of learning.
- Establish Implementation Board & Steering Group to monitor transformation, including risk assessment of projects on a monthly basis. Priority areas to include workforce , recruitment & retention.

Our Key Actions in 2018/19

- Increase number of children and young people (CYP) with a diagnosable mental health condition receiving treatment from an NHS-funded community mental health service to 32% from 2016/17 baseline by continuing to develop the early intervention mental health team.
- Continue to develop CYP IAPT services.
- Continue to increase amount of CYP accessing evidence-based community eating disorder services within 4 weeks for a routine appointment and 1 week for an urgent appointment.
- Develop services and support to access early intervention and prevention services for all ages – to include the development of community solutions and navigation roles.
- Reduce waiting times for CAMHS to 12 weeks, with the aim to reduce to 7 weeks by 2020/21.
- Continue to develop 0-25 years transition service for mental health.
- Continue to meet the early intervention in psychosis (EIP) target for 50% receiving treatment within 2 weeks and to reach Grade 2 specialist provision in line with NICE recommendations.
- Continue to increase the number of people accessing IPS by 25% from 2015/16 baseline.
- Increase the number of people with severe mental illness (SMI) who have received NICE-recommended screening and access to physical care interventions to 60%.
- Increase access to psychological therapies (IAPT) for adults to 19% with a particular focus on long term conditions.
- Eliminate the inappropriate use of acute out of area placements by 2020/21.
- Support a reduction of suicides from a 2016/17 baseline by 10% by 2020/21through the development and implementation of a suicide prevention strategy.
- Develop coherent developmental disorders pathway for CYP and adults with ADHD, autism and Asperger's.

Key Outcomes by the end of 2018/19

- ✓ 32% of CYP with diagnosable MH condition receiving treatment
- ✓ CYP IAPT service available
- ✓ Eating disorder target within 4 and 1 week to be set following 2016/17 baseline – 95% compliance by 2020/21
- ✓ Commissioned early intervention and prevention services
- ✓ CAMHS waiting times – 95% seen within 12 weeks
- ✓ 0-25 transition service in place
- ✓ Meet EIP Nice recommendations and access target
- ✓ Increased access to IPS form 2015/16 baseline by 25%
- ✓ 60% of people with SMI have screening and access to physical care interventions
- ✓ Increase access to IAPT to 19%
- ✓ Reduced OOA placements for acute inpatients
- ✓ Suicide prevention strategy
- ✓ Developmental disorders pathway developed

Mental Health

Mental Health Rehab Pathway & Out of Area Placements

Objective: Ensure people supported in out of area placements and repatriated and supported in locally provided services.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
• Redesign rehabilitation pathway and reduce out of area rehabilitation placements.	• Continue to redesign rehabilitation pathway and reduce out of area rehabilitation placements.	✓ Reduced number of out of area rehabilitation placements

Mental Health Crisis Care

Objective: Develop pathways to ensure people presenting in mental health crisis have access to timely, appropriate care.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
• Continue to develop crisis resolution and home treatment teams to be effective and properly resourced delivering best practice standards as described in the CORE fidelity criteria. • Develop appropriate crisis provision out of hours including s136 provision and support to patients experiencing a crisis as an alternative to acute inpatient admission, use of s136 or admission to emergency departments. • Continue to develop all-age acute hospital mental health liaison to achieve 'Core 24' service standard.	• Continue to develop crisis resolution and home treatment teams to be effective and properly resourced delivering best practice standards as described in the CORE fidelity criteria. • Develop appropriate crisis provision out of hours including s136 provision and support to patients experiencing a crisis as an alternative to acute inpatient admission, use of s136 or admission to emergency departments. • Continue to develop all-age acute hospital mental health liaison to achieve 'Core 24' service standard.	✓ Crisis team meets CORE fidelity ✓ Alternative crisis provision in place ✓ 24/7 all-age psychiatric liaison services

Dementia

Objective: Improve dementia diagnosis, care and support.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
• Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support to include the development of Dementia Friendly Southampton.	• Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support to include the development of Dementia Friendly Southampton.	✓ Dementia diagnosis rate of 66.7%

Supporting Enablers

Quality

Digital

Estates

Workforce

New Commissioning Models

Quality

Improving Quality in Organisations

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Further review quality indicators for Providers to ensure they are fit for purpose and will deliver quality improvement.
- Roll out of serious incident (SI) assurance panels across all Providers to ensure the CCG receives relevant and appropriate assurance around actions being taken and learning and improvement in patient safety.
- Improve reporting to include better focus on outcomes to provide evidence of improvements for patients.
- Working in partnership with the other Clinical Commissioning Groups to revise quality reporting requirements to remove the non added value elements and reduce the burden on Providers.
- Support Providers in developing new staffing models to address current recruitment problems.
- Continued quality monitoring through Clinical Quality Review meetings to obtain assurance on the quality of services we commission and to share learning and good practice.
- Enhance quality visits to Providers to test improvements in service provision are being embedded and to provide support in addressing any issues identified or sharing of good practice.
- Support Providers in ensuring there are appropriate governance arrangements in place to ensure patients are safe and services are delivered in line with local and national requirements.
- Review Provider Cost Improvement Plans (CIP) plans to ensure they do not negatively impact on the quality of services to patients.
- Maintain quality and safety of clinical care, including interdependencies in promoting joint working across providers where relevant.
- Work with Providers in relation to discharge processes to ensure patients are provided with quality care as close to home as possible and are supported to live independently.
- Further development and implementation of a Quality Framework for Primary Care to provide assurance to the CCG Board about the quality of primary care.
- Continue to develop an effective process for the monitoring and management of general medical practices in special measures to support practices to make required improvements.
- Maintain continued quality improvement within Nursing Homes to identify areas for improvement and support them to meet required standards.
- Maintain continued quality improvement within health providers ensuring compliance with CQC standards and supporting providers who are rated as requires improvement or inadequate.
- Continue to use complaints, concerns, comments and compliments to provide learning for supporting commissioning decision making and quality review of services.

Our Key Actions in 2018/19

- Embed SI assurance panels across all Providers and continuous evidence of learning to drive quality improvement where needed.
- Evidence outcomes from new staffing models to ensure that they are effective or to support Provider to further review new ways of working.
- Review quality elements of the new 2 year contracts to ensure required outcomes are being delivered.
- Improvement in and embedding quality monitoring across Primary Care.
- Sharing lessons learned from incidents reported onto NRLS by Primary Care.
- Embed any changes made to the Primary Care Framework, to ensure potentially vulnerable practices are highlighted.
- Further work with Nursing Homes to ensure they are able to provide support to enable patient/client flow across the system.
- Working in partnership with the other Clinical Commissioning Groups to continue to review and further revise quality reporting requirements to ensure reporting is meaningful and reflects improvements being made across all Providers.
- Review Provider Cost Improvement Plans (CIP) plans to ensure they do not negatively impact on the quality of services to patients.
- Continued quality monitoring through Clinical Quality Review meetings to obtain assurance on the quality of services we commission and to share learning and good practice.
- Further enhance and where required, change format of quality visits to Providers to test improvements in service provision are being embedded and to provide support in addressing any issues identified or sharing of good practice.
- Embed, as required the process for the monitoring and management of practices in special measures.

Key Outcomes by the end of 2018/19

- ✓ Improved and embedded SI assurance process
- ✓ Improvement in patient safety
- ✓ Delivery of key quality indicators / targets
- ✓ Effective implementation of new staffing roles / reduced vacancy factor
- ✓ Reduction in burden of reporting on Providers / improved assurance
- ✓ Improved quality and performance targets
- ✓ Quality visits provide improved assurance on the quality of services commissioned

Avoidable Deaths

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Support Providers in appropriate learning from serious incidents where avoidable deaths are recorded (SI's).
- Quality Team members to attend provider Mortality meetings.
- Support delivery of the new quality indicator for Southern Health NHS FT to embed outcomes from the Mazars report and the continued improvement of investigation of deaths.
- Support Providers to identify key themes from investigations into patient death and ensure appropriate actions are taken.
- Work with Providers to ensure joint investigations are undertaken where required.
- Review of avoidable deaths in primary care – building on work started in Solent NHS Trust GP practices, explore how this model can be rolled out to other GP practices in Southampton.
- Establish methods of sharing learning across the Southampton system and the wider STP patch.

