Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 6th December, 2018
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor White (Vice-Chair)
Councillor Bell
Councillor Houghton
Councillor Noon
Councillor Payne
Councillor Savage

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PUBLIC INFORMATION

ROLE OF HEALTH OVERVIEW SCRUTINY PANEL (TERMS OF REFERENCE)

The Health Overview and Scrutiny Panel's responsibilities and terms of reference are set out within Part 3 of the Council's Constitution: Responsibility for Functions

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.

MOBILE TELEPHONES: - Please switch your mobile telephones to silent whilst in the meeting.

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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.

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent lives
- Southampton is an attractive modern City, where people are proud to live and work

CONDUCT OF MEETING

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 2018/2019

2018	2019
28 June	28 February
30 August	25 April
1 November	
6 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 1st November 2018 and to deal with any matters arising, attached.

7 UPDATE ON PROGRESS - SOUTHERN HEALTH NHS FOUNDATION TRUST
(Pages 5 - 18)

Report of the Chief Executive, Southern Health NHS Foundation Trust, providing the Panel with an update on progress at Southern Health NHS Foundation Trust, an overview of the findings from the recent Care Quality Commission (CQC) comprehensive report and information relating to the temporary closure of Beaulieu Ward at Western Community Hospital.

8 HAMPSHIRE AND ISLE OF WIGHT SYSTEM REFORM PROPOSAL
(Pages 19 - 66)

Report of the Hampshire and Isle of Wight Sustainability and Transformation Partnership Senior Responsible Officer requesting that the Panel consider the proposal to reform the Hampshire and Isle of Wight health and care system.

9 HEALTH AND WELLBEING STRATEGY UPDATE
(Pages 67 - 76)

Report of the Cabinet Member for Community Wellbeing providing the Panel with an update on progress against the Health and Wellbeing Strategy.

Wednesday, 28 November 2018 Director of Legal and Governance

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 1 NOVEMBER 2018

Present: Councillors Bogle (Chair), White (Vice-Chair), Bell, Houghton, Noon, Payne and Savage

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

RESOLVED: that the minutes for the Panel meeting on 30 August 2018 be approved and signed as a correct record.

It was noted that the Panel raised concerns about figures within the Adult Social Care Performance report, in particular the number of assessments untaken by the Council. However, the Panel's concerns were responded to by the Service Director, Adults Housing and Communities who stated that assessments had been thorough and that the numbers indicated within the report were correct.

11. **SEXUAL HEALTH SERVICES**

The Panel considered the report of the Director of Public Health requesting that the Panel consider and challenge outcomes relating to sexual health in Southampton.

Dr Jason Horsley (Director of Public Health) and Tim Davis (Senior Commissioner - Healthy Lives) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel received two presentations setting out the background to the sexual health services within the City. The briefings outlined the structure and responsibilities of each of the providers of sexual health services and a brief assessment of the sexual health of the City.

Following the presentation the Panel sought insight on a number of issues including:

- An understanding of how Southampton compared statistically to other areas. The Panel learnt that a meaningful assessment of sexual health was complicated but were informed that the levels were not dissimilar to other large university cities;
- The aims of the new strategy, focussing on the need to improve the City's sexual health, were explained;
- The links between deprivation and sexual health and how certain demographical groups were likely to be affected. It was further explained that sexual health and in particular the rate of teenage pregnancy could be affected by religious beliefs and origin;
- The support given to parents and the schools to deliver advice on good sexual health. It was explained that the City's performance continued to be effected by changes in life styles such as: the use of social media to find partners; the numbers of residents originating from areas where diseases like HIV are prevalent; or the reduction in teenage drinking and drug use;

- The effects of the reduction of the service budgets over the years. The Panel noted that whilst the service had been impacted by the budget reductions this had been mitigated to some extent by the introduction of innovative practices. As an example it was explained that self-test kits were now being issued. The Panel noted that the process of issuing kits was monitored and that there is a follow up scheme; and
- The Panel also recognised that provision should be built into the plan in order for it to be regularly assessed.

RESOLVED that the Panel:

(i) Welcomed the development of the new sexual health improvement plan. The Panel hoped that as the plan developed it would seek to resolve the fragmented nature of the service and stress the importance of working with education providers; and

(ii) Requested that the action plan be brought to a future meeting of the Panel.

12. **TRANSFORMING HEALTH AND CARE FOR THE PEOPLE OF SOUTHAMPTON**

The Panel considered the report of the Chief Executive Officer, NHS Southampton Clinical Commissioning Group, requesting that the Panel consider, and provide feedback on, the current high level draft Southampton Health and Care strategy.

John Richards (Chief Executive Southampton Clinical Commissioning Group) was in attendance and, with the consent of the Chair, addressed the meeting.

It was explained that the Panel had received a high level analysis of the City's current and future health care challenges. The analysis had drawn together a number of sources of information including population growth, current health inequalities, disease prevalence, adult social care forecasting and urgent care hospital usage in order to develop a strategy to cope with the future needs of health care provision in the City.

It was further explained that the analysis undertaken was being used to target resources across the City more effectively. It was noted that the analysis had the benefit of having better quality data than that previously used to inform the current CCG plan.

It was noted that the draft plan seemed to have a far starker outlook on health issues than the current plan. The Panel questioned how the CCG had arrived at this position.

The Panel were informed that the data indicated that the level of deprivation was a big factor in indicating the health within an area. It was explained that the data had shown that there was a significant difference in the life expectancy of those from different ends of the social deprivation spectrum. It also questioned the use of the national comparison figure within the document.

The Panel stated that the paper circulated did not acknowledge the importance of child health and services linked to education. The Panel were keen to stress the importance of this and in particular the interaction with parents and children within the first 1000 days of a child's life.

It was questioned whether the potential additional usage of the City's hospital from other areas like the Isle of Wight would have a negative effect on the services offered to the City. The Panel also reflected upon potential measures to reduce the numbers of patients being admitted to hospital by ambulance including the use of paramedics.

The Panel were advised of the opportunity to attend an engagement event hosted by the CCG on 20th November 2018.

RESOLVED that the Panel

(i) noted the draft of the 5 year strategic plan;
(ii) questioned why the plan did not include an emphasis on child health; and
(iii) requested that the supporting data be made available to Panel Members.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON PROGRESS – SOUTHERN HEALTH NHS FOUNDATION TRUST		
DATE OF DECISION:		6 DECEMBER 2018		
REPORT OF:		CHIEF EXECUTIVE – SOUTHERN HEALTH NHS FOUNDATION TRUST		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Jenny Renyard**	**Tel:**	**023 8087 4070**
	E-mail:	**Jenny.renyard@southernhealth.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report provides the Panel with an update on progress at Southern Health NHS Foundation Trust and an overview of the findings from the recent Care Quality Commission (CQC) comprehensive report into Southern Health NHS Foundation Trust published on 3 October 2018.

In addition, following the difficult decision on 13 November 2018 to temporarily close Beaulieu Ward at Western Community Hospital for up to six months, additional information relating to the decision is attached.

The Panel are requested to consider the appendices and discuss the key issues with the invited representatives from Southern Health NHS Foundation Trust.

RECOMMENDATIONS:		
	(i)	That the Panel consider the attached updates on progress and staffing issues within our Older People's Mental Health Services with representatives from Southern Health NHS Foundation Trust.

REASONS FOR REPORT RECOMMENDATIONS	
1.	To enable the Panel to effectively scrutinise the issues impacting on health services in Southampton.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None.

DETAIL (Including consultation carried out)	
3.	On 3 October 2018 the Care Quality Commission (CQC) published their comprehensive report into Southern Health NHS Foundation Trust. A summary of the key findings from the inspection, as well as an update on a number of important developments at Southern Health NHS Foundation Trust is attached as Appendix 1.
4.	In November 2018 the HOSP were informed of a decision made by Southern Health NHS Foundation Trust to temporarily close Beaulieu Ward at Western Community Hospital, for up to six months, due to the Trust being unable to recruit the registered nurses needed to ensure Beaulieu Ward is a safe place for our patients and staff. Patient safety and the health and wellbeing of our

	staff are always our priority and we feel there is no alternative option at this current time.
5.	Attached as Appendix 2 is the update provided to the HOSP on 13 November 2018 informing the Panel of the Trust's decision. In addition, attached as Appendix 3 is the response to the supplementary questions raised by the Chair of the HOSP.
6.	The Panel are requested to consider the updates on progress and staffing issues within our Older People's Mental Health Services with representatives from Southern Health NHS Foundation Trust.
RESOURCE IMPLICATIONS	
Capital/Revenue	
7.	N/A
Property/Other	
8.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
9.	N/A
Other Legal Implications:	
10.	None
POLICY FRAMEWORK IMPLICATIONS	
11.	N/A
KEY DECISION	N/A
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Southern Health Progress Update
2.	HOSP update on staffing issues within our Older People's Mental Health Services
3.	Response to supplementary questions from Southampton HOSP
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?	No
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	No

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

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Southampton City Council
Health and Overview Scrutiny
November 2018

Summary

The Trust continues to make progress in a number of key areas including the involvement of patients, families and carers, transformation and quality improvement, and further joining up mental and physical health services to improve patient care, aligning to the Sustainability and Transformation Partnership's emerging system reform proposals.

At the same time, the Trust continues to tackle ongoing challenges, most notably the reliance on 'out-of-area' mental health beds, and staff recruitment and retention. These are complex and firmly established challenges which require sophisticated, long term plans, and considerable action is taking place in these areas alongside system partners. Sustainable improvements in measured engagement and satisfaction of Trust staff and recent successful recruitment campaigns are encouraging signs that action is making an impact, and the vacancy rate across the Trust is on an improving trajectory.

The Care Quality Commission published its comprehensive report in October, following a series of inspections earlier this year – the first report of its type since 2014. Whilst the Trust overall rating remains one of 'requires improvement', significant and numerous positive changes have been recognised by the regulator and the overall picture is one of steady progress. Of particular note, our community services across Hampshire are now rated 'good' overall, and our learning disability inpatient services are rated 'outstanding' overall. Perhaps unsurprisingly, staffing levels were linked to most areas identified for improvement. The report has provided additional confidence that the organisation's approach is making headway, and the trust remains committed to building on this in the coming months and years.

Southern Health is working in partnership with other agencies across the system to prepare for winter. Our focus is on increasing our capacity and capability to support people to remain independent and at home wherever possible, and expediting safe and timely discharge from acute hospital for those admitted. A number of new schemes, initiatives and campaigns are now in place to enhance our ability to achieve this.

Recent Care Quality Commission (CQC) comprehensive report

On 3 October the Care Quality Commission (CQC) published their comprehensive report into Southern Health NHS Foundation Trust. Whilst the Trust's overall rating remains as 'requires improvement', the CQC found many signs of progress across the organisation, with over 84% of service areas now rated as 'good or 'outstanding'. The inspection took place in June/July 2018 and is the first comprehensive report into the Trust since 2014. The Trust's community services have received a rating of 'good' overall and our inpatient services for people with a learning disability have been rated as 'outstanding' overall.

It also reflects the significant strides the Trust has made to improve its relationship and involvement with the families and carers of our patients and service users, with the CQC feedback showing that: '*Staff had made a genuine commitment to engaging with patients.*

We saw that they were patient and diligent in helping patients express their views, and liaised with them in all aspects of their care. The feedback from patients and carers was clear that they felt they were not only listened to, but included and involved in their care.'

The report describes how staff told inspectors they now feel more valued and supported, and that the CQC has seen a positive change in culture at Southern Health.

Whilst the report gives cause for optimism, clearly the Trust has more work to do: particularly in relation to our staffing levels and ensuring there are enough trained staff to best support patients. The Trust remains committed to continuously improving its services to deliver the best possible care.

The CQC's findings have been incorporated into a trust-wide quality improvement plan, which is themed across a number of areas. There is executive-level ownership for each theme, and it is hope that this approach will help staff and stakeholders better understand the improvements required and how progress is being made against each theme.

Below are the Trust CQC 'scorecards' which show ratings for each domain (safe, effective, caring, responsive, well-led, and overall) against each core service from 2014 and the latest report from October 2018 (note, I=inadequate, RI=requires improvement, G=good, O=outstanding):

2014:

CORE SERVICE	Safe	Effective	Caring	Responsive	Well-led	Overall
	2014					
OVERALL PROVIDER RATING	RI	RI	G	G	RI	RI
Community health services for adults	RI	G	G	RI	G	RI
Community health services for children & young people	G	G	G	G	G	G
Community health inpatient services	RI	G	G	G	G	G
Community end of life care	RI	RI	G	G	G	RI
Urgent care	RI	RI	G	RI	RI	RI
Acute wards for adults of working age & PICUs	RI	RI	G	RI	RI	RI
Long-stay or rehab mental health wards	G	G	G	G	G	G
Forensic inpatient or secure wards	I	G	G	G	RI	RI
Child and adolescent mental health wards	RI	RI	G	G	G	RI
Wards for older people with MH problems	RI	G	G	G	G	G

Wards for people with a learning disability/autism	RI	RI	G	G	RI	RI
Community-based mental health services	G	G	G	G	G	G
MH crisis services / health-based places of safety	RI	RI	G	RI	RI	RI
Community mental health services for older people	G	G	G	G	G	G
Community services for people with a learning disability/autism	G	G	G	G	RI	G
Eating Disorder service (not inspected in 2018) *	G	G	G	G	G	G
Perinatal services (not inspected in 2018) *	O	O	O	O	O	O

* These services were not included in the aggregation of the overall provider rating

2018

CORE SERVICE	Safe	Effective	Caring	Responsive	Well-led	Overall
	2018					
OVERALL PROVIDER RATING	RI	RI	G	G	RI	RI
Community health services for adults	G	G	O	G	G	G
Community health services for children & young people	G	G	G	G	G	G
Community health inpatient services	G	G	G	G	G	G
Community end of life care	G	RI	G	G	G	G
Urgent care	G	G	G	G	G	G
Acute wards for adults of working age & PICUs	RI	G	G	G	RI	RI
Long-stay or rehab mental health wards	G	G	G	O	O	O
Forensic inpatient or secure wards	G	G	G	G	G	G
Child and adolescent mental health wards	RI	G	G	G	RI	RI
Wards for older people with MH problems	RI	RI	G	I	RI	RI
Wards for people with a learning disability/autism	G	G	O	O	G	O
Community-based mental health services	G	RI	G	G	G	G

MH crisis services / health-based places of safety	G	RI	G	G	RI	RI
Community mental health services for older people	G	RI	G	G	G	G
Community services for people with a learning disability/autism	G	G	O	G	G	G
Eating Disorder service (not inspected in 2018)	G	G	G	G	G	G
Perinatal services (not inspected in 2018)	O	O	O	O	O	O

The full CQC report can be found here: https://www.southernhealth.nhs.uk/news/cqc-finds-further-improvements-at-southern-health/

Changing Southern Health's structure to enable more joined-up care

Providing both mental and physical health services brings opportunities to better integrate these services for the benefit of patients. Evidence also suggests that people with severe mental health problems have a shorter life expectancy and to a large extent this is due to physical health problems not being properly managed. People with long term physical health conditions are also more likely to experience mental health problems. So, the case for integration is powerful and Southern Health has a huge opportunity to do this.

Examples of more joined up care already happening include our diabetes service providing direct care into our medium secure mental health unit, and our psychological therapy service (italk) providing support to people with long term physical health problems.

The Trust is now consulting on plans to create a new organisational structure which will further enable this more joined up way of working to flourish. Services will be planned and managed based on local populations (aligned to system-level footprints), ensuring mental, physical and learning disability health needs are met for patients in each area. The new structure will make more collaborative working between professions more straightforward, whilst maintaining professional skills and networks. It is expected that this new structure will be launched in the New Year, which will lay the foundations for ongoing improvements to integrated care: ultimately delivering better patient experience and outcomes.

Involving patients, carers and families

Improving the way the Trust works in partnership with people who use services, their families and carers is a strategic priority for Southern Health. A considerable amount of progress has been made in recent weeks following the appointment of an experienced head of patient engagement. One example is the new Working in Partnership Committee, which has been recently been established and reports directly to the Trust Board. This committee is chaired by a carer and is attended by representatives from service user, carer, and family groups from across the organisation. It is hoped that this committee will give a greater voice to people using our services and result in tangible and meaningful improvements.

