Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 24th October, 2019
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 Professor Margetts
Councillor Noon
Councillor Payne

Contacts

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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 2019/2020

2019	2020
27 June	27 February
29 August	23 April
24 October	
5 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 29 August 2019 and to deal with any matters arising, attached.

7 HAMPSHIRE HOSPITALS FOUNDATION TRUST - PROPOSED ORTHOPAEDIC TRANSFORMATION

(Pages 5 - 18)

Report of the Chair of the Health Overview and Scrutiny Panel requesting that the Panel review and comment on the draft service proposals for Trauma and Orthopaedic services at Hampshire Hospitals.

8 ADULT SOCIAL CARE UPDATE

(Pages 19 - 88)

Joint report of the Service Director for Adults, Housing and Communities and the Director of Quality and Integration providing an update for the Panel on the transformation journey being undertaken by Adult Social Care in Southampton.

9 HAMPSHIRE AND ISLE OF WIGHT LONG TERM PLAN (Pages 89 - 104)

Report of the Senior Responsible Officer for the Hampshire and Isle of Wight Sustainability and Transformation Partnership requesting that the Panel consider the priorities detailed in the draft long term plan.

10 SOUTHAMPTON CITY FIVE YEAR HEALTH AND CARE STRATEGY 2020-2025 UPDATE
(Pages 105 - 114)

Report of the Managing Director, NHS Southampton City CCG, updating the Panel of the progress being made to complete the five year strategic plan.

11 MONITORING SCRUTINY RECOMMENDATIONS
(Pages 115 - 126)

Report of the Director, Legal and Governance enabling the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.

Wednesday, 16 October 2019 Director of Legal and Governance

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 29 AUGUST 2019

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

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

RESOLVED: that the minutes for the Panel meeting on 27 June 2019 be approved and signed as a correct record.

7. **CONTINUING HEALTHCARE**

The Panel considered the report of the Associate Director of Quality, NHS Southampton City Clinical Commissioning Group (CCG), providing the Panel with an overview of Continuing Healthcare in Southampton.

Stephanie Ramsey - Director of Quality and Integration and Chief Nurse, NHS Southampton City CCG, Carol Alstrom – Associate Director of Quality, NHS Southampton City CCG and Tania Emery - Interim Clinical Lead for Continuing Healthcare, NHS Southampton City CCG were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- the complexity of the rules regarding eligibility for continuing healthcare. It was explained that eligibility criteria was set by the Government and that each application is assessed by a Multi–Disciplinary Team (MDT). It was stressed that should an applicant be assessed as requiring continuing healthcare by the MDT then this would be funded by the CCG. The Panel were informed about the timescales involved and the appeals process. It was further noted that there is a different scheme for patients who require end of life care and that these patients were fast tracked to ensure that they receive the care they required;
- how the MDT was constituted. The Panel noted that training is an ongoing process, and that the CCG are regularly audited to ensure consistency in decision making, but recognised that there were concerns with regards to the level and suitability of training provided.
- the apparent variation between the numbers of Continuing Healthcare assessments and the numbers determined to be eligible for Continuing Healthcare during the period between Quarter 3 in 2017/18 and Quarter 1 in 2018/19. The Panel were unable to ascertain why there appeared to be an increasing disparity between those applying for support and those deemed eligible. The Panel requested that metrics that detailed the numbers of recipients of support in Southampton be supplied alongside comparisons of other comparable local authorities; and
- the need to lobby Government to simplify the process and criteria.

RESOLVED that the Panel requested that:

(i) Southampton City CCG undertake and provide analysis for the Panel that would clarify the reasons for the variation between the numbers of Continuing Healthcare assessments and the numbers determined to be eligible for Continuing Healthcare during the period between Quarter 3 in 2017/18 and Quarter 1 in 2018/19;

(ii) the Panel be provided with a suite of benchmarked performance metrics to enable the Panel to compare performance in Southampton with other areas of the country in regard to Continuing Healthcare provision;

(iii) NHS Southampton City CCG investigate the use of mobile conference facilities for care homes to enable health and care professionals to attend multi-disciplinary team assessments remotely.

(iv) The issue of Continuing Healthcare is considered when the proposed Social Care Green paper is discussed by the Panel.

NOTE: Councillor Professor Margetts explained to the Panel that he had some knowledge of the system as he had a personal experience of the service

8. **PRIMARY CARE IN SOUTHAMPTON**

The Panel considered the report of the Director of System Delivery, NHS Southampton City Clinical Care Group (CCG), providing the Panel with an update on developments relating to primary care in Southampton.

James Rimmer - Managing Director, NHS Southampton City CCG, Phil Aubrey-Harris – Associate Director of Primary Care, NHS Southampton City CCG and Dr Mark Kelsey Chair of NHS Southampton City CCG were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- the need for the estates review. It was explained that the review would produce detailed estates plans for primary care for each city locality that will form a core component of the CCG and partner organisations delivery plans for 2020/21 and beyond;
- the numbers of GP practices within the City. The Panel noted that the number of practices across the City had reduced but questioned whether the number of available doctors and nursing staff had declined. The Panel discussed the difficulties in attracting staff to undertake the various roles of a GP and noted that most of the practices within the City were private businesses. It was explained that as private businesses with differing priorities it was difficult to drive a uniformed approach to primary care in the City.
- the potential opportunities for practices to provide information to patients on hold whilst calling the surgery. It was acknowledge that more could be done to signpost patient pathways that could potentially relieve the workload of GPs and enable more effective treatment for patients;

RESOLVED that

(i) the Panel agreed that at this stage the proposed Estates Review does not constitute a substantial variation or development and therefore does not require separate consultation with the Panel, however, the Panel did request that the review terms of reference were circulated to HOSP members.

(ii) That, in addition to patient list numbers and practice boundaries, the Panel are provided with the following information from NHS Southampton City CCG:

a. The number of GPs, nurses and allied health professionals working within each registered GP practice in Southampton.
b. The ratio of GPs per 10,000 population in Southampton over a ten year period.