Our Key Actions in 2018/19

- Support Providers in further embedding a continuous learning culture.
- Embed SI assurance process in relation to patient death investigations.
- Test improved partnership working across Providers through review of investigations.
- Embed across primary care review of avoidable deaths.

Key Outcomes by the end of 2018/19

- ✓ Evidence of learning and improvements from serious incidents
- ✓ Improved and embedded SI assurance process in relation to patient deaths
- ✓ Reduction in number of patients deaths with the same root cause / contributory factors

Safeguarding

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Continue to improve GP engagement with the safeguarding process e.g. embed GP supervision, establish a GP safeguarding leads network.
- Contribute to Local Safeguarding Board strategies and ensure commissioned health services have systems in place to recognise and respond appropriately to safeguarding concerns e.g. childhood neglect/self-neglect, MCA/DoLS and domestic abuse.
- Work collaboratively to support unaccompanied asylum seeker children and looked after children to meet their health needs in appropriate timescales.

Our Key Actions in 2018/19

- Continue to improve GP engagement with safeguarding process e.g. support development of Safeguarding "champions" within Primary Care.
- Continue to support greater system-wide learning, review and actions and evaluate outcomes of all domestic homicide reviews, serious case reviews action plans and Significant Incident Learning Process (SILP) of both single and inter-agency action to receive assurance that plans have been implemented and in turn improves outcomes for children and adults with care and support needs.

Key Outcomes by the end of 2018/19

- ✓ High standards of safeguarding practice across the health system
- ✓ Improvements in the quality and safeguarding practice of Primary Care
- ✓ Ensure the effectiveness of multiagency arrangements to safeguard and promote the wellbeing of children and adults at risk from abuse or neglect.
- ✓ Continue to commission services which promote quality safeguarding practice and protect individuals at risk.
- ✓ Ensure collaboration of multi-agency partners to support delivery of NHS England safeguarding work streams

Quality

Sepsis & Clostridium Difficile (CDI)

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- In line with Government targets work to establish a robust reporting metric a wider range of infections in line with reducing the impact of serious infections, specifically within our acute providers.
- Work closely with our providers at reducing the number of HCAI's; focussing on those identified within the NHS Quality Premium 2017-19 as well as the current mandated HCAIs.
- In line with the Quality Premium Indicator 17/18 &18/19 for Blood Stream Infections (part A) work toward a 50% reduction of Gram Negative blood stream infections.
- Work to establish a sepsis pathway within the social care sector, as well as the primary care sector, which would provide assurance around care delivery to the deteriorating resident or patient.
- Continue to monitor all cases of CDI, whether within the Acute or Community sector to establish that no trends are developing.
- Continue to drive a reduction in high-risk antimicrobial prescribing and PPI's, specifically within the primary care sector, which are known triggers for CDI.
- Continue to contribute to the collegiate approach to CDI appeals to ensure that lapse of care was not a factor in the CDI.

Our Key Actions in 2018/19

- Utilising the metrics identified and created in 2017-18, work with our providers to drive the reductions required.
- Work closely with our providers at reducing the number of HCAI's; in particular around those identified within the NHS Quality Premium 2017-19.
- In line with the Quality Premium Indicator 17/18 & 18/19 for Blood Stream Infections part A work toward the aims of the O'Neill review for a 50% reduction of Gram Negative blood stream infections.
- Monitor the embedding of the sepsis pathway within the social care sector.
- Continue to drive a reduction in high-risk antimicrobial prescribing and proton pump inhibitors (PPI's), specifically within the primary care sector, which are known triggers for CDI.
- Continue to monitor all cases of CDI, whether within the Acute or Community sector to establish that no trends are developing .

Key Outcomes by the end of 2018/19

Sepsis:

- ✓ 90% of cases of Sepsis accurately identified on admission to ED
- ✓ 100% of identified patients with sepsis receiving the 1st course of appropriate antibiotics within 60 minutes of admission to the acute setting.
- ✓ A reduction in the number of deaths where sepsis is identified on the death certificate as a key cause of death.

C-Difficile:

- ✓ All CDI cases within both the Acute and Community settings are identified and a RCA completed.
- ✓ Continue to drive down the number of CDI incidences in line with national initiatives.
- ✓ All decisions around CDI's that are not as a result of lapse in care are agreed by consensus.

Personal Health Budgets

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Review existing Continuing Health Care (CHC) PHB policies and processes ensuring learning from the first PHB's has been incorporated into these.
- Review, refine and further strengthen a comprehensive CHC PHB offer including a menu of brokerage, support , training and insurance options for individuals interested in PHB's to chose from.
- Ensure the CHC PHB offer is published and readily available for CHC clients and their families to view.
- Support further development PHB offer beyond CHC.
- Evaluate options for offering PHB within fast track and end of life care.

Our Key Actions in 2018/19

- Establish reasons for non-uptake of PHB's when offered and develop approaches to address these barriers to PHB take-up.
- Work with local providers and community representatives to support wider take-up of PHB's.
- Investigate development of the PHB offer for use within nursing and residential homes.

Key Outcomes by the end of 2018/19

- ✓ Reasons for non-take up of all PHB's offered to CHC clients to be clearly documented.
- ✓ For there to be evidenced creative approaches to overcoming barriers to PHB take-up and the effectiveness of these approaches to have been evaluated.
- ✓ Evidence of continued increase in take up of PHB's within CHC.

Quality

Antimicrobial Prescribing

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

The Quality Premium Indicator 17/18 &18/19 for Blood Stream Infections requires:

- Part b) reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care
- Part c) sustained reduction of inappropriate antibiotic prescribing in primary

We will:

- Publicise key antibiotic messages in our GP / prescriber bulletin 'Antidote' to highlight antimicrobial prescribing.
- Monitor ongoing surgery level data for both volume (Antibiotic STAR-PU) and quality UTI prescribing.
- Monitoring of antimicrobial prescribing via the CQRM process for OOHs.
- Support the government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates using.

Our Key Actions in 2018/19

- Support GP practices through the use and application of the Antibiotic Prescribing Guidelines (2014) available electronically, in paper format and as a phone App, both for In-Hours and Out of Hours prescribing.
- Provide Medicines Management team input into GP TARGET training days throughout the year to ensure wider circulation and support for prescribers.
- Provide Medicines Management lead GP Task Group meetings (5 per year) to inform prescribing leads who will disseminate information within their GP practices.
- Include targets in our prescribing work programmes with GP surgeries with incentives.
- Give support and feedback to GPs at GP surgery specific meetings (at least 2 per year) as part of this work programme where we challenge inappropriate prescribing in UTIs and high antibiotic prescribing (Antibiotic STAR-PU).

Key Outcomes by the end of 2018/19

- ✓ Reach the required targets of
- ✓ A 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prescribing ratio based on CCG baseline data (June 2015-May 2016)
- ✓ a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June 2015-May 2016)
- ✓ Demonstrate a sustained reduction of inappropriate antibiotic prescribing in primary care - items per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR-PU) must be equal to or below England 2013/14 mean performance value of
- ✓ 1.161 items per STAR-PU

Maternity

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Work with maternity services in relation to local delivery of the local maternity review and delivery and service development and improvement plan.
- In first year implementation: Work with local maternity service and neighbouring commissioners to deliver progress on key elements of the national Better Births review for full roll out to 2020.
- Development of our national maternity pioneer personalisation and choice proposals.
- Work with local maternity service and neighbouring providers and commissioners to improve the consistency of care in relation to the maternity service specification in line with the STP plan for the SHIP8 area.
- Commission maternity services that promote breastfeeding and prioritise reducing smoking in pregnancy.