Transformation and quality improvement

The Trust is committed to carrying out large scale change to transform its services, and to adopt proven quality improvement techniques to ensure this is carried out in the most effective way. The Trust continues to train staff from across the Trust in these techniques who are working with teams to carry out local quality improvement projects. Current projects underway include those aiming to improve recruitment processes, reduce violence and aggression on mental health inpatient wards, improve access to psychological therapy for older people, and improve the prevention of pressure ulcers. Over 200 staff, patients and carers recently attended the Trusts first transformation conference where these projects were showcased.

Secure Services re-provision

Plans are progressing well to build a new learning disability residential unit (LDRU) at Tatchbury Mount, and to develop Woodhaven Hospital to provide additional and much needed beds for young people will severe mental health problems. Construction has begun on the LDRU, and the new unit and additional beds for young people are due to open in Winter 2019. Patients and families have been closely involved throughout, including on the design and layout of the new unit.

Suicide and self-harm awareness, reduction and prevention

As a mental health provider the Trust supports some of the most vulnerable people in Hampshire, many of whom are at a high risk of self-harm. The Trust is part of local suicide prevention strategies and has signed up to the Zero Suicide Alliance. The Trust is working hard to do all it can to reduce and ultimately prevent suicide amongst the people it supports. This includes training, awareness raising and ensuring it is adopting the best practice. In December the trust is joining forces with Solent NHS Trust to host a suicide reduction conference, to improve collaboration between professionals in both organisations and learning from national and international experts on this subject.

Recruitment and retention

Along with the wider NHS, staff recruitment and retention are challenging. The scale of the problem for the trust is broadly in line with that faced by other NHS organisations.

Significant efforts are underway and ongoing to attract and retain our workforce, including a new workforce strategy which is now being implemented, and an increased focus on social media campaigns and passive recruitment. Thanks to these efforts we have reduced the Trust's vacancy rate, and reduced the amount we spend on agency staff by £1m. However there remain specific areas of challenge including consultants, for which an ongoing campaign in national medical journals is taking place.

Out-of-area mental health placements

The Trust continues to place some Hampshire patients out-of-county for inpatient mental health care in cases were no suitable bed can be made available in Hampshire. This is far from ideal for the patients and their families and is also not the best use of resources. Many attempts have been made to tackle this challenge, with varied success, but it remains a key problem. This complex problem requires a multifaceted solution, the trust is now seeking the involvement of our staff and patients on this matter, under the leadership and fresh perspective of our new medical director.

Winter preparedness

The Trust is working closely with system partners on joint plans to meet the demands of winter. A successful winter recruitment campaign has resulted in over two dozen new staff joining the Trust in teams expected to face additional demands. New initiatives aimed at supporting people at home and preventing hospital admissions have begun, including a new frailty support service which has supported over 800 patients in the New Forest and prevented hospital admissions in 81% of cases. In Gosport, a new complex care team has been created, as well as multi-disciplinary long term condition hubs, which aim to improve access to specialist clinicians in local GP surgeries, and 'health connectors' who work with patients to help them find and access health and wellbeing services in their local area. The Trust is working with system partners on public-facing campaigns to ensure people make informed decisions about how and where to access care during winter, and tips and guidance for staying well and independent. The Trust has also launched two campaigns aimed at patients in our community hospitals – one 'End PJ Paralysis' encourages patients to get up and dressed to improve mobility, and another 'Why not home, why not today?' encourages patients and their families to discuss discharge plans with their clinicians.

About the Trust

Southern Health NHS Foundation Trust provides mental health, learning disability and community health services across Hampshire. Employing 6,000 staff and with funding of £309m, it is one of the larger providers of these types of services. It supports 280,000 individual patients each year, with over 1.5 million care contacts. Over 90% of people who rate their care with the trust say they would recommend it to their friends and family. The trust is rated as 'requires improvement' by the Care Quality Commission and its main challenge is staff recruitment and retention. The organisation has faced significant challenges in recent years and is working hard to make care better, more joined up, and to work more inclusively with patients, families and communities.

Southern Health
NHS Foundation Trust

13 November 2018

HOSP update on staffing issues within our Older People's Mental Health Services

I wrote to you back in October 2018 to make you aware of some challenges we have been experiencing in maintaining our staffing levels across our Older People's Mental Health services. We took the difficult decision to suspend admissions to Poppy Ward, based at Gosport War Memorial Hospital (GWMH) and Beaulieu Ward based at The Western, Southampton to ensure we maintained a safe level of care to our patients. We have now reviewed this and want to provide you with an update.

Poppy Ward, GWMH
I am pleased to say that after carrying out some focussed work on our rosters and ensuring shifts are requested in a more timely way for NHSP and agency we have managed to establish consistent and improved staffing levels on Poppy Ward. As a result of this piece of work we have now reopened the ward to admissions.

Beaulieu Ward, Western Community Hospital
Despite considerable efforts, we have been unable to recruit the registered nurses needed to ensure Beaulieu Ward is a safe place for our patients and staff. We are currently relying on a high number of bank and agency staff which is not sustainable.

As a result we have taken the difficult decision to temporarily close Beaulieu Ward, for up to six months (depending on our ability to recruit registered nurses). Patient safety and the health and wellbeing of our staff are always our priority and we feel there is no alternative option at this current time.

Staff on Beaulieu Ward
We have spoken to staff this morning to explain why we are closing the ward and to discuss with them the next steps to support them and the patients.. We hope to be able to use their skills across our other OPMH wards and they will be supported to find their best alternative place of work. They will also be offered the opportunity to undertake additional training and development and to help us reopen the ward as quickly as possible.

Patients on Beaulieu Ward
We will be talking to the seven patients and their families/carers later today to discuss the most appropriate options for meeting the patients' future care, which may include moving to a bed on an alternative ward, a care home placement or being cared for in the community in their own homes. We are working to safely discharge all patients by Friday 16 November. Patients are being reviewed to ensure that care plans and risk assessments are up to date and meet the needs of the patient.

The future
The decision to temporarily close Beaulieu Ward will provide us with the opportunity focus on alternative options for recruiting into the service. We are doing all we can to find a solution to our recruitment issues and a further recruitment plan for OPMH services is currently being devised.

We met with the Hampshire and Southampton Commissioners at the end of last week to discuss the proposal to temporarily close the ward but also the need to take this time to review our services to patients with Dementia and work with them to redesign services that are appropriate for the future across Southampton and Hampshire. Our plan is to reopen Beaulieu Ward as soon as we have the Registered Nurses in post to safely staff the ward.

We will be reviewing this decision on a monthly basis and will keep you fully informed of developments.

Trust Headquarters, Sterne 7, Sterne Road, Tatchbury Mount, Calmore, Southampton SO40 2RZ

Please find below an overview of the actions being taken. If you have any further questions, please feel free to contact Nicky Macdonald, Associate Director for Learning Disability and Older Persons Mental Health Services by e-mail Nicky.MacDonald@SouthernHealth.nhs.uk or by telephone on 023 80874681or Sarah Constantine, Associate Medical Director, by e-mail Sarah.Constantine@SouthernHealth.nhs.uk or by telephone 02380 874319.

Yours sincerely

Paula Hull
Director of Allied Health Professionals & Nursing

Actions being taken to ensure safe services across our Older People with Mental Health Services	
Patients	**Staff**
All staff across all seven of our OPMH wards are currently looking at managing care plans and are working closely with adult services at HCC and the CCG to identify which patients can be safely discharged. Options include: - Appropriate care homes - Moving forward on Delayed transfers of care (DTOC) - Discharge to community team - Possible Out of Area beds. We are working with patients and their families to keep people safe and expedite long term discharge plans with partners. Our Trust's Patient Experience Lead is enabling families to feedback their experience and our freedom of speak up guardian within the Trust has attended to provide opportunity for staff feedback.	Daily staffing calls are being held to help maintain safe staffing levels on the wards – these address staffing levels shift by shift and day by day. We are working with our Trust's Safer Staffing Lead to help maintain safe staffing levels and a good skill mix. The senior team have cleared diaries to ensure that they can focus on staffing issues and are visible on both the wards on a daily basis to support staff on the wards.
Our OPMH Bed Manager for the Trust is attending extraordinary meetings with HCC adult services and South East Clinical Commissioning Groups to try and see how they can provide additional support.	A new matron and Ward Manager have started with Beaulieu Ward over the last few weeks. They will be leading the review and the recruitment plan and will be looking at staff training and development.
There are currently 12 delayed transfers of care (DTOC) patients across the three organic wards two on Beaulieu, six on Poppy and four on Elmwood and the Trust continues to work with commissioners and adult services to address these difficult to place patients. We are maintaining a steady flow of patients with organic needs through Elmwood at Parklands (Our other Organic ward) – this means that we can admit any new OPMH patients with organic needs to Elmwood and Poppy if appropriate as opposed to Beaulieu Ward.	We are also working with system partners to ensure a joined up approach to resolve staffing challenges and ensure patients are able to receive the most appropriate care in the right setting as swiftly as possible, throughout this period.
We are liaising with the psychiatric liaison services in the acute hospitals to ensure that only patients appropriate to be nursed on these wards, are transferred.	The organisational development team are also working with the service to organise sessions with the staff to support the changes required.
A new model of Dementia care is currently being explored with Commissioners and the Trust have identified a number of key clinicians and managers to lead on this work.	

Response to supplementary questions from Southampton HOSP 27.11.18

The service provided at Beaulieu Ward, inc number of beds

Beaulieu Ward is, a 17 bed, acute admission (short stay) assessment and treatment ward, providing care for older people with organic mental health needs. In most cases this is dementia.

The reasons for closure

Despite considerable efforts, we have been unable to recruit the registered nurses needed to ensure Beaulieu Ward is a safe place for our patients and staff. We were relying on a high number of bank and agency staff which is not sustainable.

As a result we have taken the difficult decision to temporarily close Beaulieu Ward, for up to six months (depending on our ability to recruit registered nurses). Patient safety and the health and wellbeing of our staff are always our priority and we feel there is no alternative option at this current time.

The alternate OPMH wards (Dementia) in Hampshire (inc Solent NHS Trust Wards in Portsmouth)

Poppy ward, based at Gosport War Memorial Hospital
Elmwood ward, based at Parklands Hospital in Basingstoke

The number of Southampton residents in Beaulieu Ward at time of closure decision

Three patients were Southampton residents, who have since been transferred to care homes.

The proposed pathway for Southampton residents requiring OPMH services akin to those delivered at Beaulieu Ward, following closure

Each patient will be assessed based on their individual care need and the patients and their family members will be involved in this discussion. We will consider alternatives to admission including care home placement, and additional support in the community. For people who do require inpatient care, patients and families will be given the option of being transferred to Poppy ward based at Gosport Ward Memorial Hospital or Elmwood based, at Parklands in Basingstoke. We will speak with individual families to offer support to cover additional transport needs they may have in order to visit loved ones.

Support to be provided to family members

We recognise the impact that caring for a loved one with dementia can have on family members, and have apologised for the additional disruption that this change has caused. Our staff work closely with families and carers to provide advice,

guidance and awareness of additional support available to them, and this will not change during the closure period.

Support is being offered to cover additional transport needs families may have in order to visit loved ones during this period.

As soon as it became apparent that a temporary closure was the only option, we immediately began to have conversations with patients being supported on the ward and their families.

Staff met with patients and their families to discuss the most appropriate options for meeting the patients' future care needs. This included moving to a bed on an alternative ward, a care home placement or being cared for in the community in their own homes.

Proposals to increase the number of qualified nurses employed by Southern

Extensive recruitment activity is already taking place and ongoing. This includes recruitment campaigns, open days, links with universities, and social media recruitment. Specific recruitment activity is also taking place for older peoples mental health nurses: A recruitment action plan is in place to help us recruit more registered nurses and health care professionals into this particular service.

We are working to develop new career pathways and roles, and a new care model for older people's mental health. This aims to deliver more effective care and make working in this service a more attractive proposition for clinicians.

During the period of closure, staff redeployed from Beaulieu Ward are being supported to remain as a 'virtual team' – with ongoing supervision and development. It is hoped they will gain new skills and experience from working in different settings and this will benefit patients when they return to Beaulieu Ward.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:		HAMPSHIRE AND ISLE OF WIGHT SYSTEM REFORM PROPOSAL
DATE OF DECISION:		6 DECEMBER 2018
REPORT OF:		HAMPSHIRE AND ISLE OF WIGHT SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP SENIOR RESPONSIBLE OFFICER
CONTACT DETAILS		
AUTHOR:	**Name:**	**Richard Samuel**
	E-mail:	**SEHCCG.HIOW-STP@nhs.net**
STATEMENT OF CONFIDENTIALITY		
None		

BRIEF SUMMARY

The Hampshire and the Isle of Wight (HIOW) health and care system has identified the need to achieve more and in a faster time for citizens to improve both the quality and efficiency of the system. As such, partner organisations have worked together to develop a proposal which sets out a potential change to the way in which the system works.

The proposal, attached, has been received at Governing Bodies and Boards across the HIOW health and care system and describes the component parts of a reformed system and their function.

RECOMMENDATIONS:		
	(i)	That the Panel notes and considers the proposal, attached as Appendix 1, and the process by which it has been developed.

REASONS FOR REPORT RECOMMENDATIONS	
1.	To enable the Panel to discuss the proposal to reform the Hampshire and Isle of Wight health and care system.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	Not applicable
DETAIL (Including consultation carried out)	
3.	Over the last two years the Southampton Health Overview and Scrutiny Panel (HOSP) has considered the delivery plan for the Hampshire and the Isle of Wight (HIOW) Sustainability and Transformation Partnership (STP) and a progress update.
4.	The Panel agreed to review and monitor the development of the Partnership on a regular basis. Attached as Appendix 1 is a proposal from the HIOW STP detailing the proposed changes to the system.
RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	N/A

Property/Other		
6.	N/A	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
7.	N/A	
Other Legal Implications:		
RISK MANAGEMENT IMPLICATIONS		
8.	N/A	
POLICY FRAMEWORK IMPLICATIONS		
9.	N/A	
KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Hampshire and Isle of Wight Sustainability and Transformation Partnership system reform proposal	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?	No	
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) 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	

NHS
Hampshire and Isle of Wight
Sustainability and Transformation Partnership

Hampshire and Isle of Wight System reform proposal

Statutory body pack

August 2018

MOVING FORWARD TOGETHER

Contents

Introduction and context

Purpose of this document

This document summarises the system reform proposal as developed to date through the work of the Hampshire and Isle of Wight Sustainability and Transformation Partnership's (STP) Executive Delivery Group (EDG) and informed by the broader health and care system leadership.

It forms the basis for NHS provider board, CCG governing body and local government cabinet consideration at their respective meetings in autumn 2018.

Context

The health and care system across Hampshire and the Isle of Wight has been working together to develop a response to the national ambition to improve the integration of health and care for the benefit of local people.

As the Care Quality Commission put it in its 2016/17 State of Care report:

"People should be able to expect good, safe care when they need it, regardless of how this care is delivered... It's clear that where care providers, professionals and local stakeholders have been able to do this – where they have stopped thinking in terms of 'health care' and 'social care' (or specialties within these) and instead focused their combined efforts around the needs of people – there is improvement in the quality of care that people receive. To deliver good, safe care that is sustainable into the future, providers will have to think beyond their traditional boundaries to reflect the experience of the people they support."

National context

The most recent mandate given by the Government to NHS England includes increasing integration with social care so that care is more joined up to meet physical health, mental health and social care needs. More recently, the House of Commons Health and Social Care Committee has expressed its support for improving integration of care, highlighting its potential to improve patient experience.

NHS England's policy goals in relation to this area have been clear for some time. NHS England's ambition to transform the delivery of care in this spirit was first described in 2014's Five Year Forward View (FYFV):

"The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three"

Case for change

What do our citizens and our staff tell us?