(iii) That, to improve access to GP appointments, consideration is given to encouraging GP practices to provide advice on answerphone messages of the alternative options that are available to obtain an appointment with a GP in Southampton.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		HAMPSHIRE HOSPITALS FOUNDATION TRUST - PROPOSED ORTHOPAEDIC TRANSFORMATION		
DATE OF DECISION:		24 OCTOBER 2019		
REPORT OF:		CHAIR OF THE HEALTH OVERVIEW AND SCRUTINY PANEL		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY		
Hampshire Hospitals Foundation Trust (HHFT) have published proposals for Trauma and Orthopaedic services at Hampshire Hospitals (Andover, Winchester and Basingstoke). The proposals are outlined in Appendix 1.		
RECOMMENDATION:		
	(i)	That the Panel review and comment on the draft service proposals for Trauma and Orthopaedic services at Hampshire Hospitals and the wider system, attached as Appendix 1.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To enable the Panel to discuss the proposals for Trauma and Orthopaedic services with representatives from HHFT.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	The draft proposals for Trauma and Orthopaedic services at Hampshire Hospitals are attached as Appendix 1. Representatives from HHFT have been invited to present the proposals to the Panel.	
4.	The Panel are requested to consider the proposals and agree any feedback for HHFT to consider prior to finalising their approach.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	None	
Property/Other		
6.	None	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		

7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.	
Other Legal Implications:		
8.	None	
RISK MANAGEMENT IMPLICATIONS		
9.	None	
POLICY FRAMEWORK IMPLICATIONS		
10.	None	
KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Proposed Orthopaedic Transformation - HHFT	
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	

Report to Southampton Health Overview and Scrutiny Panel

Proposed Orthopaedic Transformation

1.0 Purpose

This report summarises the proposal to centralise inpatient orthopaedic trauma operations, and create an Arthroplasty centre of excellence within the North & Mid Hampshire local care system.

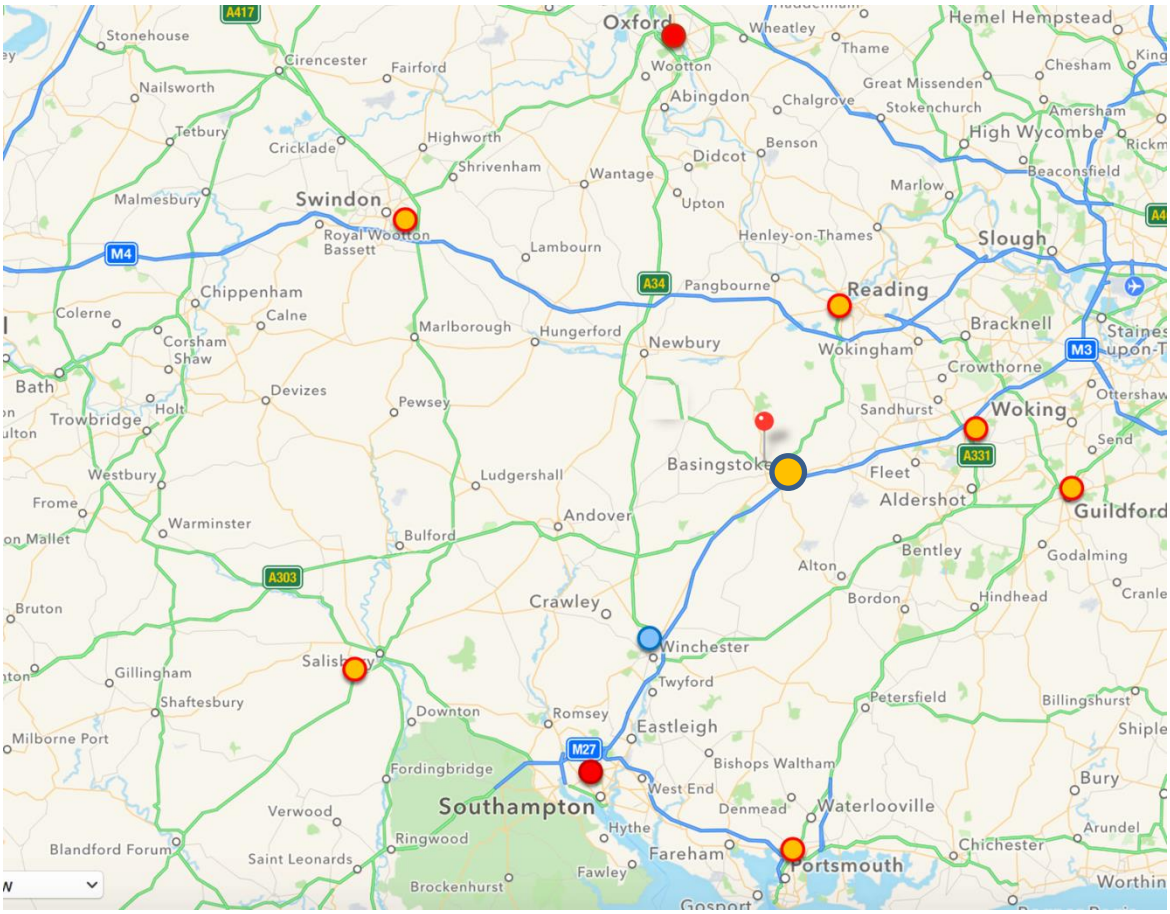
Orthopaedic elective work is planned work on bones and joints. This includes large operations which require a general anaesthetic and a stay in hospital, for example planned hip and knee replacements known as arthroplasty. It also includes smaller operations, which can be done in the day and sometimes with just a local anaesthetic. Examples of this would be carpal tunnel surgery on hands.

Orthopaedic trauma work is unplanned work responding to an emergency. This includes large operations, for example a fractured hip due to a bad fall, as well as more minor trauma such as a broken arm, which may just require plastering.

Our vision is to:

- Ensure patients in need of significant trauma care, following an accident, receive the best possible support from our clinical teams so that they make the best possible recovery. Our proposal is to treat these patients within a best practice, 7 days a week, orthopaedic service. Minor trauma, such as a broken arm requiring plastering, would still be treated in Andover, Winchester and Basingstoke
- Create an elective centre of excellence for large operations such as hip and knee replacements. These types of operations are known as arthroplasty and we would like a national exemplar arthroplasty service. Smaller planned operations, such as day surgery, would still happen in Basingstoke and Winchester.