Our Key Actions in 2018/19

- Work with maternity service to evaluate the effectiveness of new locality working arrangements and their impact on patient experience and workforce stability, especially in relation to unplanned abstraction from community midwifery functions to birthing unit.
- Continue to work with local maternity service and neighbouring commissioners to deliver on key elements of the national Better Births review.
- 2nd year implementation – continued development of our national maternity pioneer personalisation and choice proposals.
- Continue work with local maternity service and neighbouring providers and commissioners to improve the consistency of care in relation to the maternity service specification in line with the STP plan for the SHIP8 area.

Key Outcomes by the end of 2018/19

- ✓ Improved workforce stability and lower vacancies
- ✓ Reduced levels of smoking in maternity
- ✓ Improved breastfeeding rates
- ✓ Improved normal birth rate
- ✓ Further improved Family and Friends ratings
- ✓ Area wide service consistency through shared specification

Digital

Digital Workstreams

Lead: Mark Kelsey

Southampton City CCG is part of the Southampton local delivery system for the STP and key projects will be delivered through this delivery system. We have set up a Southampton and South West Hampshire system technology delivery group, comprising of local commissioners from Southampton and West Hampshire and local providers through which local projects will be managed. Within Southampton City CCG, we also have a commissioner's ICT group to focus more on primary care technology projects. The six technology projects within the Southampton City CCG Operational Plan align directly with the equivalent STP projects, as below. Southampton City CCG is also well represented at the HIOW Digital Programme board and associated groups.

Area	Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
Integrated Digital Health & Care Record	• Our local solution, the Hampshire Health Record, will be upgraded to a new version, improving accessibility and visibility of data from multiple organisations. The new version is being tested in Southampton Q4 16-17 with wider roll out in 17/18. • Hampshire Health Record data sharing agreements reviewed and agreed by all data controllers across Hampshire. • Conduct full assessment of the current state against the universal digital capabilities and a plan for addressing these over period of plan.	• A new integration engine will be developed to improve linkage between local systems and share more data. • New data flows from mental health provider (Southern Health) will be developed to improve information shared for mental health patients.	✓ Upgrade to the HHR will enable support for mobile working and customisable dataset interfaces for clinical staff. ✓ An integration engine and master patient index will provide the backbone of integration across care settings ✓ Integrated care plans functionality will provide a single source for care plans to be created, stored and accessed ✓ Wider data sharing models will build on the success and experience of the data sharing through the HHR.
Patient Portal & Channel Shift	• A digital participation strategy will be developed jointly across Hampshire. In Southampton, we will explore linking existing UHS MyHealthRecord users into their Hampshire health record data, once the new HHR version is working. • We will continue to increase uptake of patient online services through GP practices, for repeat prescription and record viewing.	• A unified patient portal will be developed within Hampshire and we will ensure local systems are linked into this. • Further development of the portal as above will support increasing patient use of online services. • We will link with public health digital front door to allow access to self-help lifestyle interventions. • Through the work across Hampshire on apps we will promote use of health management apps in long term conditions such as diabetes, and mental health.	✓ There will be a single patient portal that is accessible by patients of all Southampton care services on multiple devices and is their main route in to the Southampton health and care system. ✓ The portal will allow patients to view their records, access self-help information, manage appointments, order repeat prescriptions and ultimately contribute to their care management alongside health and care professionals.
Mobile Working for Integrated Teams & Digital Comms across Providers	• Wifi access will be enabled across all primary care sites so that any health and care provider can securely access their own business systems from any health setting.	• Wifi access will be developed uniformly across remaining secondary, community and social care sites.	✓ Integrated health and social care teams will be able to work seamlessly across sites and organisations

Digital

Digital Workstreams

Lead: Mark Kelsey

Area	Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
E-Prescribing	• We will continue to promote uptake of EPS within primary care settings, initially for repeat prescriptions, and repeat dispensing, and then increasingly for acute prescriptions.	• Audio and video calling will be available to NHSMail users. We will work with our integrated care teams to enable them to use Skype for business for team communication and patient consultations. • Working with hospital providers we will ensure systems are available which better support medicines reconciliation across care settings.	✓ Improved medicines safety ✓ Increased use of electronic prescriptions, streamlining systems for surgeries and patients.
Care Coordination Infrastructure	• Integrating with work across Hampshire to reprocure 111 and OOH services, we will link our local enhanced access and home visiting services into the HIOW care coordination centre infrastructure.		✓ Simpler access to care, with arrangements in place to refer citizens quickly to the most appropriate service, advice or website ✓ Earlier and streamlined assessment of need, with better use of information and by securing a wider range of specialist input ✓ Improved decision support, directly influencing the effectiveness and efficiency of resource deployment across the system ✓ Support more people in their own home or community (shifting care from acute), by remote monitoring and/or by linking citizens to the relevant specialist by video (rather than having to travel)
Optimising Intelligence Capability	• We will identify areas where improved intelligence capability can help tackle our challenges within Southampton. • We will streamline and simplify access to existing intelligence tools to increase usage and uptake.		✓ Data-driven insights will support clinicians to increase efficiency, and improve the performance of local service delivery ✓ Unlocking data connections and building our analytical capabilities will empower us to create reliable and actionable insights ✓ The adoption of population health management will improve health outcomes and achieve behaviour change at the same time as lowering costs. ✓ The programme will deliver insight and intelligence to inform future strategies and transformation plans.

Estates

Estates

Leads: Peter Horne, Paul Benson

Our Key Actions in 2017/18

2017/18 will see continuing focus on the implementation of the Southampton Strategic Estates Plan which itself provides an important contribution to the estates workstream of the Hampshire & Isle of Wight STP. Central to this will be the project to deliver improved utilisation of the two community hospitals in Southampton – the Royal South Hampshire Hospital and the Western Community Hospital. An Outline Business Case to identify a preferred reconfiguration option is presently in development and is expected to be approved by relevant stakeholder statutory bodies by March 2017. Thus during the period 2017/18-18/19 the project will move to the next phase – the development, approval, and implementation of a Full Business Case. Work will also continue on the estate improvement elements of the Southampton City Primary Care Strategy which includes the establishment of a six Cluster Resource Centres ("hubs") across the city. Through the forum of the Southampton One Public Estate Group, the CCG will continue to examine estate rationalisation/ improvement opportunities with other public sector bodies in the city – in particular the City Council.

Royal South Hampshire Hospital & Western Community Hospital estate optimisation project

- Consequent upon approval of the OBC by all relevant stakeholders, develop and secure approval of a Full Business Case to deliver the preferred option. The complete FBC is expected no later than March 2018 and will include all necessary consents.
- Assist Comms and Engagement colleagues in engagement with public and staff stakeholders (already in progress).
- Work with colleagues in Southampton City Council and NHS Property Services to deliver a c80 unit Extra Care facility on surplus land (up to 25% of the site) at the RSH. This will provide a vital contribution in the delivery of Southampton City Council's strategy to significantly expand Extra Care capacity at key sites across Southampton which will in turn support the delivery of the Better Care Southampton Plan.

Primary Care Estate

- Finalise the business case for the development of an ETTF-funded (66%) Cluster Resource Centre (CRC) on the Shirley Health Centre site (Cluster 1).
- If the business case is approved, and if the local funding is secured, initiate the delivery programme.
- Develop a programme for the delivery of CRCs for the other five clusters (including the proposed One Public Estate development for Bitterne).
- Develop a practice infrastructure modernisation programme to support CCG Primary Care Strategy.