Our citizens have been consistent in telling us that…

- they want **better and more convenient access** to support to help them to live well for longer. We have diverse communities across Hampshire and the Isle of Wight and people want support better suited to their needs;
- **they value and have confidence in General Practice and the wider primary and community team,** but there is a bewildering array of teams who do not appear to communicate with each other. **People often have to repeat their story** multiple times, making accessing care a frustrating experience. So they want all of the clinicians and care workers involved in their care to know their care plan, to work together and to communicate with one another. Many people also want greater control of their care, from better access to their records through to personalised budgets;
- when they have an urgent care need, **rapid access to the right clinical advice and support** is the most important factor to them. They want the health and care system to make sure they know how to rapidly access a complicated and sometimes confusing system;
- when they are managing a long term physical and/or mental health condition they typically want continuity of relationship with a trusted clinician to support them; they want better support to understand and manage their condition; and they want to ensure that when they travel for specialist advice and support, then the journey is worthwhile. Currently **40% of people** whom have a long term condition tell us they **don't feel supported** to manage their condition.
- they are more **willing to travel a little further for specialist care** if the services they access will give them better outcomes. People also add however, that there is nowhere like home and that they would rather be there, than a hospital bed. Unfortunately a quarter of people in hospital still do not feel involved in decisions about getting them home.

Our workforce are telling us that:

- they are **under more pressure than ever** before. They often feel that there is not enough time in the day, with too many targets to reach and administrative tasks to perform, both of which take time away from patients;
- services are running on such **low staff numbers** that any unplanned sick leave or annual leave has a significant effect. Despite significant efforts of some providers, we continue to exceed our planned expenditure on agency and locum spend;
- care professionals want a means by which to **share information** with other professionals within the system. There is often a poor interface between primary, secondary and community care with time wasted trying to contact other care services;
- whilst it doesn't feel this way in general practice, and in the community and hospital services, our workforce has actually increased over the last few years. However so too has the number of people leaving within two years;
- many frontline staff have spent large parts of their professional careers **trying to integrate care for patients,** often working around policies that construct rather than remove barriers to integrated care at local level;
- they want **better career options** along with opportunities to improve their skills and expertise.

What does the data tell us?

We need to strengthen our approach to prevention, early intervention and supported self-management…

- We have a national reputation for developing innovative models of prevention, case finding and early intervention and supported self-management. However, we have not systematically implemented these innovative models. For example, within three years, 330 heart attacks and 490 strokes could be averted with improved detection and treatment of hypertension and atrial fibrillation. This represents a cost saving of up to £2.5m for heart attacks and £6.7m for strokes through optimal anti-hypertensive treatment of diagnosed hypertensives.
- For cancer services, for example, we have made real progress in improving the early diagnosis of cancers over the past 4 years, and are now are one of the best performing systems in the country. But we still only **diagnose just over half of cancers at stage 1 and 2**.
- The **life expectancy of people with serious mental illness is 15-20 years less** than the average life expectancy in Hampshire and the Isle of Wight, with two thirds of these deaths due to avoidable causes. And yet the number of health checks for people with severe mental illness in HIOW is below the national average.
- We are making improvements, but we are **not yet closing the inequalities gap -** the life expectancy gap (and disability-free years gap) across HIOW is not closing.

The complexity and fragmentation of our current system (including siloed budgets and payment systems) is currently holding back a system focus on this agenda.

We have a significant opportunity to improve discharge and flow across Hampshire and the Isle of Wight…

- Our citizens continue to **stay in hospital for a long time** even though many are medically fit to leave. As we know the longer people stay in hospital, the more likely they are to develop complications and reduced independence; and it is also expensive to keep someone in hospital unnecessarily.
- Our flow and discharge is noted as being in the **lowest performance quartile in the country**
- We continue to be the **second poorest performing system in the country** with regards to **delayed transfers of care**.
- **We are the second poorest performer** nationally with regards to **CHC assessments in the community**.
- Recent data positions us as having one of the greatest opportunities nationally to reduce **excess bed days** and super-stranded patients.
- There has been a relentless focus on improving discharge and flow across all of our systems and yet despite this the number of delayed transfers of care per 100,000 population remains at the same rate it did two years ago*

This data would indicate that continuing to operate as we have done in the past will not yield a different outcome. We need to reform the system in a way that best allows us to tackle the challenges we face.

* with the exception of the Isle of Wight which now operates with three times fewer delays as other HIOW systems.

What do we know about new models of care?

The past four years have seen significant progress in developing 'new care models' which are founded on integration between partners and a systematic focus on the whole population's needs. Nationally we have seen both Multispecialty Community Provider and the Integrated Primary and Acute Care Systems develop. More recently the Next Steps on the Five Year Forward View further articulated the ambition ***'to make the biggest national move to integrated care of any major western country'.***

Within our patch we are reporting very tangible benefits for our citizens as a result of health and care partners working together / integrating more effectively than we have seen before. In the most developed systems we are seeing:

- **1% reduced emergency admissions** compared to an average of 3.5% growth nationally;
- New models of care are successfully managing and treating people more effectively in the community **reducing potentially "avoidable" emergency admissions by 10%** on last year;
- **4% reduction in GP referrals** on last year;
- **Reduction in the number of people experiencing mental health crisis** / emergency admission to acute mental health beds as a result of enhanced support in the community
- **A&E attendances are holding at the same level** as last year compared to demographically similar systems which have increased activity on last year;
- Citizens engaging with integrated care teams are reporting **significant improvements in health status, personal wellbeing, experience and health confidence;**
- **Staff satisfaction rates significantly improving** where they are operating in integrated care teams.

These achievements are both important for citizens, staff and for the financial health of the system. We know that new models of care work, however, our integrated primary and community teams are at different stages of development and so too are their interfaces with local health and wellbeing footprints and the acute physical and mental health system.

Finance and efficiency

Increasing value for money

The current funding and budget systems make it hard to reallocate resources to where they are needed most. This can also be prohibitive to collaborative working between partner organisations. Frustratingly for all, the current payment systems can be unhelpful – rewarding activity rather than outcomes.

Our financial position is unsustainable. Hampshire and Isle of Wight NHS has forecast a 'do nothing' gap of £577million gap by 2020/21 (23% of our £2.5bn allocation) and in addition to this, the pressures in social care and local government more broadly are unprecedented. Whilst the required level of efficiency has been delivered to date we require a step change in productivity and cost reduction to ensure we meet our financial targets.

In many organisations too much resource and energy is focused on seeking to suppress expenditure in providers or generate additional income from commissioners, rather than work in partnership to focus on cost reduction, quality improvement and living within the system's finite resources. **We will require different approaches**, including **collaboration**, e.g. pathology, pharmacy distribution centres; scale, eg: collective procurement; **back-office optimisation**, eg: HR, finance; **greater partnerships**, eg: increasing retention of our workforce, reducing bank and agency costs; and **reduced unwarranted variation** in practice.

If we are to make the transformational changes required to improve outcomes, experience, satisfaction, quality, performance, financial sustainability and address our workforce challenges **we must radically enhance our functionality, removing obstacles to enable far greater collaboration and integration**. These radical changes will become a reality only if there is a collective commitment from all partners to transform and implement a new way of working.

Reducing complexity

- We have **21 NHS and local authority statutory partners** as signatories to our transformation partnership **and three non-statutory partners** (with leadership responsibilities around workforce, innovation and research).
- We have **grown our workforce by 4.5%** over the past three years. Too much of this growth has, however, been in non-clinical roles. One of the key drivers for this is the continuing burden of reporting, assurance and inter-organisational contract management.
- **We are a complex system.** Whilst there has been collaboration between provider, commissioner and regulatory partners, our system reform work over the past six months has demonstrated significantly greater opportunity to reduce system complexity; reduce the burden of assurance and reporting and ensure all partners collaborate towards clearer strategic goals;
- NHS England and NHS Improvement are currently undergoing a national and regional integration programme. The expectation is that locally the Hampshire and Isle of Wight system will develop **simpler but more effective self-regulation and assurance models** that will allow NHSE/I to work more strategically with the system.

The system reform programme is a means by which we can reduce this complexity and develop strong self-regulation and assurance models.

The proposed system

Our vision

"Our vision is to support citizens to lead healthier lives, by promoting wellbeing in addition to treating illness, and supporting people to take responsibility for their own health and care. We will ensure that our citizens have access to high quality consistent care 24/7, as close to home as possible.

Our vision – tomorrow's system

We are taking action to prevent ill-health and promote self care...

- Empowering citizens, patients, service users and communities
- Harnessing technology more effectively to support wellbeing

We are strengthening local primary and community care...

- Developing integrated health and social care teams designed to support the needs of the local communities they serve
- Ensuring a strong and appropriately resourced primary care workforce
- Providing care in the right place at the right time by reducing over-reliance on hospitals and care homes
- Using technology to revolutionise people's experiences and outcomes;

We are improving services for people who need specialist care...

- Identifying, understanding and reducing unwarranted variation in outcomes, clinical quality, efficiency;
- Through consolidating more specialised care on fewer sites;

We will make intelligent use of data and information to empower citizens, patients, service users and support our workforce to be more efficient and effective in delivering high-quality care

Integrated care systems

The HIOW Executive Delivery Group (EDG) – representing the HIOW health and care system – recommend that to deliver our vision for health and care, we need to reform our system to ensure 'form follows function', signalling a shift from the separation of provision and commissioning to integrated planning and delivery. Nationally there is a similar realisation, which has led to the national guidance on Integrated Care Systems.

What is an integrated care system (ICS)?

NHS England defines ICS as those systems in which:

"Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations".

What will an integrated care system do?

National guidance sets a number of expectations for ICS:

- ICS are expected to produce together a credible plan that delivers a single system control total, resolving any disputes themselves.
- ICS will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.
- [ICS] will be given the flexibility, on a net neutral basis, and in agreement with NHS regulators, to vary individual control totals during the planning process and agree in-year offsets in one organisation against financial under-performance in another.
- NHS England (NHSE) and NHS Improvement (NHSI) will focus on the assurance of system plans for ICS rather than organisation-level plans.

There is an expectation that, over time, ICSs will replace STPs.

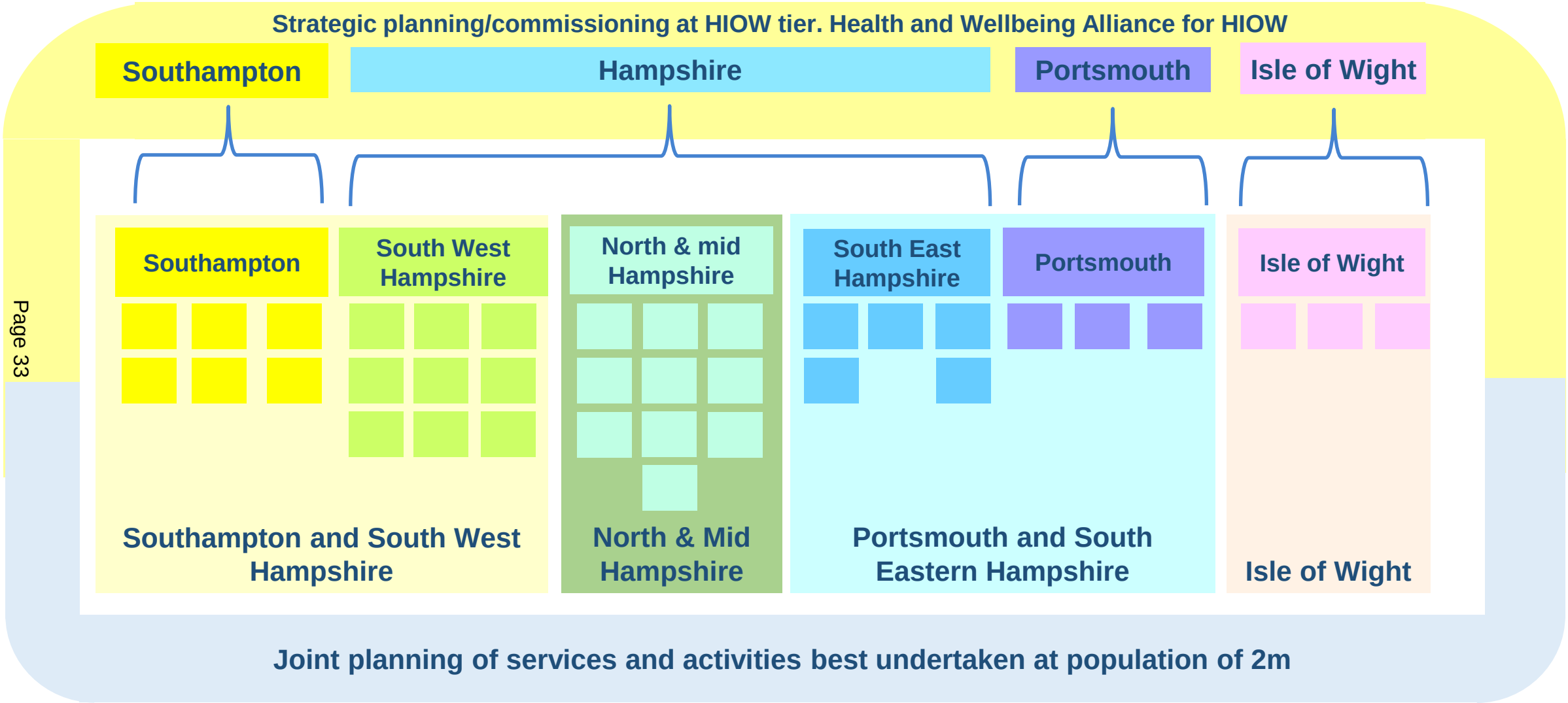
Benefits of ICS – the national view

- Creating more robust cross-organisational arrangements to tackle the systemic challenges facing the health and care;
- Supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- Delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- Allowing systems to take collective responsibility for financial and operational performance and health outcomes.

Local alignment

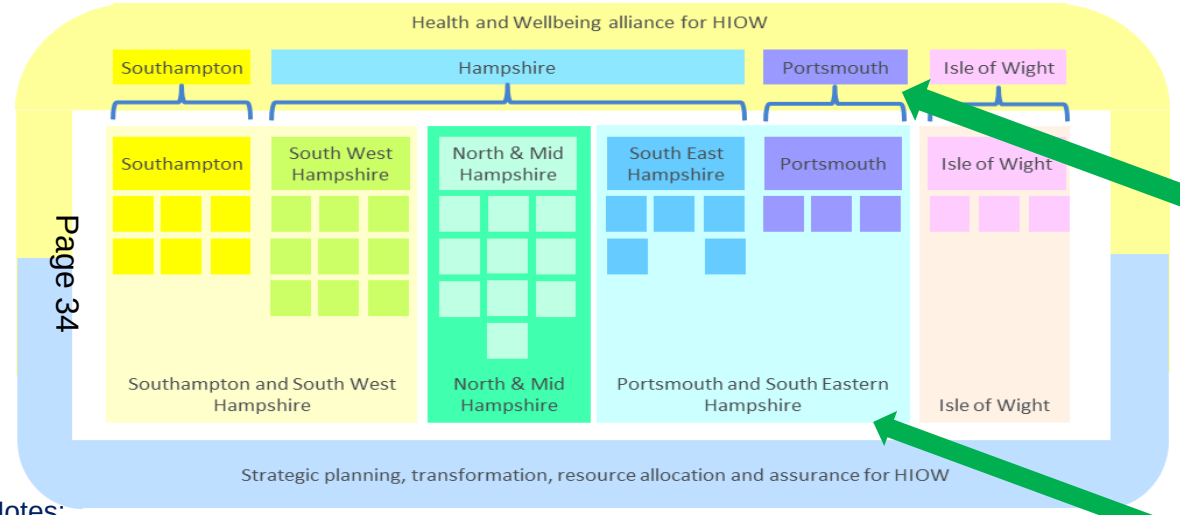
The EDG tasked a sub-set of its members, supported by others, to form a series of task and finish groups to develop the key elements of a proposal for moving the HIOW system towards ICS ("the system reform programme").

How could HIOW look in the future?