The map below shows the existing trauma centre provision within the local area:



- Level 3 Trauma Centre (Southampton and Oxford)
- Level 2 Trauma Centre (Salisbury, Swindon, Reading, Frimley, Guildford and Basingstoke)

West Hampshire CCG (WHCCG), North Hampshire CCG (NHCCG) and HHFT seek to inform Southampton Health Overview & Scrutiny Panel (HOSP) on the development of these draft proposals. We are engaging with staff, patients and carers, and key stakeholders to further understand the potential impact of proposed changes and develop options that optimise benefits for patients and provide quality healthcare services.

This report has been provided to:

- Outline draft service proposals for Trauma & Orthopaedic services at Hampshire Hospitals and the wider system.
- Describe the approach to engagement to meet and exceed best practice public involvement and ensure that any proposed service change is in the best interests of our patients and communities.
- Provide assurance about the impact on Southampton University Hospital

2.0 Drivers for change

The key drivers for making changes to the existing configuration of Trauma and Orthopaedics services within Hampshire Hospitals and the wider care system are:

(1) Consultant care; There are now a number of consultants that specialise in different types of complex surgery of bones and joints and we want to ensure our patients are treated by the right consultant for their injury 7 days a week. Consolidating this

specialist workforce across less acute hospital sites increases our ability to ensure our patients have access to the best possible trauma care any day of the week.

(2) Frail elderly population in need of care; our population is growing older and with age comes an increased risk from falls and fractures, which are common forms of orthopaedic trauma. Older people can become more frail and less mobile following an injury and often need intensive rehabilitation to prepare them for home and the best place for this rehabilitation is not a busy hospital ward.

(3) "Getting it Right First Time"; A review of Hampshire Hospitals' trauma and orthopaedics services by Professor Tim Briggs, National Director of Clinical Improvement, highlighted that the number of people who die following hip fracture in Hampshire Hospitals is above the National average. The average mortality following hip fracture at the Hampshire Hospitals was approximately 10% in 2017/8, compared to a National average of 7%.

(4) Waiting times; People waiting for planned operations (such as hip and knee replacement) are waiting longer than we would want, especially during the winter because their operation may be postponed with priority being given to emergency admissions.

Centralisation of trauma and orthopaedic services has been successful in many other Trusts, including Cheltenham and Gloucester, East Kent and the United Lincolnshire Hospitals and is recommended in the NHS Long Term Plan. The principle of centralising some services is already in place for Hampshire for patients in need of cardiology (centralised in Basingstoke) and stroke care (centralised in Winchester).

3.0 Draft Proposals

The NHS Long Term Plan encourages organisations to consider separating urgent and planned care to improve patient outcomes. The transformation of the orthopaedic service is a key part of Hampshire Hospital's clinical strategy and reflects a commitment to provide services that are high quality and sustainable for the future.

To address the drivers for change HHFT have developed the draft proposal below to reconfigure Trauma and Orthopaedic services. It is recognised that this is a complex project and that there are significant interdependencies in relation to wider services and stakeholders. There is a need to establish data, stakeholder mapping and patient outcomes to further develop options for the future delivery of these services, and these are currently in process.

Winchester Hospital Inpatient Trauma undertaken at alternative Acute Hospital site, predominantly Basingstoke and North Hampshire Hospital, and development of Arthroplasty (joint replacement) Centre at Winchester Hospital. This would include:

- Patients requiring inpatient procedures or treatments relating to trauma or non-elective orthopaedic conditions usually admitted to Winchester Hospital would be re-directed to an alternative Acute Hospital that has the right specialist consultant capability and capacity to meet the needs of these patients. A full review of local capacity and service delivery is underway to ensure our patients receive the right care, in the right place, and the right time.
- Capacity at Winchester Hospital from undertaking less emergency operations would be utilised to create a 'centre of excellence' for elective care. The creation of a 'centre of excellence' ensures staff are able to consolidate and develop their skills, creating training and sub-specialism opportunities, and would be a great addition for our local population. The existing space, beds and theatre capacity, would be fully utilised to transfer as many elective arthroplasty (joint surgery) procedures as

possible to this centre. This would ensure routine surgery would be able to proceed as planned during winter months, and aims to improve waiting times and patient experience.

- Day case surgery and overnight stay for elective procedures would continue to be provided on both acute sites, and to a lesser degree in Andover, in line with the clinical strategy of "Local where Possible". Outpatient and pre-operative assessment clinic appointments would also continue to be provided on all sites in line with current services.

Full relocation of all HHFT Hip and Knee Arthroplasty to Winchester Hospital

We are also looking into the opportunities to further expand the centre of excellence at Winchester Hospital to include all major hip and knee procedures. This step change is likely to require additional operating theatre capacity and orthopaedic elective beds. This would require some reconfiguration of other services within HHFT to accommodate this work. Options are being developed to explore these further and would be linked to the wider engagement work underway in relation to these proposals. No concrete decisions have been made at this time so that feedback can be considered in the development of the best options for our patients, carers and staff as well as wider stakeholder groups.

L**ink to Hampshire & IOW STP**

There is a local aspiration to expand services provided in Winchester to incorporate the repatriation of patients currently sent by the NHS to the private sector for treatment as a consequence of the capacity constraints in the system. This is likely to require investment by the wider system in order to develop appropriate outpatient facilities, theatre capacity and beds. Some of this has already been secured following a successful bid to enhance our orthopaedic outpatient services as part of wider STP funding.

4.0 Potential Impact of Service Changes

4.1 Benefits

Improved patient experience and outcomes would be achieved by:

Providing faster access to specialised care delivered in Winchester as a centre of excellence for joint replacement (arthroplasty) which would provide a modernised service and improve both experience and results for patients. It would reduce waiting times for first clinic appointment, reduce waiting times for surgery and reduce the length of stay in hospital following surgery.

Improved onward care that enables elderly patients to age well through the provision of improved specialist care. Dedicated rehabilitation therapy would be available to maximise the opportunities for patients to be discharged back to their normal place of residence by actively mobilising them during the post-operative recovery phase. This would significantly reduce length of stay in hospital and reduce the risk of other complications arising.