Our Key Actions in 2018/19

2018/19 will see implementation of the first phases of the **Royal South Hampshire Hospital & Western Community Hospital estate optimisation project.** Key actions will include:

- Rationalisation of the current usage of the RSH (in particular the Mary Seacole block) to ensure that it is used only for services that need to be in a community hospital location for operational reasons - alternative, and less costly "office" accommodation will be arranged.
- Following-on from this, adaptation/construction of a new location for Lower Brambles (OP rehabilitation ward) and the demolition of the current building. The site will be used for a Cluster Resource Centre for the Nicholstown/Newtown neighbourhood.
- If the business case is agreed, building works to establish a Cluster Resource Centre at Shirley Health Centre will be completed.
- Again subject to an approved business case, demolition of the redundant Dept of Psychiatry building at the Royal South Hants Hospital and the construction of a c80 unit Extra Care facility in a project led by Southampton City Council.
- Work will continue on implementation of the Primary Care Estate Strategy which will include the establishment of a network of five further Cluster Resource Centres and also an infrastructure modernisation programme to ensure that all primary care premises are fit for their purpose.

Key Outcomes by the end of 2018/19

- ✓ Completion of the ETTF-funded (66%) Cluster Resource Centre at Shirley Health Centre.
- ✓ Implementation of a programme, including capital funding arrangements (eg LIFT or Project Phoenix) to provide five (non-ETTF) CRCs in key locations across the city.
- ✓ An approved Full Business Case for the optimisation of the Royal South Hants Hospital and the Western Community Hospital: this will include the replacement of accommodation that is no longer fit for inpatients (Kite Unit/Lower Brambles Ward).
- ✓ Following on from the above, the release of surplus NHS land for Extra Care accommodation and key worker/affordable housing. Specifically, we expect to see a c80 unit Extra Care facility adjacent to the RSH.
- ✓ An agreed site master plan for both the Royal South Hants Hospital and the Western Community Hospital which will map out how the sites are to be developed across the next 10 years

Workforce

Leads: CCG Managers and Providers

Our Key Actions in 2017/18

- Continue to work with providers to support the development of a flexible workforce: new roles, changes to skill mix and support recruitment and retention initiatives.
- Ensure reviews of CIP and QIPP schemes to determine impact on the workforce.
- Support providers with their recruitment and retention, and staffing redesign plans including the introduction of new roles in relation to Adult Mental Health services and particularly ensuring safe staffing at Antelope House.
- Review CCG engagement with Health Education England to ensure appropriate representation is in place to support providers in the development of the workforce to deliver the 2017-19 plans.
- Ensure the continuation of CCG engagement methods with providers in relation to workforce, including a focus on safer staffing at CQRMs and via contracting processes to ensure appropriately trained and skilled staff are available to support services.

Our Key Actions in 2018/19

- Continue to make further progress with key actions from 2017/18.
- Work as one system to develop the right people, skills and capabilities to support the transformed health and care system.
- Continue to work with providers for a flexible workforce shared across geographical and organisational boundaries, working in new ways with extended skills to deliver the workforce transformation.
- Increase the time our staff spend making the best use of their skills/experience.
- Explore the potential of new technology and reduce unnecessary competition for limited staffing resources.

Key Outcomes by the end of 2018/19

- ✓ No overall growth in the workforce over the next five years
- ✓ Improved recruitment and retention
- ✓ Reduction in use of temporary and agency workers
- ✓ QIPP delivery

Continuing Healthcare (CHC)

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Refine and develop normal business process to embed existing and emerging best practice in NHS Continuing Healthcare and Continuing care for children. This will include but not be limited to - NHS England operating model for Continuing Healthcare, Continuing Healthcare Assessment tool, emerging best practice in local and national CHC networks.
- Refine and develop normal business process to embed the 6c's (care, compassion, competent, communication, courage and commitment) in every interaction or transaction that the team has.
- Refine and develop existing successful normal business process to maximise delivery of cost efficiencies alongside care and patient/family experience that is safe, effective and timely.
- Refine and develop educational and other support for system partners and stakeholders, supporting delivery of increased number, quality and timeliness of assessments for patients.
- Support commissioning colleagues and systems partners in reviewing service specifications/contracts across a range of areas (particularly primary care and community nursing) to embed appropriate levers/incentives that support increased engagement and involvement in CHC.
- Collaborate with system partners to develop, agree and implement new system wide approaches to reducing the number of CHC assessments completed in acute settings.
- Collaborate with systems partners to deliver integrated services for Adults with learning disabilities (LD) in Southampton.
- Support commissioning colleagues in refining, further developing and improving existing community end of life services and care pathways in Southampton.

Our Key Actions in 2018/19

- Continuous review, refinement and where appropriate further development of all 2017-18 actions/areas.
- Refine and develop use of technology to improve efficiency, transition between services and patient/family experience.
- Refine and develop links with community groups and third sector colleagues in supporting policy and process development (for example – expanding scope of independent panel chairs, increased involvement in policy development and stakeholder groups).
- Collaborate with system partners and care providers in Southampton to deliver earlier identification and assessment of potential CHC eligibility in care settings.
- Further refine, progress and develop integrated working and commissioning to maximise opportunities to share best practice, maximise cost efficiencies and deliver safe, appropriate and timely care.
- Support work across STP area to maximise best practice and cost efficiency in CHC.

Key Outcomes by the end of 2018/19

- ✓ Normal CHC business incorporates local, regional and national best practice in both NHS Continuing Healthcare and Continuing care for children.
- ✓ Feedback from clients, families and system partners clearly evidences embedding of the 6c's in normal CHC business.
- ✓ Integrated whole system approach to CHC assessment and applications.
- ✓ Increased number, quality and timeliness of CHC assessment and applications.
- ✓ Increased number of CHC applications that originate from outside of the acute hospital setting, delivering or surpassing nationally mandated metric.
- ✓ Improved quality and patient/family experience in Adult LD services and end of life services to population of Southampton.
- ✓ Continued robust delivery of cost efficiencies alongside safe, effective and timely care – leading and contributing to wider delivery across STP area.

New Commissioning Models

Prescribing & Medicines Management

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Cost–effective use of generic medicines, from new and existing patent expiry savings. Requires year on year work.
- Continuing to support cost–effective prescribing by promoting tools at the point of prescribing in GP surgeries: OptimiseRx.
- Reducing the use of Items less suitable for prescribing.

Other Practice Based Interventions

- Antidepressant Work: Examining the pathway and use of Antidepressants: We are an outlier in Right Care for antidepressant prescribing as spend per ASTRO-PU (weighted population). This requires a system wide review of all available support for depression rather than an isolated look at prescribing. We will need Clinical Leadership and patient engagement. We will develop a work plan across two years.
- Care Home medicines waste reduction (ordering systems): Ordering systems are complex and prone to create waste through poor communication. We have a pilot tested project plan which will require robust NHSBSA data (due Jan 2017) to spread further and give meaningful results.
- Reducing Repeats within Community Pharmacy Systems: These systems can lead to errors and medicines waste and remove control of prescribing from the patients and GP. We need to support the transfer of prescription ordering to Electronic Repeat Dispensing. This will require specific patient engagement. By doing this we anticipate we can reduce prescription items by 1%.
- Ensuring Appropriate Infant Feed Prescribing: Drug Usage Review (a pre audit review) vs. Hampshire Infant Feeding Guidelines to ensure appropriate use of these specialist feeds.
- Pharmacy support for multidisciplinary medication review of patients within the care home environment: Use of the STOPP START tool.
- Benchmarking of PbR excluded high cost medicines across HIOW providers including maximising the use of Biosimilars. Southampton are the national leaders in this area by way of operating a gain share system.

Our Key Actions in 2018/19

- Cost–effective use of generic medicines, from new and existing patent expiry savings. Requires year on year work.
- Continuing to support cost – effective prescribing by promoting tools at the point of prescribing in GP surgeries: OptimiseRx.
- Maintenance of savings made: by reducing Items less suitable for prescribing Cost avoidance in these areas.