The proposed HIOW integrated care system:
A whole system planning, delivering and transforming in collaboration

The proposed reformed system envisages providers, commissioners and local authorities working in ever closer collaboration with each other and with citizens and voluntary sector organisations to address the case for change, empowering and supporting citizens to best manage their own health and wellbeing and frontline teams to provide and sustain the best possible services and care.



Component	Purpose and description
Accelerated implementation of 36 clusters Natural communities of 20-100,000 people	• The foundations of the reformed system • Strengthening primary care • Delivering integrated mental and physical health, care and wider services to cluster population • 36 clusters, aligned to 'natural communities'. • Proactively managing the population health needs
Ongoing development of place based planning Existing Health & Wellbeing Board footprints	• Integrated local authority & NHS planning • Aligned to HWB (local authority) footprints • Health & LA aligned commissioning resource & agreed leadership/management models • Basis of the JSNA, means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health
Simplified structure of 4 integrated care partnerships populations of c600k served by acute partners	• Support the vertical alignment of care enabling the optimisation of acute physical & mental health services • Design and implement optimal care pathways • Support improved operational, quality and financial delivery
HIOW integrated care system Drawing together the above component parts, delivering some functions at a scale of 2 million population	• System strategy and planning • Implementing strategic change across multiple integrated care partnership footprints/places • Alignment of strategic health and LA commissioning • Provider alliances (acute physical & mental health) • Oversight of performance and single system interface with regulators

Notes:

1. The term 'cluster' is used for consistency to describe the foundation of the system where general practices with statutory and voluntary community health and care services work together in 20-100k populations to meet the needs of local residents. A variety of terms are currently used to describe this including localities, extended primary care teams, natural communities of care, neighbourhood teams.
2. Where HWB and integrated care partnerships are coterminous, activities are undertaken together. In areas where integrated care partnerships span more than one HWB footprint, the partners will work together to determine the most appropriate allocation of responsibilities between HWB area and the integrated care partnership to achieve the shared objectives.
3. The Hampshire HWB area also includes North East Hampshire, which is also part of the Frimley Integrated Care System and therefore omitted from the figure above

Conditions for integration

The development of an ICS for Hampshire and Isle of Wight has been based upon a variety of national guidance and evidence from around the country about best practice approaches. We have studied the work ongoing in Surrey Heartlands Dorset, Manchester and South Yorkshire and Bassetlaw and learnt from their experiences.

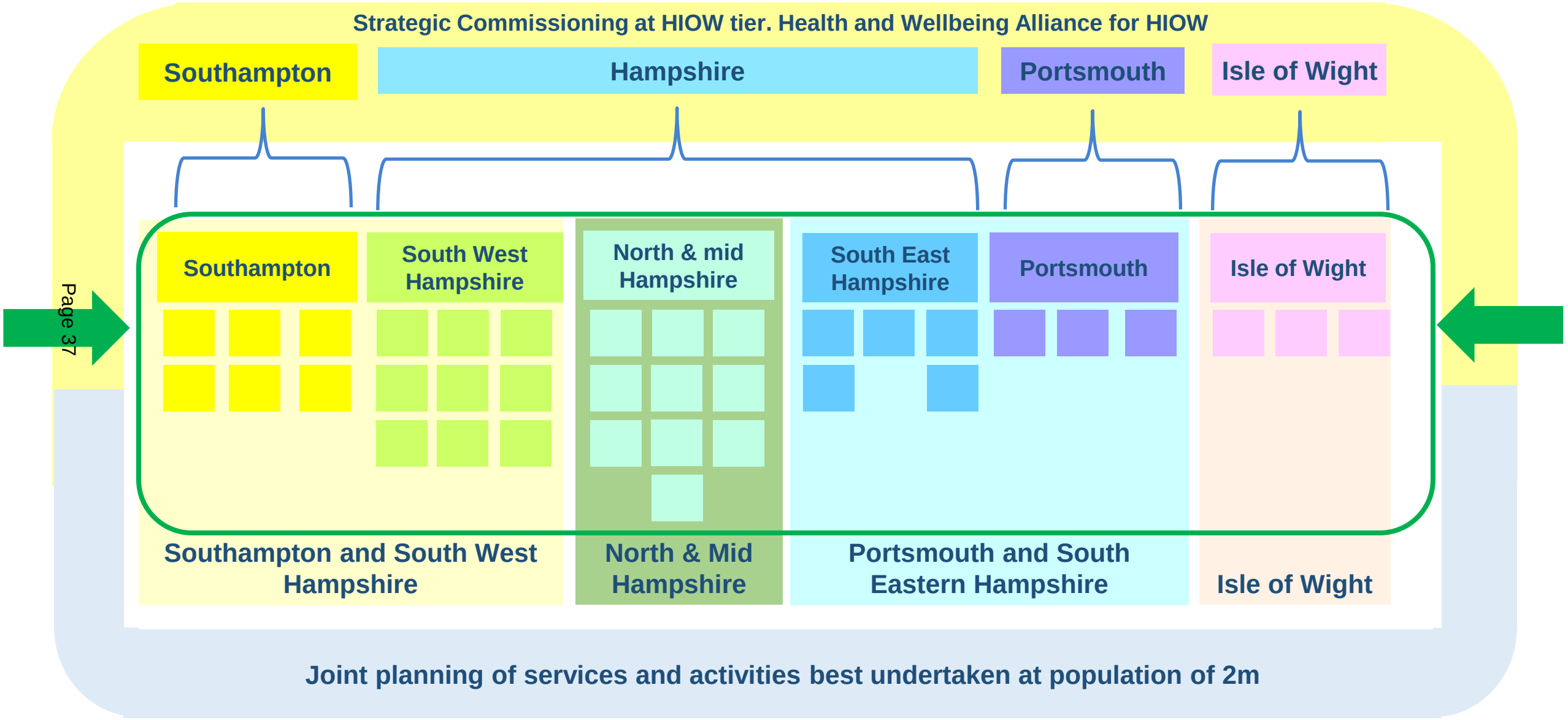
The work of the Kings Fund on integration is also helpful in setting out conditions which support greater integration. Their assessment is that current and future ICS must address the following development needs if they are to succeed in transforming health and care, building on new care models and related initiatives:

- Developing trust and relationships among and between leadership teams
- Establishing governance arrangement to support system working
- Committing to a shared vision and plans for implementing the vision
- Identifying people with the right skills and experience to do the work
- Communicating and engaging with partner organisations, staff and the public
- Aligning commissioning behind the plans of the system
- Working towards single regulatory oversight
- Planning for a system control total and financial risk sharing.

The work involved in addressing these needs is time consuming and cannot be rushed: ‘progress occurs at the speed of trust’, **collaborative rather than heroic leadership holds the key to progress.**

Components of the system

Clusters - integrated primary and community care teams



Clusters - integrated primary and community care teams

Clusters will be the bedrock of the reformed delivery system. The key purpose of our wider system reform arrangements is to support empowered clusters.

Role and benefits of clusters:

- Clusters will see health and care professionals, GPs, the voluntary sector and the community working as one team to support the health and care needs of their local community. They will focus on helping people to manage long term conditions and improve access to information about healthier lifestyles and improving/maintaining wellbeing.

- Evidence shows that the most successful work of this type will reduce the overall number of people who need to be cared for in hospital and improve the health and wellbeing of communities. Clusters will shift the pattern of care and services to be more preventative, proactive and local for people of all ages

Impact of clusters for people

- ✓ People are supported to stay well and take greater responsibility for their own health and wellbeing
- ✓ People can easily access support and advice that is timely, delivered close to home and with the right professional to meet their needs
- ✓ People with chronic or complex illness receive care that is consistent, joined up and centred around their needs and wishes, with fewer hand-offs and reduced duplication
- ✓ People are only in hospital for the acute phase of their illness and injury and are supported to regain/retain independence in their usual place of residence
- ✓ People have greater choice and control over decisions that affect their own health and wellbeing

Impact of clusters for HIOW system

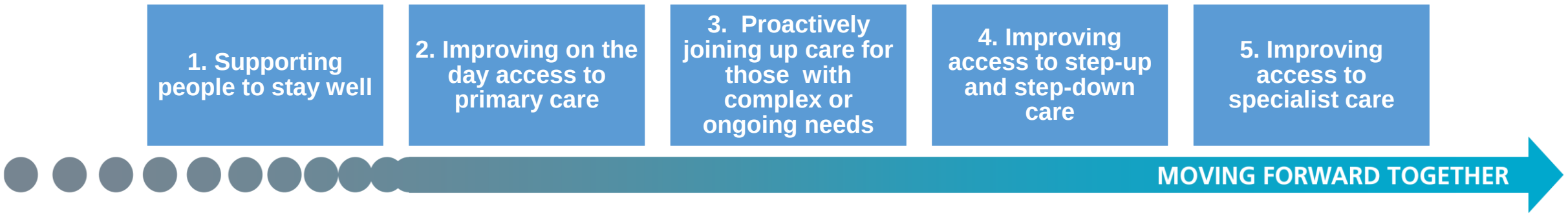
- ✓ Increased capacity in primary and community care to manage local health and care needs
- ✓ Reduction in rate of acute mental and physical acute non-elective activity growth and demand for urgent care services
- ✓ Optimised resource utilisation as a result of better managed chronic conditions and reduction in preventable conditions
- ✓ Reduction in variation in access and outcomes
- ✓ Fewer permanent admissions to residential and nursing care
- ✓ Primary care is sustainable and supported leading to improving GP recruitment and retention rates
- ✓ Attract and retain right workforce in all sectors with particular emphasis on those sectors in greater need such as mental health
- ✓ More efficient bed use and fewer delayed transfers of care

Characteristics of clusters

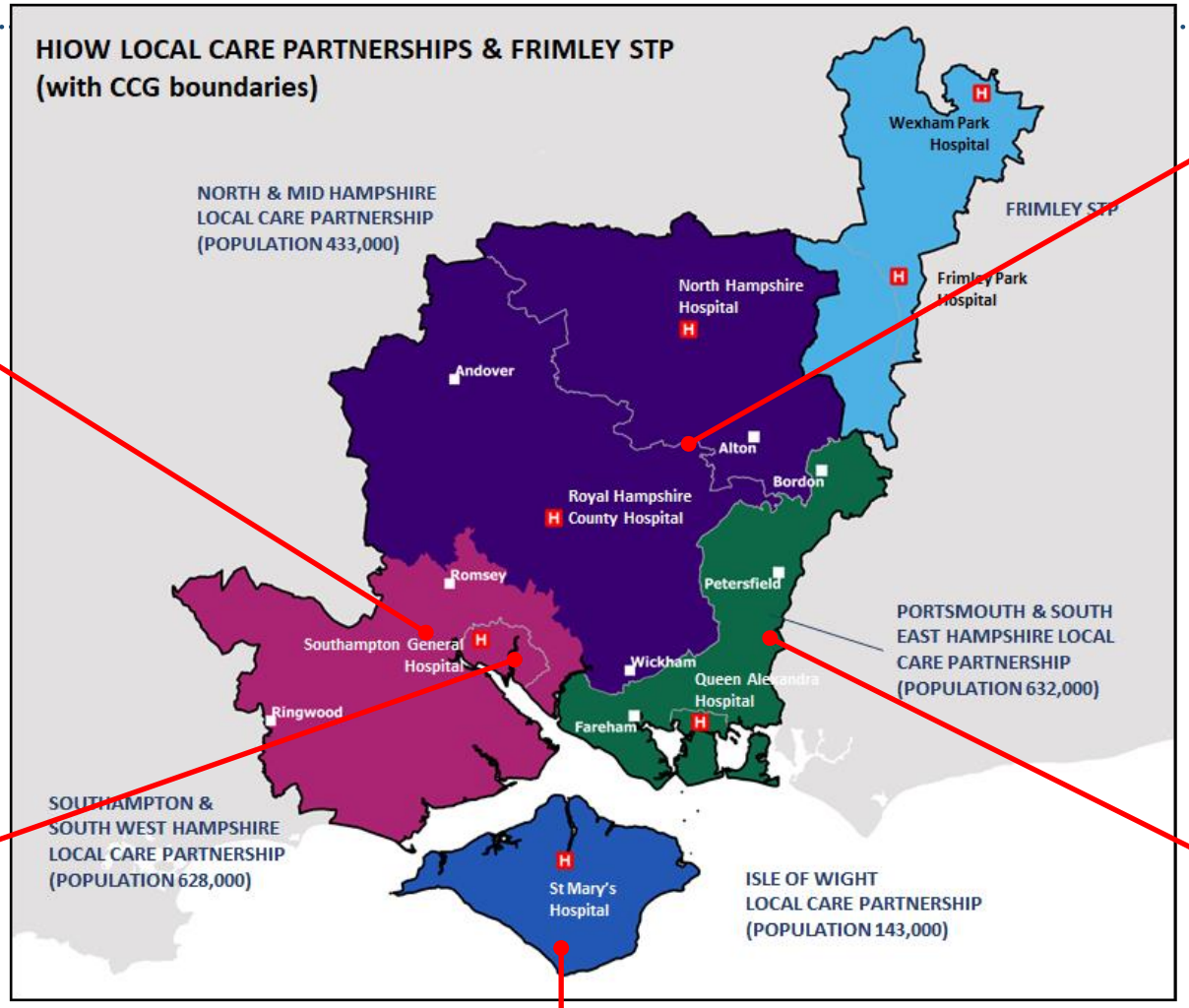
Clusters will vary based on the needs of the communities they serve, but will be built on a common foundation and share common characteristics:

- Clusters will be empowered to innovate in order to best serve their populations. In order to facilitate this, they will work to a specification which is outcome-based, but which is common across HIOW. Developing this specification will be an early priority.
- Cluster footprints align to 'natural communities of care.' Areas must be meaningful to those they serve, as they provide the basis for community-focussed services. Clusters' population range provides flexibility in cluster boundaries to ensure they align with both natural communities and GP registered lists.
- Clusters will include a range of mental and physical health, care and wider services in one place. Multi-professional working will be supported by multi-agency information sharing and, wherever possible, physical co-location.
- Co-ordinate services and teams from across organisations through alignment arrangements (MOU, alliance contract or joint venture) – allowing professionals to maintain their current employment status.
- Multi-professional (including clinical) leadership. Each cluster will have a named lead, and will be supported by a professional managerial team, who will be responsible and accountable for the performance of cluster services and the management of an indicative cluster budget. Clusters will manage their performance based on agreed datasets.
- GP federations will be vital in facilitating clinical leadership in clusters, as well as in leading the transformation of primary care, which will be vital to clusters' capability.
- Clusters will identify, understand and reduce unwarranted variation between their practices. Colleagues and systems across the footprint of HWB and integrated care partnerships will support clusters in this, as well as identifying unwarranted variation between clusters (see below).
- Clusters and acute physical and mental health providers will work together in integrated care partnerships, to ensure alignment of pathways and integrate services to optimise the health and care support they provide, responsive to the populations they serve.

The 5 core functions of a cluster:



36 clusters across HIOW (as at August 2018)



South West Hampshire

1. Eastleigh
2. Eastleigh Southern Parishes
3. Chandler's Ford
4. North Baddesley
5. Avon Valley
6. New Milton
7. Lymington
8. Totton
9. Waterside

Southampton

1. Cluster 1
2. Cluster 2
3. Cluster 3
4. Cluster 4
5. Cluster 5
6. Cluster 6

North and Mid Hampshire 20

1. Mosaic
2. Whitewater Loddon
3. Acorn
4. A31
5. Rural West
6. Andover
7. Winchester City
8. Winchester Rural North
9. Winchester Rural East
10. Winchester Rural South

Portsmouth and South East Hampshire

1. East Hampshire
2. Waterlooville
3. Havant
4. Fareham
5. Gosport

1. Portsmouth North
2. Portsmouth Central
3. Portsmouth South

Isle of Wight

1. North and East
2. West and Central
3. South Wight

Balancing autonomy and standardisation in clusters

A key test of this proposal overall is that cluster governance must accelerate and facilitate, rather than impede, local change and improvement. Therefore clusters will be encouraged to innovate and improve services for their citizens.

This innovation will be facilitated by both their contract /incentive structure and support from HWB and integrated care partnerships (see next slides).