Reduced waiting times by protecting and prioritising elective care. The separation of trauma and planned activity would mean patients waiting for planned operations would be much less likely to be postponed, reducing wait times for first clinic appointment, improving referral to treatment times and reducing length of stay in hospital.

Improved outcomes for trauma patients as a result of ensuring our patients are treated by the right specialist consultant for their surgery 7 days a week.

Maintaining patient choice as routine outpatient treatment for minor broken bones would continue in Basingstoke and Winchester Emergency Departments. The majority of patients would be safely discharged home pending a triage phone call, advice from a dedicated senior orthopaedic clinician and/or potential fracture clinic attendance prior to planned surgery if this is required.

4.2 Impact on population

Work is underway to quantify the impact the draft service proposal may have on our local population. This includes;

- A collaborative data analysis between HHFT, CCG and South Coast Ambulance Service (SCAS) to identify; should the Royal Hampshire County Hospital no longer undertake emergency inpatient trauma procedures following the identified need to consolidate our specialist workforce in order to improve outcomes, which site(s) will best meet the needs local people,
- An Equality Impact Assessment to ensure we understand the potential impact of any proposal on people with different protected characteristics and to identify potential mitigating steps to reduce or remove adverse impacts.
- A Quality Impact Assessment to ensure any proposal has a neutral or positive impact on quality.
- Understanding the impact on family and carers; previous service transformation examples have highlighted concerns from the public on travel times and identified this is a key challenge that centralisation of services may bring to visiting family members in hospital. This is acknowledged as one main area of concerns within the proposed service model and we commit to understanding this better and options for minimising any inconvenience to family and carers are being developed.

4.3 Impact on University Hospitals Southampton

A concern has been raised by University Hospitals Southampton NHS FT, that additional trauma patients will be conveyed to Southampton, which is already at capacity for trauma care. The clinical teams across HHFT, UHSFT and SCAS are working together to minimise or eliminate this risk. There are a variety of options.

- SCAS convey all relevant patients to Basingstoke Hospital directly.
- SCAS continue to bring patients to Winchester Hospital and HHFT contract a private ambulance to take the 1-2 patients a day who need inpatient trauma care to Basingstoke from Winchester.
- SCAS convey all relevant patients to the nearest appropriate hospital which will result in 1-2 additional patients being brought to UHS each day. HHFT then repatriate other patients to Winchester in order to provide capacity in Southampton.

These options are being worked through, and there is a clear commitment from HHFT to ensure that these changes benefit patients and do not place unacceptable additional demand on University Hospitals Southampton.

5.0 Engagement

5.1 Pre-Engagement

Initial pre-engagement has focused on work with key partners and staff. This has been prioritised to help develop a broad overview of what the clinical changes could look like and the implications of those changes. A summary of this pre-engagement is shown below.

Date		**Activity**
2017	Aug	Transforming Clinical Services (TCS) undertook pre-consultation research with public a broad range of stakeholders that identified a majority support for the principle of acute service centralisation-
2018	July – Sept	Need for change identified / flagged externally by NHS Improvement's national Getting It Right First Time (GIRFT) programme and the National Hip Fracture Database
	Sept – Dec	Internal agreement that change is required and clinical discussions about service change ideas and options
2019	Jan	Clinical strategy, including trauma and orthopaedics, shared with Health and Adult Social Care Select (Overview and Scrutiny). Committee (*HASC*).
	Jan – Mar	Informal, internal discussions
	Mar	Formal project structure launched
	May	CCG / HHFT joint agreement to work together to re-design trauma & orthopaedic services.
	June	HHFT Board agrees, in principle, to proceed with project. HHFT presentation of high level proposals to Local A&E Delivery Board
	July	High level staff consultation to formalise staff input / feedback
	Aug	Review of progress and plans developed for wider and more formal engagement

5.2 Engagement

The Trust and CCGs have now embarked upon an intensive period of stakeholder engagement that targets specific groups to look at progressing an alternative service model for trauma and orthopaedics.

We would like to implement changes to this service provision as soon as possible to support us through the peak period of winter, and we recognise the need to work collaboratively with our stakeholders to identify if this is feasible.

Our priority for the next two months is to undertake engagement with key stakeholders (with particular reference to the ambulance trust, neighbouring acute and community/mental health trusts and HCC teams) supported by patient experience input from Healthwatch, recent and current patients, carers and other local people.

The effectiveness of engagement will determine the level of public consultation required or demonstrate adequate engagement and support has been secured so consultation is not required.

5.3 Engagement principles and objectives

We will be open, honest and responsive in our communications and engagement activities to support the key test of strengthened patient and public involvement.

The objectives of this communication and engagement plan are to:

- plan and manage the engagement process
- use outcomes to guide any formal consultation
- provide a range of opportunities for stakeholders to give their views, ask questions, raise concerns and make comments
- recognise the different needs and current levels of understanding amongst different audiences and develop communications that are consistent, clear and tailored to their needs
- ensure all feedback gathered is fed into the overall service development
- deliver clear, co-ordinated, consistent and timely communications to all audiences relating to engagement and consultation around potential changes to trauma and orthopaedic services
- ensure any short-term, temporary or interim changes to trauma and orthopaedic services are communicated and the opportunity to provide feedback about those changes is clear so they can be incorporated into the final service development and acted on immediately if necessary (e.g. revert back to the current service model)
- manage media interest throughout the engagement period and beyond, in order to maintain the reputation of all organisations involved and ensure the correct messages are being relayed to the public

5.4 Audiences

Communications, engagement and involvement is planned for the following audiences

Audience	**Aims**
Internal audiences: • Directly affected staff (clinical and non-clinical) • Indirectly affected staff (clinical and non-clinical) • Unaffected / minimally-impacted staff (clinical and non-clinical)	To raise awareness and ensure staff engagement and involvement wherever possible To ensure a consistent understanding of the proposals and the reasons for change To ensure staff know how to get involved and provide feedback about the proposals For staff to be able to provide accurate updates to patients and visitors
Partner and stakeholder organisations (including organisations in neighbouring geographies where relevant)	To ensure the impact on their services is fully understood To enable the service to be developed in a 'whole-system' way To seek support for the final service model To understand / identify any additional key audiences

Audience	Aims
Patients and their families / carers	To gain an understanding of the potential implications and benefits for patients and their families / carers based on their previous patient experience
Local people / general public	To inform and engage the public in relation to service change proposals and enable open and honest dialogue which informs Trust and CCG decision-making
Local media	To ensure local media have a sound background understanding of the proposals and rationale to enable balanced reporting with neutral rather than negative reporting

5.5 Engagement timeline

The summary timeline below outlines the planned engagement programme.