Other Practice Based Interventions

- Antidepressant Work Continued: We plan to release savings from prescribing but may need to invest elsewhere in the pathway to ensure we can offer the best outcome for our patients.
- Care Home medicines waste reduction (ordering systems): This will take up to 18 months to spread depending on start time. By improving relationships between 3 key partners: GPs, Pharmacies & Care homes we aim to reduce medicines waste and ensure cost effective & safer use of medicines leading to better patient care.
- Reducing Repeats within Community Pharmacy Systems: Continuing this project roll out across remaining GP practices. Outcomes: Returning to Patient & GP control of medicine ordering which is safer and more cost effective.
- Ensuring Appropriate Infant Feed Prescribing: Safer & cost effective prescribing .Maintenance of savings – cost avoidance. Better patient care in early years.
- Review of current up take of primary care rebates on specific medicines which are offered by the pharma industry – evaluation at scale across the HIOW system to share effort and savings.
- Transfer of care initiatives to refer patients to community pharmacy following an in patient stay. Following on from the Newcastle experience.

Key Outcomes by the end of 2018/19

- ✓ Safer and cost effective prescribing
- ✓ Safer ordering, reduction in medicines waste
- ✓ Better patient care

Southampton System Delivery of the Sustainability and Transformation Plan (STP)

Strategic Oversight and Governance	At a local level, the Southampton Health and Wellbeing Board will be the vehicle for maintaining oversight of local system delivery, ensuring alignment of CCG plans with the priorities of the revised Southampton Health and Wellbeing Strategy; This will also provide the means by which to ensure alignment between local planning and implementation and the wider HIOW STP via participation in the new Joint Committee of the four HWBs.
HIOW Executive Delivery Group	The CCG will participate fully in the EDG through its Accountable Officer and expect to be held to account to deliver its Operating Plan in full alignment with the STP.
Local Delivery System	Southampton System Chiefs is an established group comprising CEOs of the CCG, City Council, UHSFT, Solent NHS Trust and Southern Health FT. This group will oversee the development of: • Integrated commissioning for the City (currently undertaking an option appraisal which will build on the establishment of the integrated commissioning unit) based on the 'one city' with a single budget and a single vision approach. • Integrated provision for the City based on an MCP model through the Better Care Southampton programme, joined up health and social care, physical and emotional health and primary and community services, built around six clusters of 30-50,000 people. • Links to wider new care models (eg PACS) via the Solent Acute Alliance. • Improved mental health services through implementation of the 'Mental Health Matters' programme. The System Chiefs Group will agree new terms of reference, programme management and resourcing arrangements and is likely to expand its membership to include other key delivery partners including the independent, voluntary and primary care sector providers.
HIOW Commissioning Board	• The CCG will work collaboratively with CCGs in HIOW and specialised commissioners to set out a coherent and cohesive view of future requirements (including robust capacity and demand planning) and develop new and simplified approaches to contracting that support the aims of the STP, share and mitigate risk and enable new models of care.

Finance, Activity, RightCare & QIPP

Sustainable Finances

Objective: Creating a financially sustainable health system for the future.

Leads: James Rimmer, Kay Rothwell

Our Key Actions in 2017/18

- Contribute to the STP wide financial savings requirements of £577m by 2020/21. For Southampton City CCG in 2017/18, this is £10.55m or 2.9% of turnover.
- Continue to support the meetings of the Directors of Finance of all the health and social care organisations within the STP footprint, for 2017/18 this will be focusing upon delivery of the indicative system control total through monthly monitoring or the finances reporting to the STP Board where corrective action is required.
- The CCG's main providers within the STP footprint of Solent, Southern and UHS see their control totals improve by £12m in 2017/18 compared to 2016/17. The CCG will need to be conscious of this as it concludes its contract negotiations.
- Within the £577m savings requirement is £63m of savings yet to be identified, the FDs need to update the financial of the STP reflecting of some known allocation changes and impacts of the 2017/18 contract round, with any yet to be identified gap closed during 2017/18.
- Following agreement of 2 year contracts for 2017/18 and 2018/19, the CCG will need to carefully monitor its monthly activity performance against plan taking any corrective actions as required to deliver its share of the STP.
- Southampton City CCG to achieve in year breakeven in 2017/18, as in line with the business rules we have a 1% cumulative surplus.
- Ensure the IR transfer of responsibility for commissioning certain activity between the CCG and specialised commissioner flows as expected in the contract for 2017/18 and where this is not the case seek tripartite agreement for allocations adjustments to correct.
- Ensure the NHS Property Services move to market rent is cost neutral in line with any funding from NHS England and any voids the CCG funds are minimised.
- Continue to support the RightCare pathway review approach, embedding the changes identified from the two pathway reviews undertaken in 2016/17 and complete the work in 2017/18 ready for delivery. See page 47 for more information on RightCare.

Our Key Actions in 2018/19

- Contribute to the STP wide financial savings requirements of £577m by 2020/21. for NHS Southampton City CCG in 2018/19 this is £10.77m or 2.9% of turnover.
- Continue to support the meetings of the Directors of Finance of all the health and social care organisations within the STP footprint, in 2018/19 this will likely be focusing upon delivery of a formal system control total through monthly monitoring or the finances reporting to the STP Board where corrective action is required.
- The CCG's main providers within the STP footprint of Solent, Southern and UHS see their control totals improve by £7.1m in 2018/19 compared to 2016/17. The CCG will need to be conscious of this as it concludes its contract negotiations.
- Look towards 2019/20-2020/21 contracts and prepare 2 year contract offers with finance and activity plans inline with the STP.
- Southampton City CCG to achieve in year breakeven in 2018/19, as in line with the business rules we have a 1% cumulative surplus.
- Continue to support the RightCare pathway review approach, embedding the changes identified to the pathway reviews undertaken in 2017/18 and complete the work in 2018/19 ready for delivery in 2019/20.
- Commence work on identification of 2 year QIPP schemes ready for delivery from 2019/20.

Key Outcomes by the end of 2018/19

- ✓ Deliver £21.32m of QIPP.
- ✓ Maintain 1% cumulative surplus.
- ✓ System to achieve its control totals in both 2017/18 and 2018/19.

Sustainable Finances (cont.)

Objective: Creating a financially sustainable health system for the future.

Leads: James Rimmer, Kay Rothwell

Our Key Actions in 2017/18

- Invest £662k in New Care Models at Solent NHS Trust in line with the STP model in order to reduce demand in the acute sector. This new investment is in addition to tariff and population growth funding of £172k in Solent NHS Trust.
- Invest £419k in mental health services in line with the MH FYFV and the STP model in order to partly reduce demand in the acute sector and support improvements to mental health services. This new investment is in addition to tariff and population growth funding of £177k in Southern Health NHS Foundation Trust.
- Invest £366k in children's mental health services in line with the MH FYFV and the STP model in order to support improvements to mental health services. This new investment is in addition to tariff and population growth funding of £26k in Solent NHS Trust.
- Other investments in children's and adults MH services will be made in line with the MH 5YFV with providers outside of the STP footprint / NHS family of £252k.
- All acute contract growth for NHS providers within the STP footprint is in line with the IHAM growth model adjusted then downward to reflect the STP solutions for reducing acute demand, in Southampton much of this will relate to the investment in new care models and RightCare.
- Growth in the CCG's primary care allocation is £2.1m, whilst some of this will be required to fund list size growth and inflationary pressures the balance will be used to drive new investments in primary care in the City. The CCG ends 2017/18 5.1% underfunded in its primary care allocation.
- Growth of the CCG's programme allocation per capita is 1.4% in 2017/18, this level of growth is significantly challenging when meeting all the required pressures and investments required, hence the STP overall challenge and the CCG QIPP gap. The CCG ends 2017/18 4.7% underfunded on its programme allocation.
- The CCG's use of specialised services see it being over using its indicative allocation by £11.6m in 2017/18 seeing its closing overfunding at 17.2%.
- CCGs are required to hold 1% headroom, which is £3.57m in 2017/18. 50% of this can be committed upfront, of which £415k will be deployed with the local practices to support delivery of the high impact changes as per the GPFV the balance of £1.374m will be used to further bring forward transformation schemes to speed up delivery. The remaining £1.789m is held and cannot be spent without NHS England's permission.