HWB and partnerships will support clusters in identifying and reducing unwarranted variation, including striking the right balance between standardisation / consistency and local flexibility (ie. standardising only where this adds value).

Standardisation may apply across a HWB or partnership footprint, or more widely, as appropriate. We would expect some pathways, services, systems and processes to be standardised across HWB or partnership footprints, some to be standardised across the whole of HIOW. Elements not standardised will allow each cluster to take the approach which works best for them, but with encouragement and support to consider what other clusters are doing and the potential to spread best practice where it adds value (or reduces duplication of effort) to do so.

As part of this freedom to innovate, we recognise that clusters will continue to evolve. The current structure of clusters across HIOW (see next slide) may therefore change as clusters become established and take on an increasing role in service delivery.

Operationalising clusters is a key priority. This will include developing an outcomes-based cluster specification and providing management and development resources to clusters from CCGs

Accelerating the implementation of clusters

Every part of the HIOW system has confirmed the development of integrated cluster teams as a key priority for 2018/19, and every area has a change programme in place to deliver this.

- The 36 cluster teams across HIOW are at variable stages of development and maturity.
- The most established teams, formed under Better Care and Vanguard programmes, offer a wealth of evidence and learning about what works; however we are yet to effectively capitalise on this across HIOW.
- There are currently different names for cluster teams in each care system, reflective of evolutionary local plans.
- However, there are high levels of congruence in the overall description of the function and form of these teams across the system.

Therefore, the ambition for cluster development for 2018/19 is to:

- Accelerate and embed the infrastructure for all 36 cluster teams by March 2019
- Evidence impact on patient outcomes, primary care capacity, hospital admissions and system flow

Current thinking about the development of the clusters by March 2019 and March 2020 is described on the following page.

The developing role of clusters

	October 2018 – March 2019	By April 2020
Strategy and Planning	• Cluster priorities identified and delivery plan in place • Cluster level population data available and used to support priority setting and planning	• Longer-term cluster objectives being shaped, informed by data • Mechanism in place for co-production of plans and services with local people
Care Redesign	• Practices working together to improve access and resilience • Core cluster team membership defined • Integrated primary and community care teams in place with joint assessment and planning processes • Prototypes in place for highest risk groups • Gap analysis undertaken, end state defined for key functions	• Components of delivery model in place for each of key functions (minimum 50% completion) • Active signposting to community assets in place • Shift of specialist resources into cluster teams • Integrated teams fully functioning and include social care
Workforce development	• Cluster workforce plan defined with targeted action to support recruitment/retention of key roles • Cluster level OD/team development plan in place	• Development of new/extended roles in cluster teams to meet local need • Beginning to share workforce and skills within clusters
Accountability & performance management	• Information sharing agreements in place between all partners • Plan for shared care record confirmed • Cluster responsibilities documented via MOU/alliance agreement	• Data used to drive improvement and reduction in variation within and between clusters • Shared care record (health) in place • Cluster monitoring impact on key outcomes
Managing collective resources	• Cluster assets mapped to inform future planning (estate, back office, people, funding) • Resources identified to enable/support cluster plan delivery (eg change management) • Cluster level dashboard including outcomes in place	• Shift of specialist resources into cluster teams • Clusters have sight of resource use and can pilot new incentive schemes • Cluster level plan to optimise use of assets and early components in place
Leadership & governance	• Dedicated professional and operational leadership in place in each cluster • Governance arrangements in place in each cluster, eg cluster board • Cluster partners identified and engaged in the development and delivery of the cluster plan • Cluster engaged in integrated care partnership decision making	• Cluster leadership embedded with defined responsibilities for co-ordination of cluster responsibilities • Mechanism in place to share learning between clusters • Practices have defined how they wish to work together going forward • Cluster is full decision making member of integrated care partnership

Statutory bodies are asked to:

Endorse:

1. **The developing role of clusters as outlined on the previous slide**
2. **The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development**
3. **the proposed next steps for the cluster task and finish group which are summarised as follows:**

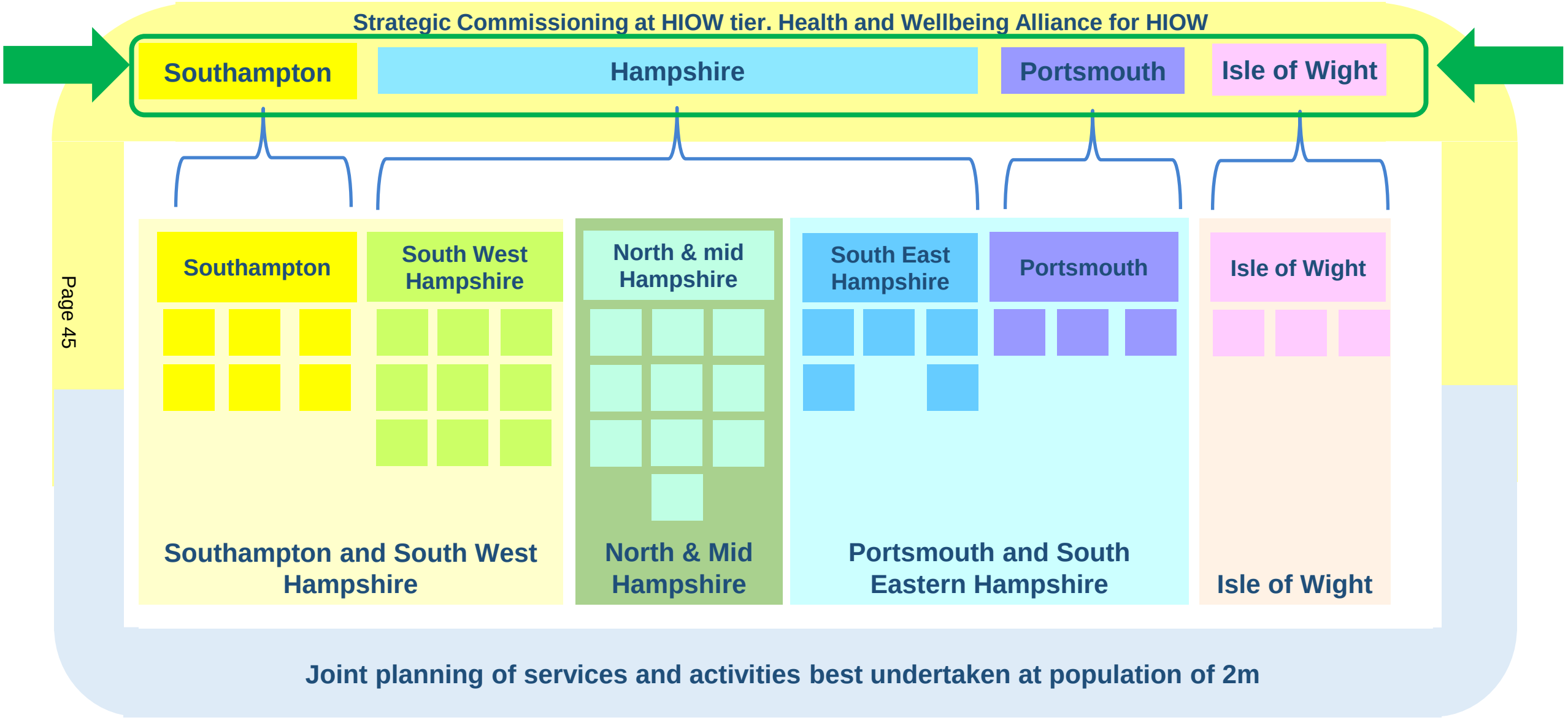
    a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW

    b. Describe the support requirements and responsibilities to accelerate full cluster implementation

    c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures

    d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

Integrated planning for a place: Health and Wellbeing Board footprints



Restating the function of Health and Wellbeing Board footprints within an integrated care system

Local government partners have convened to start work on restating the critical function of integrated health and care planning and delivery on a Health & Wellbeing Board (HWB) footprint.

An early draft definition of the function is summarised below:

HWB footprints will continue to be **the focus for place-based planning** (undertaking population needs assessment) and for aligning health, care and other sector resources to focus on delivering the improved outcomes for local people, building on the long-established integrated working arrangements, e.g. Better Care Fund, Section 75 arrangements, etc. Working in collaboration, partners will maximise the potential to further improve wellbeing, independence and social connectivity through the wider determinants of health including public health, housing, employment, leisure and environment.

The statutory role of the HWB with their political and clinical leadership, means that they should be central to the governance of health and care planning for a 'place'. The sustainability of the health and care system depends on public and political acceptability and support – as well as the right systems of design and delivery. So the active and effective democratic engagement at all levels (cluster through to whole HIOW) is vital. Strong and equitable relationships between NHS and local government will provide the necessary collective energy and focus required for system change. Furthermore, cross sectoral partnerships of public, private and voluntary and community organisations have important roles in all components of the system.

Much of our prevention and health improvement activities will continue to be designed and delivered in HWB footprints. We will use our ability to align / pool monies between NHS and local government partners to ensure that a clear focus for each HWB footprint is the resourcing of our 36 clusters (integrated primary and community care teams).

Our HWBs are based on local authority footprints. We will continue to integrate our CCG and LA teams focused on place-based health and care planning on these HWB footprints, reducing complexity and duplication. We will also be deploying some of our health (CCG) and care staff directly to support the operationalisation of our 36 clusters.

All four LAs have committed to meet with health provider and commissioner colleagues during August/September as a task and finish group to further develop the above definition and proposed next steps (see more detailed recommendation on the next page).

Statutory bodies are asked to:

Endorse the following recommendations from the EDG, informed by the task and finish group work to date:

1. **The emerging ‘restatement’ of the function of partnership working on a HWB footprint as described on the previous slide**

2. **The proposed next steps for a task and finish group by the end of September, which are to:**

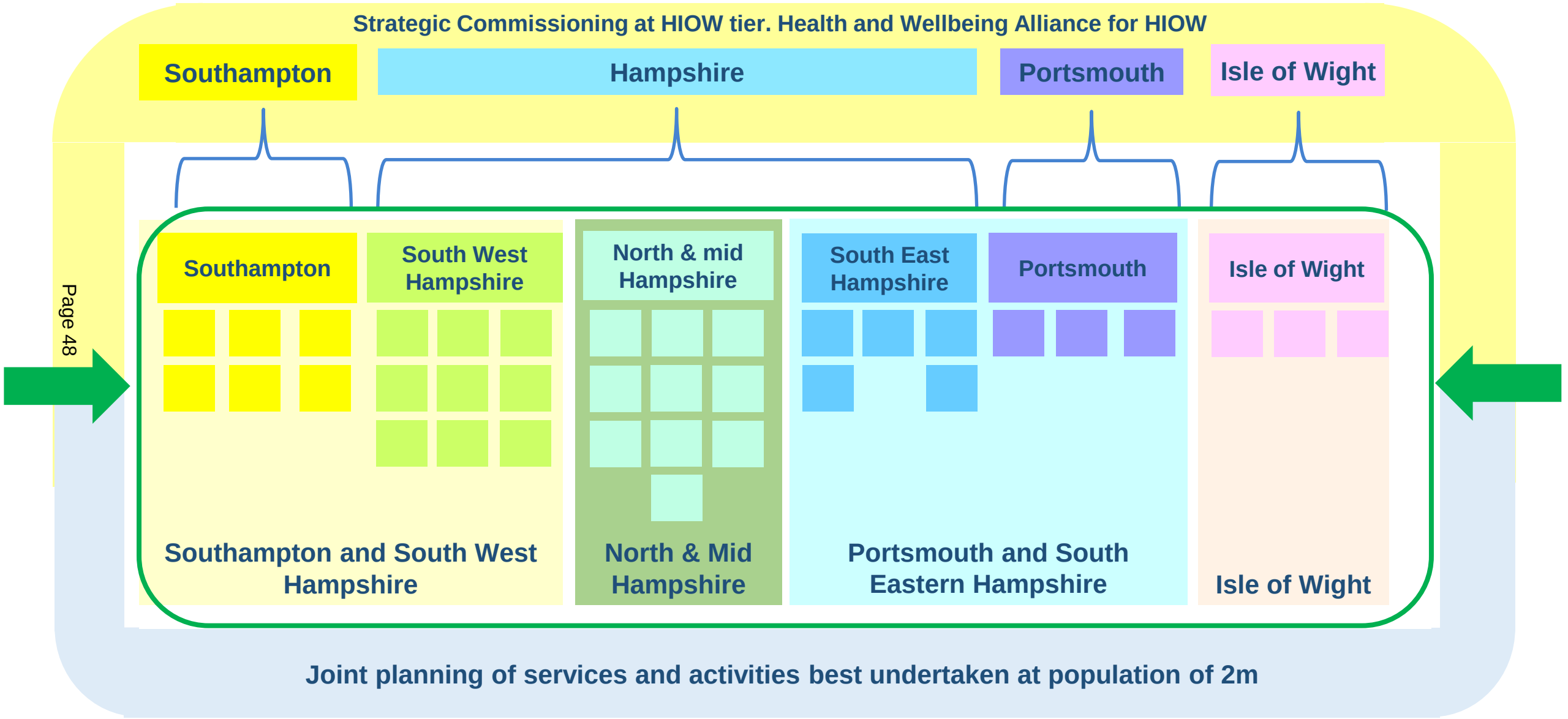
a. define the common functions of the role of HWB footprints in an integrated care system

b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system

c. set out a mechanism for achieving ‘active and effective democratic engagement at all levels’ across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

Leads from the other Hampshire and Isle of Wight task and finish groups on integrated care partnerships, strategic commissioning and clusters will be involved in developing this thinking.

Integrated care partnerships



Integrated care partnerships

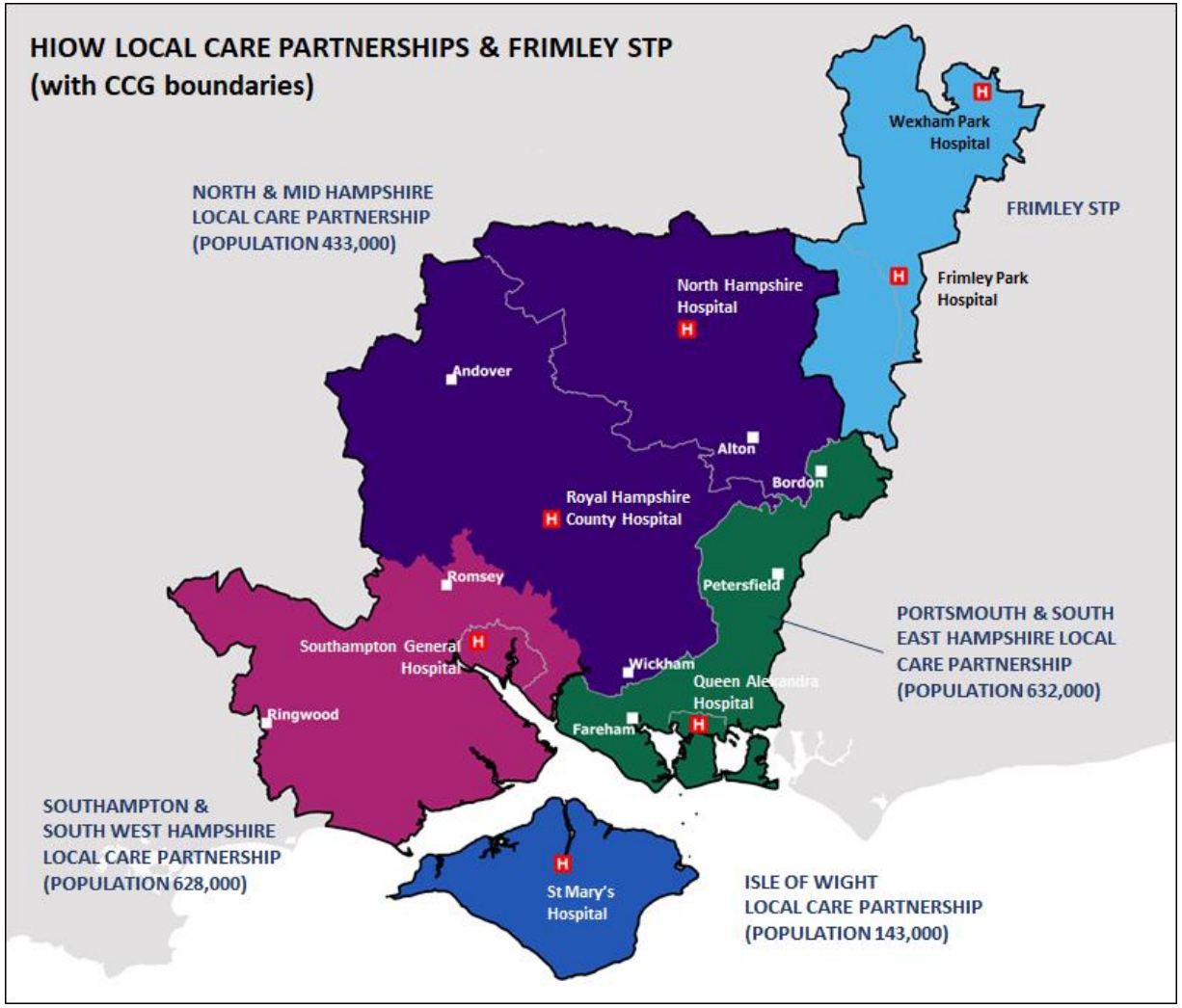
Integrated care partnerships are where we align the work of the local clusters, community services, acute and specialised physical and mental health services, for the benefit of the local population.