<table>
<tr><th colspan="8">Timeline 1 – Informal Engagement</th></tr>
<tr><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th></tr>
<tr><td colspan="2">Engagement & EQIA completed</td><td>Review engagement feedback</td><td colspan="4">Implement (changes to service made if required)</td><td>Implement final service model</td></tr>
<tr><td colspan="3"></td><td colspan="2">Review and feedback</td><td>Incorporate feedback into long term proposals</td><td></td><td></td></tr>
<tr><td colspan="3"></td><td colspan="4">Local media engagement</td><td></td></tr>
</table>

5.6 Engagement Activities

A summary of engagement activity for key stakeholders is outlined below in **Appendix A**. A more detailed, operational action plan to deliver this activity is being developed.

5.7 Engagement / evidence log

Logs of engagement activity and feedback are being kept to enable the CCGs and Trust to keep track of the views of individual stakeholders and ensure all feedback is considered as the service model is finalised.

6 Timeline & Next Steps

The next two months are critical in terms of developing our understanding of the impact of proposed changes, engaging with patients and stakeholders and developing proposals.

The Hampshire Health and Adult Social Care Select Committee considered the proposed changes at its meeting in September and noted the update and current challenges, and determined that the proposed change was in the interest of the service users affected in particular the positive impact on reducing cancellations of planned orthopaedic operations over the winter. On the basis of this the HASC supported the proposal to test the changes over the coming winter and to receive an further update at its March committee.

The Health Overview and Scrutiny Panel is asked to:

- Review and comment on the outlined draft service proposals for Trauma & Orthopaedic services at Hampshire Hospitals and the wider system.
- Review and comment on the approach to engagement to meet and exceed best practice public involvement and ensure that any proposed service change is in the best interests of our patients and communities.

Appendix A – Engagement Activities External stakeholders

Stakeholder	Approach			Key actions	Lead	Timescale for main engagement
	Engage	Active comms	Keep informed			
HCC HASC	√			Regular attendance at HASC meetings supported by dedicated workshop if desired by HASC	CCG and HHFT	Sept 2019 – Mar 2020
Patients, carers & families		√		Review patient experience feedback of current T&O services (from PALS, complaints, 'Through your eyes' events)	HHFT	Sept 2019
				Actively seek views from current patients using the service (incl knee & hip school and fracture clinics) via survey / focus groups		Sept – Oct 2019 (and throughout phase 1 if applicable)
				Health Focus events		Sept – Oct 2019
				Online survey		Nov 2019 – Feb 2020
				Via Healthwatch, websites, social media, local media		Sept – Nov 2019
Local people / general public		√		Health Focus events	HHFT	Nov 2019 – Feb 2020
				Staffed display / drop-in events with presentations	HHFT and CCG	
				Static displays	CCG	
				Online survey	HHFT and CCG	
				Governors' High Street 'stands'	HHFT	
				Via Healthwatch, website, social media, local media, patient and community groups	CCG and HHFT	
Patient / community groups / voluntary sector		√		Letter(s) with offer of face-to-face meeting and/or attendance at their meetings / events.	CCG and HHFT	Oct 2019 – Feb 2020
Local healthwatch		√		Initial 1:1 briefing to discuss how they want to be involved	HHFT	Sept 2019 – Feb

Stakeholder	Approach			Key actions	Lead	Timescale for
				and how they can assist. Request update to their 2015 patient stories reports		2020
Media / Press		√		Initial 1:1 briefing followed by regular updates Consider recording / interview opportunities	HHFT comms team	Sept 2019 – ongoing
MPs		√		Letter(s) and offer of face-to-face meeting	CCG and HHFT	Sept – Dec 2019
Local CCGs	√			Through existing / agreed reporting and engagement systems	CCG	Ongoing
Neighbouring CCGs	tbc			CCG to agree level of engagement desired	CCG	Sept 2019
SCAS (9s, PTS & 111)	√			1:1 discussions and Board to Board if required	HHFT and CCG	Sept 2019 – Mar 2020
Community / mental health trusts	√					
Neighbouring acute hospitals	√					
HCC (reablement, adult services, care management, continuing health care)	√			1:1 discussions	HHFT and CCG	
Deanery	√			1:1 discussions with senior medical representatives		Sept – Nov 2019
NHSI/NHSE		√		Through existing / agreed reporting and engagement systems	HHFT and CCG	Sept 2019 – Mar 2020
STP / ICS		√			HHFT and CCG	
Clinical Senate		√			HHFT and CCG	
Trauma		√			HHFT	

Stakeholder	Approach			Key actions	Lead	Timescale for
Network						
Primary Care Networks			√		HHFT and CCG	
CQC			√		HHFT	Ongoing
Care Homes			√	Through existing communication methods (eg newsletters, websites, social media, attendance at meetings / events)	HHFT and CCG	
Local Authorities			√		HHFT and CCG	
Professional bodies			√		HHFT	

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		ADULT SOCIAL CARE UPDATE		
DATE OF DECISION:		24 OCTOBER 2019		
JOINT REPORT OF:		SERVICE DIRECTOR, ADULTS, HOUSING AND COMMUNITIES, AND DIRECTOR OF QUALITY AND INTEGRATION (INTERIM DIRECTOR OF ADULT SOCIAL SERVICES)		
CONTACT DETAILS				
AUTHOR:	**Name:**	Paul Juan	**Tel:**	023 8083 2530
	E-mail:	paul.juan@southampton.gov.uk		
Director	**Name:**	Stephanie Ramsey	**Tel:**	023 8029 6941
	E-mail:	stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY
Not applicable
BRIEF SUMMARY
This paper outlines the transformation journey the service is on, including reference to the Peer Challenge findings, the council's proposed investment in staff and quality, the new 'Making Social Care' Partnership Board and the structure and approach of the Improvement Programme. Reflecting the wide remit of the service and to provide context, the service's performance is presented by way of the monthly dataset and the Care Quality Commission local profile for older people. The report briefly references developments relating to the Local Safeguarding Adults Board.