Our Key Actions in 2018/19

- Invest £713k in New Care Models at Solent NHS Trust in line with the STP model in order to reduce demand in the acute sector. This new investment is in addition to tariff and population growth funding of £185k in Solent NHS Trust.
- Invest £431k in mental health services in line with the MH FYFV and the STP model in order to partly reduce demand in the acute sector and support improvements to mental health services. This new investment is in addition to tariff and population growth funding of £181k in Southern Health NHS Foundation Trust.
- Invest £78k in children mental health services in line with the MH FYFV and the STP model in order to support improvements to mental health services. This new investment is in addition to tariff and population growth funding of £29k and Solent NHS Trust.
- Other investments in children's and adults MH services will be made in line with the MH FYFV with providers outside of the STP footprint / NHS family of £755k.
- All acute contract growth for NHS providers within the STP footprint is in line with the IHAM growth model adjusted then downward to reflect the STP solutions for reducing acute demand, in Southampton much of this will relate to the investment in new care models and RightCare.
- Growth in the CCG's primary care allocation is £1.1m, whilst some of this will be required to fund list size growth and inflationary pressures the balance will be used to drive new investments in primary care in the City. The CCG ends 2018/19 4.9% underfunded in its primary care allocation.
- Growth of the CCG's programme allocation per capita is 1.4% in 2018/19, this level of growth is significantly challenging when meeting all the required pressures and investments required, hence the STP overall challenge and the CCG QIPP gap. The CCG ends 2018/19 4.7% underfunded on its programme allocation.
- The CCG's use of specialised services see it being over using its indicative allocation by £12.1m in 2017/18 seeing its closing overfunding at 17.2%.
- CCGs are required to hold 1% headroom, which is £3.7m in 2018/19. 50% of this can be committed upfront, of which £417k will be deployed with the local practices to support delivery of the high impact changes as per the GPFV the balance of £1.456m will be used to further bring forward transformation schemes to speed up delivery. The remaining £1.873m is held and cannot be spend without NHS England's permission.

Key Outcomes by the end of 2018/19

- ✓ Ensure the investment of over £1.7m in community services delivers the changes required to stem acute activity demand.
- ✓ Ensure the investment of over £800k in children's mental health services delivers the improvements as outlined in the mental health section of this plan.
- ✓ Ensure investment of over £1.9m in adult mental health services delivers the changes required in line with the MH FYFV and the improvements set out in this operational plan.

Activity, Constitution Standards & IAF

Activity & NHS Constitution Standards

Objective: Develop robust, deliverable plans

Leads: CCG Managers

Our Key Actions for 2017/18 plans

Activity Plans

- Submit activity plans that reflect NHS England's view of 2016/17 forecast outturn.
- Develop activity plans to ensure alignment to NHS England's view of forecast outturn.
- Fully understand issues relating to coding by providers of activity defined nationally as NHS England direct commissioning activity; monitor the impact of these in 2017/18
- Apply the IHAM model growth assumptions as per the STP with explanation of any different growth used.
- Continue to agree the impact of the Identification Rules to reflect activity commissioning responsibility movements between the CCG and Specialised Commissioning.
- Identify our Southampton City CCG share of the overall HIOW transformational changes from the STP "Impacts on Activity" table within STP. Include adjustments to reflect changes that CCG has clear transformational implementation plans to support the activity changes.
- Include QIPP reductions aligned to the STP or reflective of our local plans towards achieving the STP transformation agenda.
- Agree reductions and include in provider contracts.
- Ensure Mental Health & Community Contract discussions have included workforce implications of new significant investment, including risks & mitigating actions.
- Include rebasing of referrals plan agreed in October 2016 with local NHS England team.
- Continue detailed internal reporting and monitoring of referrals and activity.
- Continue to have robust performance management processes in place to implement mitigation where and when necessary in a timely manner.

NHS Constitutional Standards

- Ensure all standards and trajectories have been agreed with providers to meet the National Standards.
- Ensure the UHS A&E trajectory is challenging, improves on previous years' performance, agreed and deliverable.
- Set trajectories using previous years' performance, seasonality, growth and efficiency reductions.
- Ensure monthly reporting is in place to monitor performance data for current and new standards, with appropriate mitigation when required.

Our Key Actions for 2018/19 plans

- Ensure any adjustments resulting from 2017/18 are bought forward into 2018/19 Plans.
- Continue with alignment of STP transformational change reductions are reflected in plans and implemented within QIPP Programmes.
- Agree plans with providers, and include in contracts.
- Ensure appropriate reporting and monitoring processes are in place.
- Continue to have robust performance management processes in place to implement mitigation where and when necessary in a timely manner.

Key Outcomes by the end of 2018/19

- ✓ Delivery of the NHS Constitution Standards
- ✓ Delivery of the activity plans
- ✓ Monitoring and reporting processes in place

Improvement & Assessment Framework

Objective: Develop the CCG Improvement and Assessment Framework

Leads: CCG Managers

Our Key Actions for 2017/18 plans	Our Key Actions for 2018/19 plans	Key Outcomes by the end of 2018/19

• As part of the new CCG Improvement & Assessment Framework (CCG IAF), an initial baseline rating for six clinical priority areas was published by NHS England in September 2016. The CCG will ensure validation and actions to improve are in place for Southampton CCG ratings:
  • Cancer – Needs Improvement
  • Dementia – Performing Well
  • Diabetes – Performing Well
  • Learning Disabilities – Needs Improvement
  • Maternity – Performing Well
• Develop the ratings derived from the indicators in the new framework looking at the CCG's current baseline performance using the most recent data available as at the end of June 2016. These provide a starting point for future assessments.
• Continue to review, validate and communicate the CCG IAF dashboard published by NHS England.
• Continue to ensure lead CCG managers are aware of performance and actions required for improvement.
	• Continue to develop the CCG IAF ratings and actions to continuously improve the CCG's position/ratings.
	• Continue to review the CCG's position in its peer group to ensure satisfactory performance and ranking.
		✓ Accurate and reliable data for ratings
		✓ Improvement actions in place
		✓ Continuous improvement

RightCare

Lead: James Rimmer, Clare Young

Our Key Actions in 2017/18

RightCare is a national programme, rolled out by NHS England in 2016/17, to equip CCGs with benchmarking resources that enable them to be able to identify areas of unwarranted variation, across both spend and quality. During 2016/17, the benchmarking resources from RightCare helped us to identify that we are a significant outlier for spend on Neurology and Gastrointestinal. We subsequently agreed to carry out deep-dive reviews of these pathways to identify improvements and efficiencies. Some improvements in Neurology and Gastrointestinal were implemented in 2016/17, the below sets out the key deliverables for 2017/18:

Neurology

- Increase GP confidence to manage and diagnose headache in primary care: GP education on different types of headache and migraine, including updated Maps of Medicine and GP tutorial. A UHS Consultant Neurologist will also run a session at TARGET in March 2017.
- Investigate reducing unnecessary emergency CT scans: Work with UHS clinicians to implement a protocol in ED for instances where a CT scan is appropriate for patients presenting with headache – this would assist juniors with decision making.
- Improve community services for Neurological long term conditions: Work with Solent to establish an improved model of community neurology services, including community nursing provision.
- Reduce Epilepsy NEL Admissions: Review of the Epilepsy pathway to look for improvement opportunities.

Gastrointestinal

- Reduce NEL abdominal pain admissions: GP education on abdominal pain, including launch of a new Map of Medicine and GP tutorial.
- Reduce unnecessary endoscopies: Launch of a new referral form for endoscopies with strengthened referral criteria.
- Reduce low complexity activity in secondary care: Implement a Community Gastrointestinal Service to shift low complexity conditions out of secondary care, into the community. This will cover IBS, Dyspepsia and Constipation.