Providers of mental and physical health and care services including general practice, NHS commissioners, local authorities and voluntary sector organisations come together in geographies based on the local catchments of acute hospitals to benefit their local population.

The term ‘integrated care partnership’ [ICP] is being used to describe the collaboration of partners on these geographies.

The ICPs across HIOW will reflect local needs and will differ in the extent of their focus and work programme. For some, the focus may be predominately on improving operational ED performance. In others there is already an intent to work together on a more comprehensive basis with established governance structures to deliver agreed improvement programmes.

The balance and focus of the planning and delivery that takes place in HWB footprints and integrated care partnerships will vary in each part of HIOW.



What could integrated care partnerships look like? 30

The nature of Integrated Care Partnerships [ICPs] will vary according to local circumstances, challenges and opportunities. For some the arrangements will mirror current state. For others their development is such that by **April 2020, integrated care partnerships could be working together to:**

- implement a integrated care partnership delivery plan which sets out the collective priorities of the integrated care partnership, over the medium term (3-5 years) and in the short term (1-2 years) [noting that as previously alluded to, the balance and focus of planning and delivery that takes place in integrated care partnerships is likely to vary in each part of HIOW]
- design and implement optimal care pathways, and to identify, understand and reduce unwarranted clinical, operational and service variation
- make the best use of the collective resources of the integrated care partnership, including workforce, financial resources and estate, maximising system wide efficiencies and encouraging resources to flow to address the key risks facing the partnership
- support the ongoing development of the integrated care partnership:
    - progressively building the capabilities to manage the health of the population, to keep people well and to reduce avoidable demand
    - supporting the ongoing development of clusters, as the bedrock of the local health and care system
    - in some areas, potentially managing the transition to evolved organisational form arrangements that enable members of the integrated care partnership to sustainably meet the population needs

An integrated care partnership board could lead the partnership, providing strong system leadership, actively breaking down barriers that hinder progress in the delivery of integrated care, building trust and acting together to deliver improvements for citizens, for the system as a whole and through which partners hold each other to account for delivery of the shared priorities.

In integrated care partnerships, NHS providers including primary care, commissioners and local authorities work to overcome the barriers to collaboration associated with the separation of provision and commissioning. Whilst recognising the important individual statutory responsibilities of each partner, it is envisaged that:

- CCGs will deploy their people and resources to work collaboratively with other CCGs in the integrated care partnership, focussed on implementation of the integrated care partnership delivery plan – improving services, improving operational performance and delivering cost reduction.
- NHS providers will work together to make strategic and operational decisions that are in the best interest of the integrated care partnership.
- Where possible, in order to reduce duplication and bureaucracy, CCGs, NHS providers and if relevant local authorities, will seek opportunities to optimise corporate support services and infrastructure such as finance, quality, communications and governance teams.

Current thinking about the development of integrated care partnerships by March 2019 and March 2020 is described on a subsequent slide.

ICPs: an example of a different approach

We anticipate seeing:

- CCGs deploying their people and resources to work collaboratively with other CCGs in the local care system and with providers
- Providers making decisions and delivering care together – provider alliances
- CCGs, NHS providers and potentially local authorities sharing corporate support services and infrastructure?
- Over the next 18 months, working through together the impact on financial flows, contractual models and organisational forms (drawing national models such as the ICP contract consultation)

Enabling us to have:

- Better grip on improving the money, performance and quality
- Integrated care partnerships supporting clusters to develop and thrive
- Whole system implementation of improved care pathways, and reduction in unwarranted clinical, operational and service variation
- Collective support for all services in the integrated care partnership to meet operational performance and quality standards
- Reduced transaction costs

The ICP Task and Finish Group has been developing a vision of how the future might look. Each ICP will develop proposals that reflect their local context, challenges and opportunities

A potential timeline for the development of ICPs

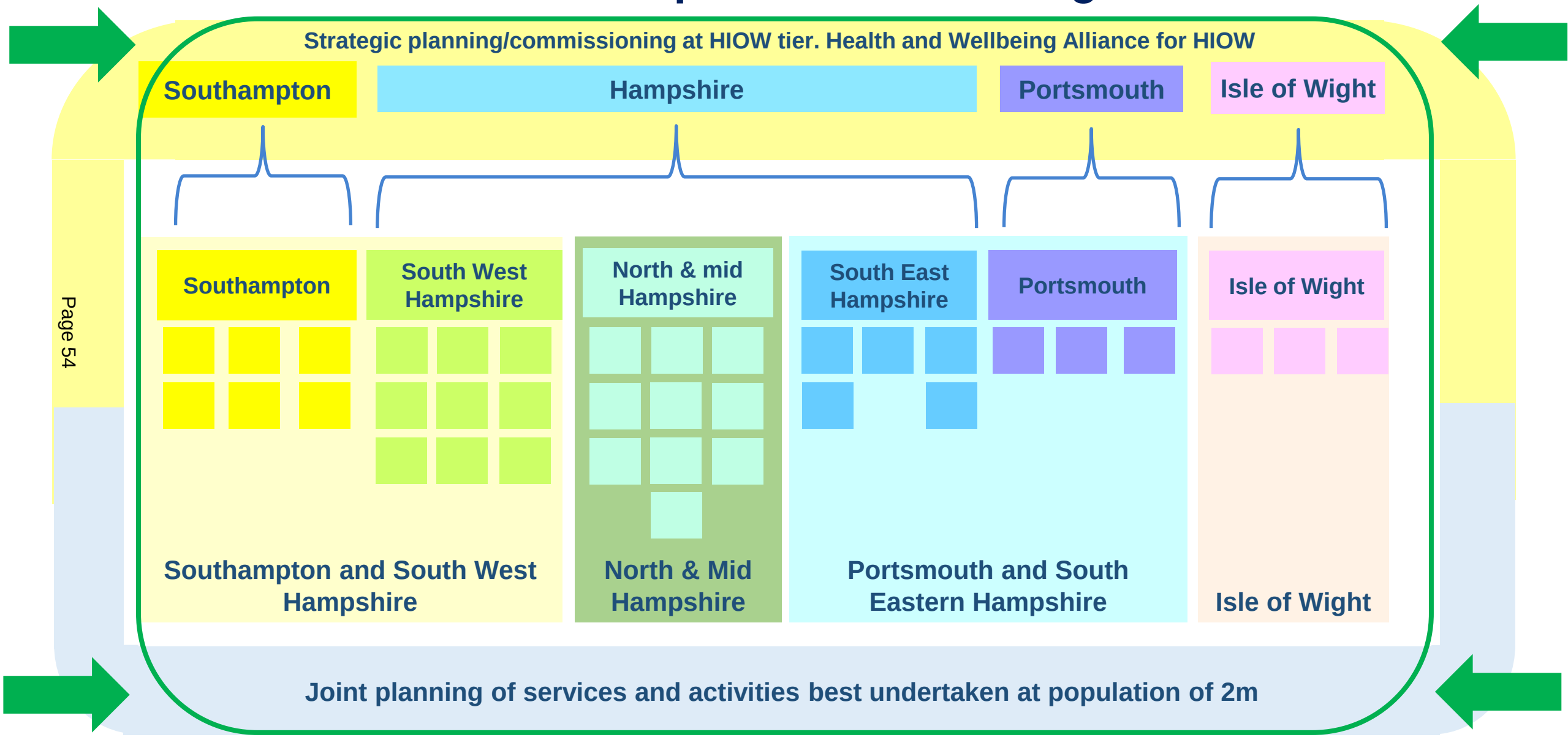
	October 2018 – March 2019	By April 2020
Strategy and Planning	• Develop and agree plan to make optimal use of acute and specialised physical and mental health services • Aligning the work of clusters at HWB footprint with community and acute physical and mental health services	• Agreed single strategy and operational plan for the integrated care partnership describing collective priorities and how those priorities will be delivered • Planning undertaken jointly by CCGs, providers and LAs
Care Redesign	• Implementing Urgent & Emergency Care priorities for the integrated care partnership • Developing optimal care pathways across the integrated care partnership • Agreed plan to support the development of clusters • Engaging staff and local communities in redesign	• 100% of clusters thriving, with lower mental and physical acute care demand as integrated teams support people to stay well at home • Managing a comprehensive programme of service improvement to address the integrated care partnership priorities • Population groups with high service utilisation or unmet need identified and action agreed
Workforce development	• Understanding the workforce issues for the integrated care partnership	• Securing the right workforce, in the right place with the right skills in the integrated care partnership, and ensuring the wellbeing of staff
Accountability & performance management	• Working together to monitor and improve delivery of constitutional standards	• Instigating clinically led quality improvement • Extensive use of data to drive improvement • Oversight of delivery in clusters • Leading recovery of standards without outside intervention
Managing collective resources	• Understand current resource use in the integrated care partnership • Working together to make the best use of the collective resources (workforce, estate, financial) in the integrated care partnership • Test new approaches to manage funding flows (e.g. DTOC) • Maximising system wide efficiencies	• Managing the collective resources of the integrated care partnership • Capable of taking on a delegated budget • Directing resources to address the key integrated care partnership risks • Shared corporate support services • Shared medium term financial plan including efficiencies
Leadership & governance	• Understanding the context, ambitions and challenges of each member of the integrated care partnership, building trust, acting together • Governance structure in place to enable collaboration • Cluster leaders engaged in integrated care partnership planning and decision making • Members of the integrated care partnership working together to agree any changes required to organisational structures	• Joint provider, CCG and LA leadership to enable planning and delivery in the integrated care partnership • Care professionals leading service integration • Governance mechanisms in place to enable decisions to be made in the best interests of the system and residents • Implementing agreed changes to organisational structures to better enable delivery in the integrated care partnership

Statutory bodies are asked to:

Work with geographically aligned partners within the identified four ICP footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight



Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight

In order to support and add value to the work of clusters, HWB footprints and integrated care partnerships, it is envisaged that providers, commissioners and local authorities will work together to undertake strategic planning, transformation, resource allocation and oversight activities at HIOW level.

This could be achieved, by April 2020, through a single entity for HIOW which, in its mature form, would develop strategy, set priorities and provide strategic leadership and direction to the HIOW integrated care system.

The strategic planning and transformation function in the HIOW integrated care system would:

- include the input and expertise of providers, CCGs and local authorities
- programme manage the implementation of HIOW level transformational change (change that spans more than one integrated care partnership or which is most appropriately managed at HIOW system level)
- proactively support the development of integrated care partnerships
- manage the specialised commissioning budget for HIOW
- align the resources coming into HIOW from a wide variety of sources around the delivery of the agreed strategic priorities, in order to increase the impact for populations
- act as the assurance body for HIOW, providing oversight of operational, quality and financial performance, and enabling the HIOW integrated care system to take action to improve performance without the need for outside intervention.

Whilst recognising the important role of external regulation, it is anticipated that the integrated care system will increasingly develop the capacity and capability to role-model ‘self-regulation’ – where robust processes are in place to ensure that action is taken to identify issues and improve performance without the need for outside intervention.

Creating this strategic planning and transformation function for the HIOW, which involves providers, CCGs and local authorities, is an opportunity to bring together in one place a number of functions including: those CCG functions best undertaken at HIOW level, STP functions, functions currently undertaken by the Director of Commissioning Operations, NHS England/NHS Improvement regulatory functions, specialised services commissioning and potentially other NHS England direct commissioning activities; HIOW clinical networks.

Current thinking about the transition towards this new way of working, by March 2019 and March 2020, is described on a subsequent page.

The characteristics of the HIOW integrated care system

It is proposed that, based upon national ICS, national guidance and evidence of best practice, an entity operating at the scale of HIOW could display the following characteristics:

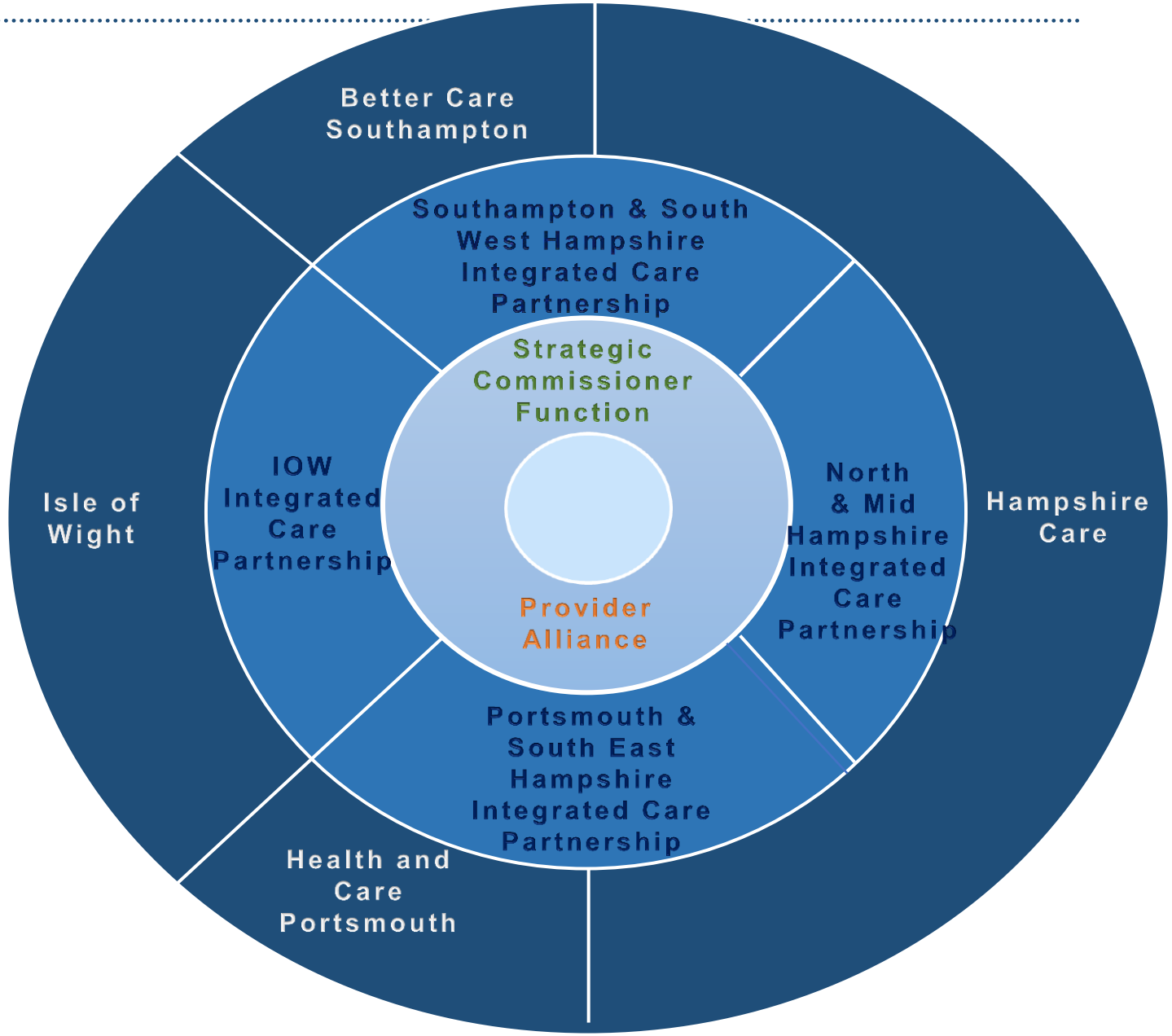
Subsidiarity: only undertaking functions that for reasons of cost or complexity need to be undertaken at the scale of 2m+ population. Unnecessary complexity and bureaucracy are stripped out with 80% of the transformation process led by local place-based teams;

Inclusive: national models / guidance show that prospective ICSare founded on partnership; for HIOW this would draw together:

- A newly established strategic commissioning function
- the four HWB footprints
- the four integrated care partnerships
- provider alliance

Founded on self-regulation: all components of reformed systems have effective self-regulation and enable a model of collective assurance at the scale of the ICS. This allows NHS England and NHS Improvement to deploy resource into the ICS and have a single touch point on delivery to the newly reformed regional and national infrastructure;

Politically-led: prospective ICS all demonstrate strong political leadership and close connection with Health and Wellbeing Strategies and Boards.