RECOMMENDATIONS:		
	(i)	That the Panel notes the current performance in Adult Social Care and the progress being made towards improving services in line with the findings of the Local Government Association peer challenge.
	(ii)	That the Panel notes the council's response to the Local Authority Data Profile: Older People's Pathway, published by the Care Quality Commission.
	(iii)	That the Panel notes the arrangements in place for the interim Chair of the Local Safeguarding Adults Board and steps being taken to recruit a permanent Chair.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Chair of the Health Overview and Scrutiny Panel has requested an update on these topics.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	Not applicable.

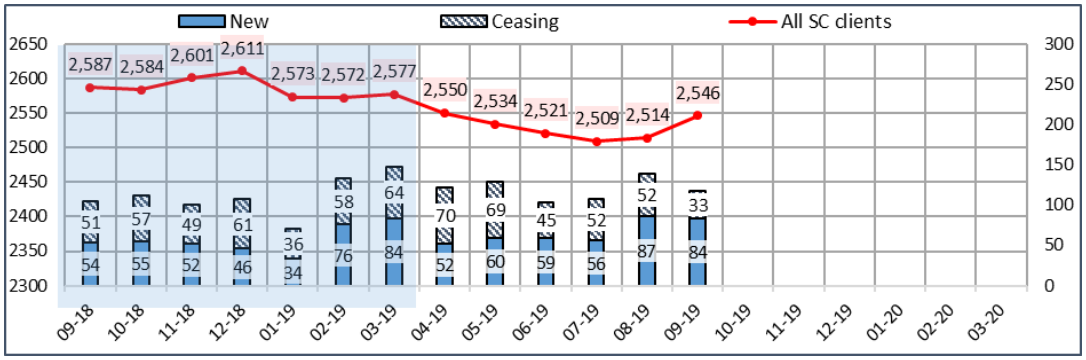
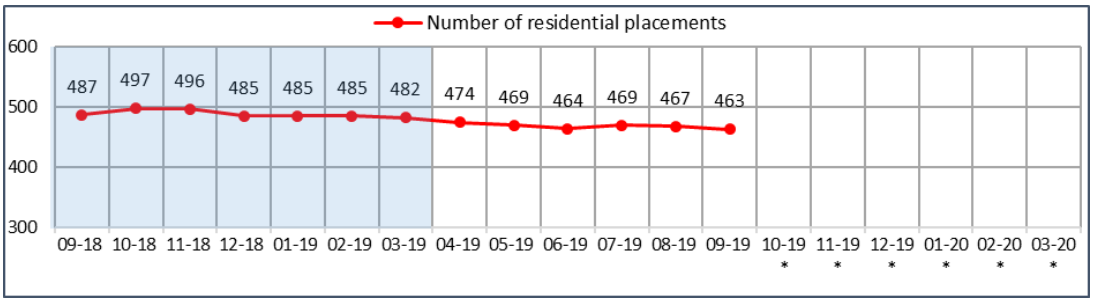
DETAIL (Including consultation carried out)	
LOCAL GOVERNMENT ASSOCIATION PEER CHALLENGE	
3.	The report of the Peer Challenge was finalised on 18 September 2019, has been published on the council's website and is attached at Appendix 1. Paragraphs 4 to 10 below are adapted from the Executive Summary of this report.
4.	The council requested that the Local Government Association undertake an Adult Social Care Peer Challenge at the council and with partners. The work was commissioned by Sandy Hopkins, Chief Executive, and Richard Crouch, Chief Operations Officer. They were seeking an external view on the state of the adult social care service and to use the findings as a marker on their improvement journey. The specific scope was to give a clear base from which to reframe the work of the department, in particular: • Is social work practice in line with delivering within the statutory requirements of the Care Act? • Do we have sufficient capacity and capability within the workforce? • Is the budget set at the correct levels? • Does the council have the right strategy and governance arrangements in place to deliver its adult social care objectives?
5.	It was clear to the peer team from the pre-reading and the conversations they engaged in while onsite in Southampton that senior leaders from across the council, both Members and officers see a significant opportunity to transform the council. They found the adult social care management team to be commendably honest about the position of the service in the self-assessment for this work. Throughout the onsite work there were few things of which they were unaware. If peer challenge is, in part, an assessment of self-awareness it is to their credit that very few things were discussed with them were a surprise. Being in this position makes it easier to improve.
6.	The key changes that need to be made are fully understood by the leadership in that the strategic resources review needs to be agreed and fully implemented. As part of this there will be the appointment of a permanent Director of Adult Social Services (DASS) with statutory responsibility for both commissioning and delivery of adult social care which should ensure that there are clear lines of accountability, responsibility and reporting to Members, partners and staff. This will provide the stability adult social care requires.
7.	Through this process in adult social care it needs to be ensured that there is sufficient leadership and capacity at all levels to deliver the service from the Director of Adult Social Services, through the Assistant Director level, middle and frontline managers. When this structure is put in place, it is recommended that the council considers how to ensure there is a good understanding of social work practice and safeguarding at a senior level, so that when decisions about frontline service delivery are made they are informed by this knowledge, with senior colleagues and Elected Members fully appraised of risk when advice and guidance is given.