Cardiovascular

- In addition to the 2 major pathway reviews above, we also carried out a 'mini' review of Cardiovascular which identified atrial fibrillation as an area to improve. In 2017/18, we will complete the pilot and commence full rollout of NICE-recommended AF detection devices, called WatchBP, in GP practices in Southampton.

New RightCare projects planned for 2017/18:

- MSK & Pain: The rationale for reviewing this pathway is that we spend £3m more than our similar CCGs on elective MSK activity, and £2m more on NEL pain admissions.

Our Key Actions in 2018/19

Implementation of recommendations from the MSK & Pain pathway review carried out in 2017/18.

Actions for 2018/19 will be determined following completion of these reviews.

Key Outcomes by the end of 2018/19

FINANCIAL OUTCOMES

- ✓ Reduction in NEL short stay Headache Admissions
- ✓ Reduction in NEL Epilepsy admissions
- ✓ Reduction in emergency CT scans
- ✓ Reduction in Outpatient Appointments for Headaches
- ✓ Reduction in NEL short stay Abdominal Pain Admissions
- ✓ Reduction in elective endoscopies
- ✓ Reduction in Stroke admissions (AF)
- ✓ Other financial outcomes from MSK & Pain to be determined in 2017/18

QUALITY OUTCOMES

- ✓ Patients only admitted as an emergency when necessary
- ✓ More appropriate GP referrals
- ✓ Patients not receiving unnecessary tests
- ✓ Reduction in NEL admissions rate for children <18yrs with epilepsy
- ✓ Reduction in mortality from Gastrointestinal disease, under 75s
- ✓ Improved GP knowledge of abdominal pain and headaches
- ✓ Reduction in strokes – increased detection of AF and anticoagulation
- ✓ Improved management of conditions in the community – care closer to home
- ✓ Other quality outcomes from MSK & Pain to be determined

QIPP Programmes (Quality Innovation Productivity & Prevention)

Programme	Scheme	Short Description of Scheme	Leads	Alignment to STP Programmes
1 Continuing Healthcare (CHC)	1.1 CHC	• Delivering assurance across entire CHC client group that every element of our spend is clinically justified, delivering high quality and cost effective care. • Areas: mental health, children, normal CHC (plus others being investigated)	Stephanie Ramsey & Carol Alstrom	• New Commissioning Models
	1.2 Learning Disabilities CHC	• Integrating timely review activity, robust financial management (including high cost review) and LD complex housing. • Proposal being developed on integration of Southampton City Council's LD team with the CCG's CHC team to pool resources and use a holistic approach.	Stephanie Ramsey, Carol Alstrom & Carole Binns	
2 Medicines Management	2.1 Patent Expiries	• Ensuring continued cost effective use of generic medicines: maintain existing patent expiry savings and to realise further savings by ensuring that new generic savings are realised at a level of at least 95%	Stephanie Ramsey & Carol Alstrom	• New Commissioning Models
	2.2 OptimizeRx	• Ensuring continued cost effective prescribing through use of these valuable prompting tools at the point of prescribing in GP surgeries		
	2.3 Practice Based Interventions	• GP practice based interventions in specific therapeutic areas with the use of audit, PrescQIPP where available and other tools as appropriate. • Antidepressant prescribing • Reducing repeats within Community Pharmacy Systems • Reducing paracetamol prescribing • Infant feeds • Care home work • Rosuvastatin prescribing		

3 Planned Care	3.1 MSK
	3.2 Gynaecology
	3.3 Urology
	3.4 Ophthalmology
	3.5 Sleep Studies
	3.6 ENT
	3.7 Dermatology
	3.8 General Medicine
	3.9 General Surgery
		Further reduction in activity and cost in:
		• Referrals (A&G, SDM, MoM, thresholds) and first attendances
		• Outpatient follow up activity
		  • only when required – patient triggered
		  • increase telephone/on-line – reduce face-to-face
		  • shift to community services where appropriate
		• Inpatient activity
		  • further day case to OPPROC opportunities
		  • further inpatient to day case opportunities
		  • pathways (SDM, thresholds)
		  • shift to community/primary services where appropriate
		• One-stop clinic (OP/IP) opportunities
			Peter Horne & Lisa Sheron	• Acute Alliance & Configuration

Programme	Scheme	Short Description of Scheme	Leads	Alignment to STP Programmes
4 Urgent Care	4.1 Urgent Care Activity Shift	• Signposting and shift of ED presentations to least intensive and most appropriate care setting (e.g. SCAS conveyance to MIU rather than ED) • Shift of interventions to most appropriate care setting	Peter & Lisa	• New Models of Integrated Care • Acute Alliance & Configuration
	4.2 Working Age Adults Short Stay NEL Admissions (Better Care)	• Continued identification of frequent/complex users – implementation of cluster working, key worker role and personalised care and support planning • New Pathology screen approach to low risk chest pain pathway • Development of psychological approaches – focusing upon psychological support for individuals who have multiple long term conditions. • Implementation of new screen within primary care (hubs) for Atrial Fibrillation detection.	Stephanie & Donna	• New Models of Integrated Care • Prevention at Scale
	4.3 Older People Falls & ACS NEL Admissions (Better Care)	• Delivery of the falls prevention plan • Roll out of community navigation city wide, with a stronger focus on targeting those at risk. • A stronger focus in clusters of reducing NEL admissions • Development of support to residential and nursing homes to develop their skills and confidence in preventing avoidable admissions • Development of the community nursing offer • Supporting end of life patients to die in preferred place	Stephanie & Donna	• New Models of Integrated Care • Prevention at Scale • Effective Patient Flow & Discharge
	4.4 Reducing NEL Excess Bed Days (Better Care)	• Continuation of an accelerated discharge pathway (using discharge to assess principles) through the integrated rehab and reablement service to reduce the number of delayed transfers of care and XBDs associated with patients who have complex needs requiring a supported discharge package.	Stephanie & Donna	• Effective Patient Flow & Discharge
	4.5 Paediatric Ambulatory Care	• Taking learning from frequent users for working age adults and applying to children • Embed Wessex Healthier Together • Develop Connecting Care for Children Locality GP hubs • Embed paediatrics within Primary Care enhanced access hours service specification • New model for community acute nursing (COAST)	Stephanie & Donna	• New Models of Integrated Care

QIPP Programmes (cont.)

Programme	Scheme	Short Description of Scheme	Leads	Alignment to STP Programmes
4 Urgent Care	4.6 Respiratory NEL Admissions	• Reach those who haven't yet got a COPD diagnosis and ensure they are supported to self manage • Have a stronger push on supporting self management in the overall COPD population – through further strengthening the work with practices, medication compliance, smoking cessation, use of care technology • Develop plans for other respiratory conditions (which we so far have not significantly focussed on e.g. asthma)	Stephanie & Donna	• Prevention at Scale • New Models of Integrated Care
	4.7 Diabetes NEL Admissions	• Year 3 of savings from the Diabetes foot care pathway improvement business case – reduction in NEL admissions and NEL amputations	Stephanie & Donna	• Prevention at Scale • New Models of Integrated Care
	4.8 Deep Vein Thrombosis (DVT) NEL Admissions	• Full year effect of the improvements made to the pathway in 2016/17	Peter Horne & Lisa Sheron	• New Models of Integrated Care • Acute Alliance & Configuration
	4.9 Eye ED Attendances	• Increasing telephone triage to divert patients to the right place first time, confident re-direction of walk-in patients who can be managed in community/primary care, booking patients who require secondary care assessment and management to into 'hot clinics' at sub-specialty level and reducing follow up rates.	Peter & Lisa	• New Models of Integrated Care • Acute Alliance & Configuration
5 RightCare	5.1 Gastrointestinal	• Endoscopies - strengthen endoscopy referral form & criteria to reduce inappropriate referrals • Abdominal Pain - Improved primary care enablers (Map of Medicine & GP Tutorial), senior decision making earlier for emergency abdo pain patients and a hotline in ASU for GPs to call for urgent advice • Community Gastrointestinal Service for low complex conditions (IBS, dyspepsia and constipation)	Peter Horne & Lisa Sheron	• New Models of Integrated Care • Acute Alliance & Configuration
	5.2 Neurology	• Headache & Migraines – protocol in ED for when a CT scan is appropriate, clinical audit into NEL admissions, improved primary care enablers (map of medicine, GP tutorial and HEADMAT), improved referral criteria. • Epilepsy & Neuro Rehab – epilepsy pathway review, redesign of community neuro rehab services.	Peter Horne & Lisa Sheron Stephanie & Donna	• New Models of Integrated Care • Acute Alliance & Configuration
6 Mental Health	6.1 Mental Health Matters	• Implementing improvements following the Mental Health Matters consultation in 2016/17 – all efficiency savings will be reinvested into mental health services.	Stephanie Ramsey & Carole Binns	• Mental Health Alliance