Strategic planning/commissioning at the scale of HIOW

As an immediate next step in the transition to this future system model, it is proposed that HIOW CCGs and local authorities establish a strategic planning/commissioning function during Q3 2018/19.

By working together at HIOW level, CCGs and local authorities expect to be able to reduce fragmentation and bring the following immediate benefits:

- stronger alignment of health and local authority commissioning
- the development & agreement of consistent whole system strategic priorities for HIOW
- improved and simplified commissioning decision-making for HIOW wide issues.

The functions of the strategic planning/commissioning function in its initial form would include:

- Setting consistent commissioning strategy and strategic priorities for HIOW
- Managing whole system resilience at HIOW level
- Management and deployment of supra-allocation resources (including capital)
- Demand and capacity planning and commissioning decisions about the future configuration of acute physical and mental health services for the 2 million population of HIOW
- Oversight of NHS constitutional standards, financial performance and quality improvement – with work to be done to ensure this activity isn't duplicated elsewhere
- Work with specialised commissioners, understanding current activity flows and costs, inputting to and aligning decision making
- It is also proposed that the strategic planning/commissioning function incorporates the transformation programme function of the HIOW Sustainability and Transformation Partnership.

Proposed governance:

- Established through a joint committee, in the first instance, during Q3 2018/19
- Members include CCGs, NHS England (specialist commissioning and Regional Director of Commissioning) and local authorities
- Joint committee will have delegated authority to make binding decisions in relation to the in-scope functions and responsibilities
- Expect by April 2019 the governance and organisational arrangements evolve further

The strategic planning/commissioning function is a mechanism through which commissioners can pool skills, expertise, resources and accountability to deliver transformation at HIOW level. There is a strong desire to create a new way of working, rather than add layers to existing ways of working.

The developing functions at a scale of HIOW

	October 2018 – March 2019	By April 2020
Strategy and Planning	• Clear commissioning priorities agreed for HIOW • HIOW system strategy and priorities being refreshed/updated • Demand and capacity planning for HIOW acute services • Agree aligned planning process for 2019/20-2020/21	• CCGs, providers & LAs setting shared strategy & priorities for HIOW with aligned health & LA planning processes • Fully own a single HIOW system operating plan that brings together plans of constituent parts of the system
Care Redesign	• Decisions being made about future configuration of acute physical health and mental health crisis and acute care • Leadership of plans to improve urgent care for HIOW, including oversight of delivery of the Integrated Urgent Care Plan • Decisions about community services provision for Hampshire	• Well developed plans being enacted to support the development of integrated care partnerships • Programme managing the implementation of HIOW level strategic change programme • Leading on implementation of acute service and estate reconfiguration
Workforce development	• Understanding the workforce issues for the system • Influencing the addressing of key workforce issues	• Strategic workforce plan in place and being implemented • Influencing future workforce supply and training requirements
Accountability & performance management	• Oversight of HIOW winter resilience and preparedness • Oversight of delivery of integrated urgent care plan • Acting as interface with assurance bodies for HIOW	• Collective oversight of quality, operational performance and money • Acting as the assurance body for HIOW – supporting the system to take action to improve performance and address challenges without the ned for outside intervention
Managing collective resources	• Agree system wide capital and estate priorities and sign off wave 4 capital allocations • Develop understanding of whole system financial plans and financial risks • Plan for aligned management of specialised commissioning	• Take accountability for a HIOW system control total • Managing collective finances & risk openly and as a system • Aligning resources flowing into HIOW to achieve priorities • Support integrated care partnerships to take delegated budget • Managing the specialised commissioning budget
Leadership & governance	• CCGs operating with a single decision making committee for HIOW level commissioning business • All STP partners involved in the design of the future HIOW level system strategic planning, implementation and assurance function • STP partners providing leadership to strategic change programmes	• A single coherent entity in place that brings together HIOW level CCG functions, STP and NHSE/I functions • Strategic alignment of providers, commissioners and local authorities around the system strategy and priorities • Clear clinical leadership for the system and input from HWB footprints and integrated care partnerships in decision making

Statutory bodies are asked to:

Endorse the recommendations of the EDG, informed by the work of the strategic commissioning task and finish group, that:

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.

2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

Summary of recommendations

In summary, the governing bodies and boards of statutory organisations are asked to endorse the following recommendations from the EDG, informed by task and finish group work to date:

Clusters

1. **The developing role of clusters as outlined earlier**
2. **The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development**
3. **The proposed next steps for the cluster task and finish group which are summarised as follows:**
   a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW
   b. Describe the support requirements and responsibilities to accelerate full cluster implementation
   c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures
   d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

Health and Wellbeing Board Footprints

1. **The emerging 'restatement' of the function of partnership working on a HWB footprint as described earlier in the document**
2. **The proposed next steps for the task and finish group by the end of September, which are to:**
   a. define the common functions of the role of HWB footprints in an integrated care system
   b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system
   c. set out a mechanism for achieving 'active and effective democratic engagement at all levels' across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

Integrated care partnerships

Work with geographically aligned partners within the identified four ICP footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

Strategic commissioning

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.
2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

Next steps

System reform programme next steps

A number of recommendations have been set out linked to each component of the proposed ICS. In addition to those associated with the specific components of the proposal, there are a number of overarching 'implementation programme deliverables', some of which will result as a coming together of the outputs from the various task and finish groups. These include:

- System reform implementation programme plan
- Structure and leadership plan – transitionary and end state
- Development and implementation of a communications and engagement plan
- Request for support (endorsement , agreement in principle, technical and financial) from NHS England , NHS Improvement and other arms length bodies such as the Local Government Association, NHS Leadership Academy, Health Education England
- Proposals to replace STP infrastructure (inc. Chair & SRO) to align with future form
- Organisational change plan and talent management plan
- HIOW ICS Chair and relevant leadership appointments
- Indicative budgets and financial framework for all components of the ICS
- Three year financial plans

It is recommended that a working group is formed, reporting to the EDG, to support the development of the above. Members of EDG are asked to nominate a representative to represent the interests of their part of the system.

Glossary

Glossary of terms

Clusters - also referred to locally and nationally as neighbourhoods, localities, primary care networks. Multi-disciplinary teams delivering integrated health, care and wider services to cluster populations based on natural communities of 20-100,000 people.

Health and Wellbeing Board (HWB) footprints – also known as care systems and are based on local authority footprints. The basis of the joint strategic needs assessment (JSNA), means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health. Locally the HWB footprints come under the guise of Better Care Southampton, Health and Care Portsmouth, Hampshire Care and the Isle of Wight Care Board.

Integrated care partnerships – also know as local care partnerships and are based on acute (physical) hospital footprints. Integrating care delivered in clusters with broader community and acute physical and mental health services; optimising the utilisation of acute services; designing and implementing optimal care pathways.

Integrated care system - the Hampshire and Isle of Wight health and care system, serving a population of 2 million citizens.

NHS England defines ICS as those systems in which:

“Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations”.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		HEALTH AND WELLBEING STRATEGY UPDATE		
DATE OF DECISION:		6 DECEMBER 2018		
REPORT OF:		CABINET MEMBER FOR COMMUNITY WELLBEING		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Felicity Ridgway**	**Tel:**	**023 8283 3310**
	E-mail:	**Felicity.ridgway@southampton.gov.uk**		
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	E-mail:	**Jason.horsley@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
Not applicable
BRIEF SUMMARY
The Southampton Health and Wellbeing Strategy 2017-2025 was developed by the Health and Wellbeing Board, and adopted by Full Council in March 2017, in agreement with NHS Southampton Clinical Commissioning Group (CCG) Governing Body. Health and wellbeing is important to everyone in Southampton, whether they live, work or learn in the city. The joint Health and Wellbeing Strategy for Southampton aligns with: • the City Strategy 2015-2025 with its vision to make Southampton a 'city of opportunity where everyone thrives', and priority around 'healthier and safer communities'. • the Council Strategy 2016-2020 and its outcome 'people in Southampton live safe, healthy, independent lives'. • NHS Southampton City Five Year Health and Care Strategy and the Local Delivery Plan. The strategy sets out the strategic vision for improving the health of residents and workers, and reducing health inequalities in the city. It includes the outcomes the city wants to achieve over the next eight years, and is based on evidence from the Joint Strategic Needs Assessment (JSNA), stakeholder engagement and public consultation. This paper provides an update on the progress of the strategy in the last year.

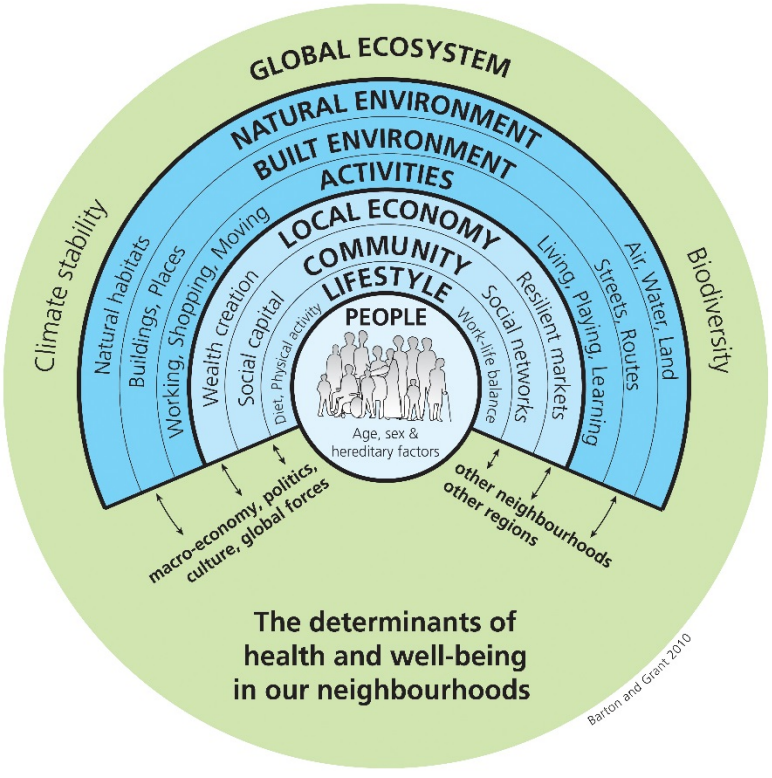
RECOMMENDATIONS:		
	(i)	That the Panel notes the progress against the Health and Wellbeing Strategy to date.

REASONS FOR REPORT RECOMMENDATIONS	
1.	Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint statutory duties to deliver a Health and Wellbeing Strategy that sets out how they plan to work together with local partners to meet health and care needs identified in the JSNA.

2.	The Health Overview and Scrutiny Panel, at their meeting in October 2017, requested an annual update on progress against the priorities in the Health and Wellbeing Strategy.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	None
DETAIL (Including consultation carried out)	
	Background
3.	The Health and Wellbeing Strategy sets out our vision that Southampton has a culture and environment that promotes, and supports, health and wellbeing for all and our ambition to significantly improve health and wellbeing outcomes and reduce citywide health inequalities in Southampton by 2025. The strategy identifies four key outcomes we want to achieve, and a number of high level activities which will contribute to achieving them.
4.	We know that improvements in health outcomes can take years to achieve at a population level, and that no single action will improve health across the city. The strategy therefore includes a number of measures from the Public Health Outcomes Framework, which will be monitored over the 8 years of the strategy. Appendix 1 provides a scorecard outlining the current position, regional, national and statistical comparators, and recent trends for each measure. This report provides an update on our overarching outcomes and progress against each of the four priority outcomes in the strategy.
	Overarching outcomes
5.	The Public Health Outcomes Framework is a comprehensive list of desired outcomes and indicators that help measure how well health and wellbeing is being improved and protected in an area. One of the Health and Wellbeing Strategy's overarching outcomes is to maximise the life expectancy of residents in Southampton. In Southampton, the life expectancy of males was 78.5 Years for the 2014-16 period. Although this continues to improve, it is still significantly lower than the England average of 79.5 years. For females, the local life expectancy was 82.8 years for the same period. This has remained fairly constant over the last 3 years and is similar to the England average of 83.1 years. In terms of healthy life expectancy in Southampton, the rate is 61.9 years for males, which has recently improved from 60.9, but still below England average (63.3), and 63.1 years for females; similar to England average of 63.9.
6.	We want to prevent avoidable deaths, ensure that people are supported to stay well for longer, are able to live active, safe and independent lives and manage their own health and wellbeing. In Southampton, 22% of total deaths were considered preventable, from 2015 to 2017. In 2016 there were 1,924 deaths registered in Southampton's resident population, and of these cancer was responsible for 27.8%, coronary heart disease 12.5%, stroke 5.6% and other circulatory diseases 8.4%.
	People in Southampton live active, safe and independent lives and manage their own health and wellbeing
7.	The strategy sets out our aim to encourage and promote healthier lifestyle choices and behaviours. In Southampton, there are many opportunities to be active in the community. The city hosts an annual cycle ride, the third largest park run in the country, a half marathon, free family activities in local parks and there are a number of indoor and outdoor sports facilities. However, recent trends show that inactivity has increased (Public Health Outcomes Framework): • 24.2% of adults are inactive (do less than 30 minutes per week) which is similar to the England average (22.2%).