8.	The service needs to create a base budget for adult social care based on need and then a strategy to deliver the service within these resources. This understanding of what is required should then be used to negotiate with colleagues both inside and outside the council about what good adult social care delivery looks like. This process should create clarity and confidence for adult social care at all levels. Thus, it should be possible to address the culture of anxiety and the capacity issues that hinder its ability to work really well for people.
9.	Lead Members are dedicated to working with adult social care staff to provide good leadership and direction and it is a positive position to be in that there are good partnership relationships across the City. There are strong relationships with health to deliver integration as well as the good work of the Joint Commissioning Board and the Integrated Commissioning Unit (ICU). The ICU's focus is on transformation and creating system change of which Adult Social Care is a key element.
10.	Senior managers recognise the need to strengthen the approach to communicating the new vision and strategy for Southampton across adult social care and its partners, so that staff are clear about the way forward and how they can play their part in it. In order to contribute to this transformation staff will need more support in managing changing cultures and ways of working.
CORPORATE RESOURCE REVIEW	
11.	As referenced in the findings of the peer challenge, a consultation on a restructure of the council's senior leadership team took place between 13 August 2019 and 26 September 2019. The new structure has been confirmed with a new role of Executive Director, Wellbeing (Adults and Health), which will oversee all elements of adult social care operations and commissioning, in line with the Peer Challenge recommendations. The post holder will be the statutory Director of Adult Social Services and will also oversee public health. The council has advertised this vacancy with a closing date of 4 November 2019 and the Chief Officers Employment Panel is scheduled to meet to consider the appointment during the week commencing 2 December 2019.
MAKING SOCIAL CARE WORK BOARD	
12.	The Peer Challenge identified the need to have a clear strategy for Adult Social care that was understood, shared and implemented by people with care and support needs, staff working in the service, the whole council and wider stakeholders. The reviewers highlighted the need to negotiate with colleagues, both inside and out of the council, about what good service delivery looks like. As a consequence, it was decided to develop the "Making Social Care Work Board" with broad representation to ensure a wide range of experiences, views and opinions. This includes users of the service, carers, community representatives, staff, councillors, GPs and other stakeholders such as providers of health care and home care providers. The Board has an independent Chair. There is a core group who are developing the vision and strategy for adult social care and other people are invited to bring in additional expertise and experience for particular topic areas. Once the strategy is developed the purpose of the Board will be to oversee implementation to

	facilitate ongoing user and carer input into assessing the effectiveness of the services provided and contribute to new developments.
13.	There is a focus on four key aspects, based on national evidence of best practice: • Prevention and early intervention • Maximise recovery and promote independence • Improve quality of life to people with care and support needs • Provide choice and control for people who have care and support needs The strategy won't cover everything that adult social care does but will concentrate the most important things that need to improve.
14.	Priorities for a future effective service that will meet the required outcomes have been identified as: • Communication that works • Better IT systems that talk to each other • Accommodation which is future proof and link to an individual's disabilities • Improved community provision • Personalised care which is tailored to an individual's needs and promotes dignity and respect • Easy and accessible information • Improve public opinion so people value social care more • Care plans which are future focused • Better links between teams and more joined up working • Support and respite for cares when they need it
15.	Work is underway on what "good" social work practice is and how success is best measured. The Board will be reviewing a first draft of the strategy in November and wider consultation will be undertaken once this is further developed. There has been internal and external communication about the work of the Board and key outputs from each meeting are posted on: www.southampton.gov.uk/making-adult-social-care-work This has prompted some interest from other residents in the city.
16.	Communication with the council has been identified as a key challenge. A separate workshop is being held to resolve issues raised and improve practice moving forward.
ADULT SOCIAL CARE IMPROVEMENT PROGRAMME	
17.	At the Peer Challenge feedback meeting, the lead reviewer said, "You are on the right track in delivering a strengths and community based approach; first focus on the basics and provide the right support for this to happen". The Improvement Programme addresses this.
18.	In addition to the Peer Challenge, there have been improvement plans, action plans, initiatives, projects, budget pressures and savings targets across Adult Social Care. Coupled with the complex nature of the service and resourcing constraints there has at times been confusion leading to under delivery of these plans and improvements. Recent reviews and audits have identified the

	strengths of the service in terms of staff engagement and integrated working and where the service needs to focus next on its improvement journey.
19.	The Improvement Programme has been established to address some of these issues by consolidating this activity into an organised and structured programme of work with dedicated resource from the Projects and Change team to ensure its delivery and clear identified benefits. The programme will improve the quality of the service provided as well as improving the customer experience. The programme will also aim to drive financial sustainability by identifying ways of forecasting and managing demand, making processes more efficient and reducing duplication.
20.	Ten projects have been identified and are being developed into project plans to be delivered over the next three years. Work is already underway in several areas and the recent Adult Social Care staff conference has helped shape the projects and the phasing of activities. The workstreams have been defined to ensure that we are addressing 'getting the basics right' as identified by the Peer Challenge: 1. <u>Information and advice</u> • To help people to help themselves in their communities • Early intervention and prevention • Options appraisal and potential improvement/replacement of the Southampton Information Directory (SID) 2. <u>Accessing services</u> • Operating model review and implementation • Ensuring consistency in experience, ensuring high quality wherever people enter the service • Effective triage, reducing handoffs, seamless experience, teams resourced to visit to resolve issues where necessary • Establish assessment capability and operation 3. <u>Assessment and Reviews</u> • Establish an effective review process • Remove the current backlog of reviews • Provide assurance regarding compliance with the Care Act - recording protocol, use of advocacy, communication with individual's carers • Employee competency and skill mix • Timely reviews 4. <u>Safeguarding Adults</u> • Approach to safeguarding has changed to a standard model to reduce duplication and handoffs – review pathway and implement improvements where necessary • Providing assurance about the safeguarding pathway (including data - dashboard showing end to end customer journey, risk and volume at each stage) 5. <u>Personalised Care and Support</u> • Embedding personalisation and strengths-based approaches to practice

	• Business process and practice • Set up and implementation of the Professional Development Academy • Assurance that assessments are high quality • Practice pathway review and implementation as required 6. <u>Simplifying billing</u> • End to end process review and implementation of improvements • Customer journey 7. <u>Customer experience</u> • Reviewing the journey/pathway/communications to carers • Asking the right questions • Getting communication and engagement right • Making sure all the key enablers are in place • Mapping the 'end to end' customer experience • Agreeing the way in which we will work and support people 8. <u>Telecare</u> • Commercial development including marketing • Horizon scanning/product delivery and evaluation • Improving IT infrastructure • Next generation networks (digital) upgrade programme • Training, awareness raising with practitioners 9. <u>Making finance personal</u> • Personal budgets methodology • Direct payments Information, Advice and Guidance service roll out • Improved consistency for service users • Calculating carers personal budget process • Streamlining financial approval processes 10. <u>Southampton Day Services</u> • Making best use of the current day services offer • Developing employment opportunities for people living with disability • Supporting independence and promoting wellbeing
21.	Current activity is focused on the priority areas of Assessments and Reviews, Personalised Care and Support, and Simplifying Billing. In addition, there is a tactical improvement gateway that will ensure that any required improvements to the current client case management system, Paris, are considered appropriately alongside the programme that is implementing the replacement that the council has procured, CareDirector, which will be operational from November 2020. Additional project resource will be joining the Improvement Programme over the next couple of months which will be further supported by the role of Transformation Lead for Adults which is currently being recruited to.
ADULT SOCIAL CARE DEMAND AND PERFORMANCE	
22.	September's Adult Social Care monthly performance dataset is attached at Appendix 2.