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Key Risks & Challenges

Key Risks & Challenges

Risk Title	Risk Description	Key Mitigation Controls
Mental Health	• Failure to respond to improvements required in implementing mental health matters.	• Exploring alternative provision if collaboration is ineffective • Regular CQRM and Contract review meetings in place. • Southern Health action plan and quality improvement plan being implemented. • Implementation of change through Mental Health Matters.
Primary Care	• Pressures on sustainability of Primary Care, failure to recruit, practices in special measures and others facing significant quality challenges.	• Process in place to support practices in special measures agreed at Clinical Governance Committee • Delegated commissioning framework - NHS England framework to support practices in crisis which there is a local provider • Locally commissioned services have specific quality requirements built in • Primary Care strategy and delivery plan in place (GPFV)
Provider Workforce	• Pressures on recruitment and retention of qualified healthcare staff such as reregistered nurses, specialist practitioners including mental health staff and non-registered support staff.	• All Health providers required to produce monthly safer staffing data which is monitored via CQRMs and Quality Managers (nursing focused). Exception reporting is in place in all CQRMs where staffing concerns may be impacting on the quality of care. • Monthly workforce data from CSU • Monitoring wider staffing concerns/intelligence e.g. Solent staff issues in Portsmouth • Nursing Homes supported via leadership training and peer support network which promotes access to training and wider support
Local Authority Funding Shortfall	• Reductions in public health grant carried through into front line service reductions, with direct impact on NHS providers and sustainability of key services to vulnerable people. • Failure of service redesign to mitigate impact of social care funding pressures for adults and children, resulting in loss of capacity in areas such as domiciliary care that are critical to successful delivery of STP priorities (e.g. delayed transfers of care reduction).	• Service efficiencies and prioritisation to maintain the most critical services; collaborative agreement to manage pace of change • Collaborative work to accelerate integration and achieve service efficiencies; alternative forms of provision; targeted CCG investment to support maintenance of priority services.
Performance	• Failure of the standard for 95% or more patients to wait no longer than 4 hours in A&E (NHS Constitution requirement).	• Weekly scrutiny of system patient flow. • Monthly oversight from the contract performance panel. • CCG scrutiny of actions and plans at monthly business meeting. • Monthly ED RAP progress monitoring meetings between UHS and commissioners
Engagement	• Engagement of members and localities may not be sufficiently robust to enable the CCG to achieve its objectives and carry out its functions and responsibilities.	• TARGET (Time for Audit, Research, Governance Education and Training) • Local improvement schemes • Dedicated Clinical Leads
Out of Hours Contract	• The ability of the provider to respond to developing requirements, including GP access and integrated 111/OOH.	• Monthly contractual meeting. • Weekly exception reports on operational issues are being provided to Commissioners from PHL.
Financial Sustainability & Savings	• Failure to achieve our CCG planned surplus. Non-delivery of our savings plans.	• All budgets delegated to directors and authorisation limits of all staff reviewed. • Monthly financial reporting and forecasting is used to identify risk areas. • Bi-monthly Board Finance and Performance report and CFO internal monthly review of year end forecasts. • Monthly Senior Business Team Meeting in place to monitor QIPP delivery and milestones. • Primary Medical Committee will give additional focus to the primary care delegated budgets.

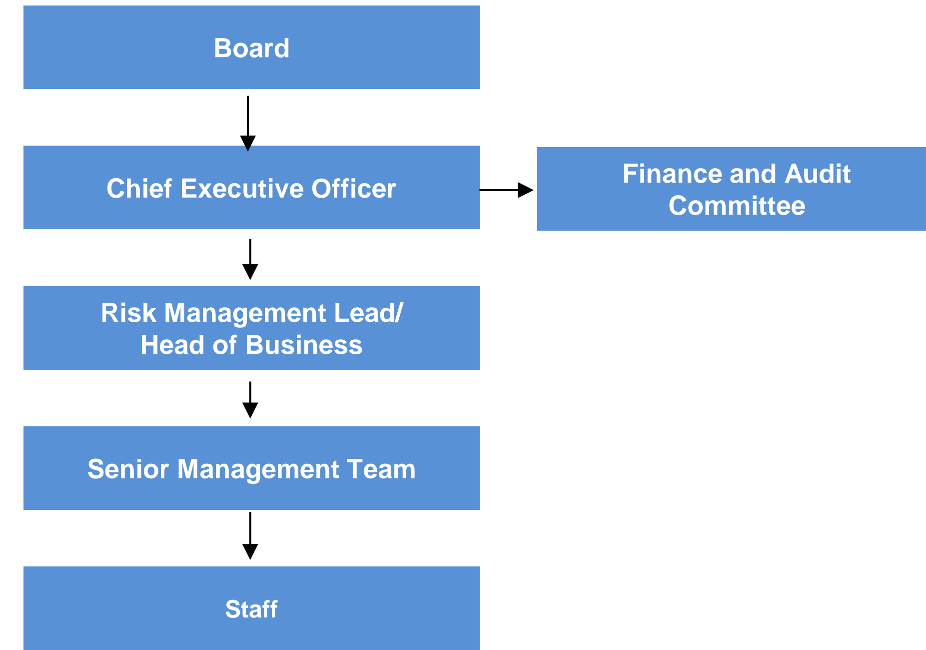
CCG Risk Management Policy & Process

The CCG has a robust Risk Management Policy and process in place. The aim of the policy is to enable a common approach to the identification and management of risk, to include:

- Outline Southampton City CCG's approach to Risk management;
- Ensure there are internal systems and processes to provide assurance that Southampton City CCG is able to discharge its responsibilities;
- Set out the accountability arrangements for Southampton City CCG.

Responsibilities for Risk Management

- **The CCG Board** is ultimately and collectively responsible for effective risk management within the CCG.
- The **Finance and Audit Committee** is responsible for reviewing the establishment and maintenance of an effective system of risk management and internal control across the whole of the CCG's activities that support the achievement of its objectives.
- The **Accountable Officer** will have executive responsibility for Risk management in the CCG.
- The **Risk Management Lead** (Head of Business) is a central point for risk management issues within the CCG and facilitates the risk management process. The Risk Management Lead is responsible for the maintenance of the Board Assurance Framework and CCG Risk Register, ensuring that there is sufficient and timely engagement from CCG staff.
- The **Senior Management Team (SMT)** is responsible for reviewing an effective system of risk management across the whole of the CCG's activities that support the achievement of its objectives. The role of SMT is to also provide challenge to the risk score if necessary.
- **Leadership and Management Teams –** All managers and clinical leads within the CCG are accountable for the day-to-day management of risks of all types within their area of responsibility.
- **Internal and External Audit -** The auditors are responsible for agreeing (with the Finance and Audit Committee) a programme of audits which assess the exposure and adequacy of mitigation of the principal risks affecting the organisation.



Southampton City CCG will operate an assurance framework where strategic objectives will be defined on a yearly basis and strategic risks outlined against each objective. The CCG Board then reviews this in public, bi monthly. The Board Assurance Framework is informed by the CCG Risk Register and will contain all risks graded 10 and above.

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