	• 65.2% adults in Southampton do at least 150 minutes of activity per week this is similar to the England average (66.0%). • Nationally it is estimated that of 5-15 year olds only 23% boys and 20% girls met the physical activity guidelines. • Inactivity increases with age, with a greater proportion of older age groups classed as inactive compared to younger groups. To address some of the challenges and opportunities in this area, a Healthy Weight Plan and Physical Activity strategy has been developed with the Health and Wellbeing Board to enable citywide approaches to behaviour change.
8.	Smoking is the leading cause of preventable death and disease in the UK. In Southampton, smoking prevalence is higher than the England average and 2nd highest amongst neighbouring authorities. Furthermore, Southampton has a higher rate of hospital admissions for alcohol in 2016/17 than England and is amongst the highest compared to similar areas. In order to address this, we have run a number of local campaigns in support of national initiatives, such as Stoptober, and are preparing for Dry January in the new year. Both aim to raise awareness of the harmful effects of smoking and alcohol.
9.	To encourage and promote healthier lifestyle choices, a new behaviour change service was commissioned by Southampton City Council and launched in April 2017 'Southampton Healthy Living'. It is a partnership between NHS and voluntary services, with Social Care in Action as the lead provider. This service was delivered to more than 5,000 adults in 2017/18. In the first year, 147 people received a mini cardiovascular health check, 329 people who were overweight lost at least 5% of their body weight and 432 staff in other organisations were trained in behaviour change and brief interventions. Further to this, the behaviour change service supported 562 people to stop smoking for at least 4 weeks, 817 people were recorded to have increased their physical activity and 2,176 people were screened for harmful levels of drinking.
10.	Part of enabling people to live healthy lifestyles includes ensuring that they have access to information and advice that is coordinated and accessible. To facilitate this, the community navigation pilots have been extended to reach all areas of the city, targeted at the most vulnerable populations, including older people and people living with mental health conditions. These models are being developed to reflect the learning from pilots to date.
11.	Southampton has continued to actively promote and extend a telecare service across the city to support people to be more independent in their own home and have access to their local community. We have been using GPS devices which have enabled more people to remain independent in their own home while reducing the impact on carers and emergency services when people go missing. We have further been using technology that provides a reminder to secure their accommodation at night. This has improved people's confidence for some individuals to continue to live independent and safe lives.
12.	Mental and physical wellbeing are closely linked; people with poor physical health are at higher risk of experiencing mental health problems and people with poor mental health are more likely to have poor physical health. Work has been undertaken to ensure that mental health needs are considered in all physical health care pathways. This includes investment in more psychological therapy, by NHS Southampton City Clinical Commissioning Group, for people who have co-morbid mental health and long term physical health conditions. It is hoped that those who receive the tailored psychological therapy alongside their physical health care will experience benefits to both their physical and mental health. Also, there has been an increase in access to mental health support in primary care, with more support being targeted to people in their GP practice, supporting recovery and avoiding the need for people to access secondary care mental health services.

13.	Further mental health promotion activities in 2018 have seen more investment to increase practitioners within Central and East Community Mental Health teams and Assertive Outreach services to ensure that support is available in the community when it is needed. A Crisis lounge is now open all day every day in Antelope House giving support to people who may be experiencing highly distressing symptoms; the service supports individuals in a recovery-focused way to manage their episode of crisis and helps reduce the need for hospital admission. There has been an increase in psychiatric posts at University Hospitals NHS Trust to provide improved access all day, seven days a week. The team provide psychiatric assessment and treatment to those patients who may be experiencing distress whilst in hospital and provide a valuable interface between mental and physical health services.
14.	The CAMHS (Children and Adolescent Mental Health Services) transformation plan is being implemented. This includes proposals on mental health support in schools, and a needs assessment of school age children and young peoples' mental health has been undertaken to inform the approach.
	Inequalities in health outcomes and access to health and care services are reduced.
15.	The conditions in which people are born, grow, live, work and age have profound influence on health and inequalities in health in childhood, working age and older age. The lower a person's social and economic status, the poorer their health is likely to be.
16.	Health inequalities arise from a complex interaction of many factors, such as housing, income, education, social isolation and disability, all of which are strongly affected by economic and social status. Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community. The greatest reductions in health inequalities can be achieved through providing support proportionate to level of need.
17.	Action to improve men's health to reduce the difference between male and female life expectancy is taking place and campaigns have been supported to address these health inequalities. Approaches such as: • Local Stoptober campaign included material aimed at men in routine and manual work • NHS Health Checks programme running, which identifies people at risk of Cardiovascular Diseases (CVD) in the subsequent 10 years. • Risky behaviour - commissioning for quality and innovation (smoking and alcohol) led by CCG as commissioners of community and acute Trusts. • Licensing and trading standards work for health-promoting places, particularly illegal tobacco and alcohol.
18.	We want to reduce inequalities in early childhood development by ensuring good provision of maternity services, childcare, parenting and early years support. Work with local breastfeeding support services has been undertaken to develop a Southampton breastfeeding improvement plan. The local Breastfeeding Operational Group delivered a positive Breastfeeding in Southampton programme for World Breastfeeding Week 1-7 August 2018, including a series of pictures celebrating breastfeeding in iconic Southampton public settings. Furthermore, there has been a series of engagement activities in the Hampshire and Isle of Wight Maternity Pioneer project, this includes work to introduce direct self-referral for newly pregnant women from the autumn.
19.	There has been significant progress in reducing teenage pregnancies over the past 10 years, but the rate in Southampton is still high compared with our neighbouring authorities. Between 2014-2016, the number of under 18 conceptions in Southampton was 30 per 1000 population which is higher than the national average of 20.8 per 1000 population. Under the Children and Social Work Act 2017, the

	government committed to making relationships and sex education (RSE) statutory in all schools, including LA maintained schools, academies, free schools and independent schools. All schools will soon be required to have RSE in place and an RSE policy. The personal, social, health and economic (PSHE) education network is meeting in December 2018 to support schools in meeting new requirement and provide ongoing support in schools for healthy relationships.
20.	Further to our commitments to ensure health inequalities are taken into account in policy development and commissioning service delivery, the following actions have been taken forward by the CCG: • Priority given to improve uptake of screening in Cancer Care Plan; • impact on Health inequalities is monitored by CCG Clinical Governance committee; • There is improved access to annual health checks for people with a learning disability (the target of 60% uptake for LD annual health checks in 2017-18 was achieved).
	Southampton is a healthy place to live and work with strong, active communities
21.	Evidence shows that our greatest health challenges, for example, the prevalence of non-communicable diseases, health inequities and inequalities and increasing health care costs, are highly complex and often linked through the social determinants of health. By addressing the wider issues around the health and wellbeing of our neighbourhoods and making the city a place that supports improved health and wellbeing, we can start to influence positive health outcomes for our residents. 
22.	The Health and Wellbeing Strategy 2017-25 sets out actions to address the wider determinants of health including healthy workplaces, housing quality and environmental policies. The strategy also focuses on building resilient communities that both improve the wellbeing of individuals, and reduce pressure on health services.
23.	Fuel poverty is being addressed through the refresh of the Fuel Poverty action plan and this year we have supported over 380 households. Funding has been secured from the National Grid to support Southampton Healthy Homes Programme and we

	have now launched our own ethical energy brand called CitizEn Energy which is a not-for-profit company so, unlike the private energy suppliers, any surplus made will be reinvested into local energy efficiency initiatives to deliver real savings for customers. It is hoped that this will improve housing standards and reduce illness and avoidable deaths related to fuel poverty.
24.	Southampton City Council is one of five authorities in England outside of London required to assess the need for a Clean Air Zone. The primary objective of a Clean Air Zone (CAZ) is to bring about compliance with the EU Ambient Air Quality Directive limits of nitrogen dioxide (NO2) within the shortest possible time. We have consulted on a preferred option of a B Class CAZ that would charge non-compliant Heavy Goods Vehicles, buses, coaches, taxis and private hire vehicles that do not meet a Euro 6 diesel/Euro 4 petrol minimum. Over 9,000 separate written responses were received and feedback is now being thoroughly analysed and evaluated. Following this exceptional volume of feedback, and changes to baseline data that has impacted on the air quality modelling, further exploration into social and economic impacts is being undertaken. Southampton City Council will submit their business case regarding a Clean Air Zone to Government by 31 January 2019 for approval.
	People in Southampton have improved heath experiences as a result of high quality, integrated services
25.	The Health and Wellbeing Board had responsibility for the Southampton Better Care vision which is to become a city “where everyone thrives; built on the strengths of our communities and our services are joined up around individuals”. The overall aims for integrated care in Southampton are: • Putting people at the centre of their care, meeting needs in a holistic way • Providing the right care, in the right place at the right time, and enabling individuals and families to be independent and resilient wherever possible • Making optimum use of the health and care resources available in the community • Intervening earlier and building resilience in order to secure better outcomes by providing more coordinated, proactive services • Focusing on prevention and early intervention to support people to retain and regain their independence.
26.	A key element of Better Care is to prioritise investment in and embed a prevention and early intervention approach, especially through development of clusters and integrated teams. An integrated approach to case management is being progressed to support development of integrated locality teams in line with this strategic approach. In addition, digital work across Hampshire, Portsmouth, Southampton and Isle of Wight is progressing to support the development of shared records as part of the Sustainability and Transformation Plan.
27.	To ensure that we deliver the right care, at the right time and in the right place, the focus has been to support the balance of care out of hospital settings to community providers. Developments so far include: • Enhanced Health in Care Home pilot focussing on 15 residential homes which has shown significant impact in reducing attendances and admissions to hospital; • Worked to deliver a community based approach to end of life care in line with national best practice, enabling more people to die in the manner and setting of their choosing with dignity and respect; • Significantly increased the number of people having their assessments for health or social long term care undertaken in the community.
28.	Joint Commissioning between the council and CCG has led to the development of integrated provision, including rehabilitation and reablement. This has had a significant impact on helping people remain independent and is contributing to a

	reduction in long term care needs. Furthermore, the new Southampton Living Well Service formally went live in April 2018, which will transform the current older person's day services into a new wellbeing and activity offer delivered through Community Wellbeing Centres based within communities and wider community activity.
29.	The establishment of the Southampton Joint Commissioning Board was agreed by Cabinet and Council in July 2017. The Joint Commissioning Board is now in place, and has the role of ensuring effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements for health and care between Southampton City Council and NHS Southampton City CCG. In March 2018 the Health and Wellbeing Board formally agreed to delegate responsibility for Better Care from the Health and Wellbeing Board to the Joint Commissioning Board. This will support a continued drive to deliver joined-up services that result in improved outcomes for our residents.
RESOURCE IMPLICATIONS	
Capital/Revenue	
30.	None
Property/Other	
31.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
32.	N/A
Other Legal Implications:	
33.	**None**
RISK MANAGEMENT IMPLICATIONS	
34.	**None**
POLICY FRAMEWORK IMPLICATIONS	
35.	**None**

KEY DECISION?	**No**	
WARDS/COMMUNITIES AFFECTED:		**All**
SUPPORTING DOCUMENTATION		
Appendices		
1.	Health and Wellbeing Board Scorecard	

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	No
Data Protection Impact Assessment	

Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?		No
Other Background Documents Other Background documents available for inspection at:		
Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	

Healthy Southampton

Health and Wellbeing Strategy 2017-2025

Health and Wellbeing Scorecard

November 2018

Comparison with England:	Significantly Worse	Worse (but not sig)	Similar	Better (but not sig)	Significantly Better
England Ranking Quintile:	20% Worst	2nd	3rd	4th	20% Best

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated November 2018	Updated May 2018	Updated February 2018	Direction of travel comparison with ghost rank of last time: Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Overarching	Life expectancy at birth (Male)	Years	2014-16		78.5	79.5	Significantly lower	5	49			*	↔	5	↑	46
	Life expectancy at birth (Female)	Years	2014-16		82.8	83.1	Lower	9	68			*	↔	9	↓	71
	Life expectancy at 65 years (Male)	Years	2014-16		17.9	18.8	Significantly lower	4	37			*	↓	5	↓	39
	Life expectancy at 65 years (Female)	Years	2014-16		20.8	21.1	Lower	8	64			*	↓	9	↓	73
	Healthy Life Expectancy at birth (Male)	Years	2014-16		61.9	63.3	Lower	8	64			*	↑	6	↑	49
	Healthy Life Expectancy at birth (Female)	Years	2014-16		63.1	63.9	Lower	9	74			*	↑	7	↓	77
	Under 75 years mortality rate from cardiovascular disease (Male)	per 100,000	2015-17		120.9	101.3	Significantly higher	5	41 of 150	*			↑	3	↑	35 of 149
	Under 75 years mortality rate from cardiovascular disease (Female)	per 100,000	2015-17		43.8	45.2	Lower	9	89 of 150	*			↔	9	↑	81 of 149
	Under 75 years mortality rate from respiratory disease (Male)	per 100,000	2015-17		56.8	39.9	Significantly higher	2	23 of 150	*			↔	2	↑	12 of 149
	Under 75 years mortality rate from respiratory disease (Female)	per 100,000	2015-17		34.5	29.0	Higher	7	51 of 149	*			↑	5	↑	37 of 149
	Mortality rate from causes considered preventable (Male)	per 100,000	2015-17		296.7	228.6	Significantly higher	2	21 of 151	*			↓	3	↓	22
	Mortality rate from causes considered preventable (Female)	per 100,000	2015-17		160.7	137.7	Significantly higher	4	38	*			↓	6	↓	57

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated November 2018	Updated May 2018	Updated February 2018	Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Children & Young People/Early years	Smoking status at time of delivery	%	2016/17		13.8	10.7	Significantly higher	3	39 of 149				↑	2	↑	36 of 148
	Breastfeeding prevalence at 6-8 weeks after birth	%	2016/17	Not available	Not available	Not available	Not available	Not available	Not available			*				
	Child excess weight in 4-5 year olds	%	2017/18		23.3	22.4	Higher	6	59 of 148	*		*	↓	7	↓	65
	Child excess weight in 10-11 year olds	%	2017/18		37.4	34.3	Significantly higher	4	48 of 148	*		*	↓	6	↓	77
	Population vaccination coverage – MMR for one dose (2 years old)	%	2017/18		93.9	91.2	Significantly higher	10	110 of 151	*		*	↑	9	↑	109 of 149
	Looked after children rate	per 10,000	2017		108.0	62.0	Significantly higher	2	11			*	↑	1	↑	2
	School readiness: Good level of development at the end of reception	%	2016/17		70.2	70.7	Lower	7	87			*	↓	10	↑	71
	School readiness: Year 1 pupils achieving the expected level in the phonics screening check	%	2016/17		81.6	81.1	Higher	10	82			*	↓	11	↓	94
	Children in low income families (under 16s)	%	2015		19.7	16.8	Significantly higher	7	57		*		↑	6	↓	58
	Hospital admissions from unintentional & deliberate injuries (0-14 yrs)	per 10,000	2016/17		110.3	101.5	Higher	10	59 of 148			*	↑	8	↑	28
	Under 18 years conception rate	per 1,000	2016		31.7	18.8	Significantly higher	1	7 of 150		*		↓	3	↓	20

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated November 2018	Updated May 2018	Updated February 2018	Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Adults	Smoking prevalence in adults	%	2017		17.4	14.9	Higher	2	34 of 150	*			↓	3	↓	42 of 150
	Suicide rate	per 100,000	2015-17		13.3	9.6	Significantly higher	3	13 of 149	*			↑	1	↑	6 of 149
	Depression recorded prevalence	%	2016/17		9.2	9.1	Similar	5	68 of 151		*		↔	5	↓	71 of 152
	Injuries due to falls in people aged 65+ (Persons)	per 100,000	2016/17		3134.9	2113.8	Significantly higher	2	5 of 148			*	↔	2	↓	11
	Injuries due to falls in people aged 65+ years (Male)	per 100,000	2016/17		2647.4	1714.9	Significantly higher	2	5 of 148			*	↔	2	↓	7
	Injuries due to falls in people aged 65+ years (Female)	per 100,000	2016/17		3453.8	2395.6	Significantly higher	1	4 of 148			*	↓	2	↓	13
	HIV late diagnosis	%	2015-17		49.2	41.1	Higher	4	44 of 144				↑	1	↑	16 of 145
	Under 75 years mortality rate for liver disease considered preventable	per 100,000	2015-17		21.2	16.3	Significantly higher	4	34 of 150	*			↓	7	↓	63 of 140
	TB incidence (3 year average)	per 100,000	2015-17		12.2	9.9	Higher	4	48 of 151	*			↓	5	↓	55

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated November 2018	Updated May 2018	Updated February 2018	Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Healthy settings	Fraction of mortality attributable to particulate air pollution	%	2016		6.0	5.3	Higher	3	42		*		↔	3	↑	40
	Percentage of people aged 16-64 years in employment	%	2017/18		74.7	75.2	Lower	5	67 of 151	*			↔	5	↑	45
	Excess winter deaths index (Persons)	Ratio	Aug 2014-Jul 2017		20.4	21.1	Lower	7	79 of 150	*			↓	12	↓	112
	Excess winter deaths index (Male)	Ratio	Aug 2014-Jul 2017		19.4	18.1	Higher	4	63 of 150	*			↓	12	↓	116
	Excess winter deaths index (Female)	Ratio	Aug 2014-Jul 2017		21.3	23.9	Lower	10	104 of 150	*			↑	8	↑	88

** Ranking is out of 152 Upper Tier Local Authorities unless otherwise stated*

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