23.	*Figure 1*: Number of Adult Social Care clients funded by the council, September 2018 to September 2019 (source: internal database)  There was a steady reduction in the number people supported by the council from a peak of 2,611 in December 2018 to 2,509 in July 2019, but the numbers have since increased.
24.	*Figure 2*: Number of people funded by the council in residential care placements, September 2018 to September 2019 (source: internal database)  The Peer Challenge identified the number of residential placements as an area of focus. Some research carried out separately for the council by the Local Government Association found Southampton to be the 24th highest social care authority in the country for placing older people in residential care, with only six authorities outside of the north of England placing more older people in care homes. The number of these has decreased by 24 over the past year, as people are supported to remain living independently at home or in alternatives, such as extra care housing.
CARE QUALITY COMMISSION – LOCAL AUTHORITY DATA PROFILE	
25.	The Care Quality Commission (CQC) Local Authority Data Profile is attached at Appendix 3 and provides an overview of the older people's pathway. It highlights a number of key features for Southampton.
26.	There are positive CQC ratings for the majority of social care providers in the city. This is in part due to the active work that has been undertaken by the Integrated Commissioning Unit (ICU) Quality Team supporting social care providers in driving up quality standards. Overall Southampton has seen

	130% improvement in CQC ratings and 95% of care home beds are now rated Good. No nursing homes are suspended from taking placements which has significantly reduced out of city placements and ensured best use of better value beds contracted by the council. The development of the Enhanced Health in Care Homes Programme with the Clinical Commissioning Group (CCG) offering dedicated primary care support, case management and leadership, training and policy development support has also improved outcomes.
27.	Southampton has a lower level of nursing home beds in the city, which does impact effective discharges from hospital, especially for individuals with very complex needs. There is work to develop the market further, as outlined in the council and CCG Market Position Statement (2019).
28.	Requests for support from those over 65 years has reduced and there is a reduction in the use of residential care which is positive as it is an indicator of the integrated work to help people remain independent in their own homes and the increased availability of extra care as an alternative.
29.	The lower uptake of Direct Payments has been identified as a key issue for Adult Social Care. A joint task force was set up in October 2018 to support the council to look at ways of improving the delivery and take up of Direct Payments. This has led to a number of recommendations including improved Advice, Information and Guidance, training to the council workforce, access to support planning and brokerage services and to Personal Assistants.
30.	Workforce challenges both within council provided services and the wider social care market. Southampton was chosen to host the South East launch of the 'Every day is different' campaign from the Department of Health and Social Care to try and boost recruitment into the sector. Skills for Care estimates that in Southampton, 7.8% of roles in adult social care are vacant, this equates to around 425 vacancies at any one time, similar to England at 8.0%.
31.	Primary care in the city have now been rated as Good for all practices and the availability of extended access to patients is of great benefit in support to supporting social care providers and keeping people out of hospital. The council is working as part of the health and care system to improve delayed transfers of care as demonstrated by progress against High Impact Change model. This is impacted through the role of the integrated rehabilitation and reablement service; along with reduce hospital admissions and shorter lengths of stay. Less time in a hospital bed does reduce ongoing social care needs. There has been a recent increase in emergency readmissions that is being investigated.
32.	There is active management of the market to try and ensure availability and best value. The average cost figure provided by CQC predates the re-procurement of Southampton's home care framework, which went live on 1 April 2019, and where the new average price is approximately £17 per hour, in line with UK Homecare Association's recommended sustainable funding level for this service type. Southampton's average price is in line with the regional average for residential and nursing care, which is higher than the national average because of the South's relatively higher cost of living.

	Southampton is also subject to particular pressure in relation to average cost of residential and nursing care due to proximity to Hampshire and the county council's substantially higher published rates for these services and the growing market of self-funders residing near the city border.
INDEPENDENT CHAIR OF THE LOCAL SAFEGUARDING ADULTS BOARD	
33.	The previous Chair, Robert Templeton, resigned in the summer in order to pursue an alternative employment opportunity. The council had hoped to make a joint appointment of a new Chair with Hampshire, Portsmouth and the Isle of Wight. This could have been beneficial, as many of the care providers, health, police and ambulance etc. are shared across the four areas. There is already a well-developed regional approach to adult safeguarding policy etc. which helps to ensure consistency and resilience. However, it was not possible to progress with a joint appointment, as not all authorities were in agreement, so the Local Safeguarding Adults Board Executive (comprising the council, police and health) has proceeded to advertise the role. Interviews are scheduled for 4 November 2019, with a view to the Chair being in post in time for the December Board meeting.
34.	The Chief Officer of Choices Advocacy, Judith Clayton, a member of the Board, will act as Interim Chair in order to maintain the independence of the role pending recruitment to the permanent position.
RESOURCE IMPLICATIONS	
Capital/Revenue	
35.	Subject to approval by Cabinet on 15 October 2019, the council will consult on a draft three year budget for 2020/21 to 2022/23, which will enable the recommendations made in the Peer Challenge to be addressed, by investing an extra £9.9M to employ extra social work staff and to make sure that the budget is set at a level that will meet rising costs and demand.
36.	This includes over half a million pounds a year to pay for extra social work staff, which will relieve pressure on frontline staff and managers and enable social workers to carry out timely and high-quality assessments. In addition, the proposals include employing an extra eight social workers and independence advisors for a year, to catch up with a backlog of reviews, which will help to make sure that people's social care needs are being met in the best way for them.
37.	The net investment of £9.9M over three years comprises an investment of £14M for extra staff and to meet rising costs and demand, and savings of £4.1M, which can be achieved by supporting people to be independent, to live at home safely and to make full use of support that is available from the council, the NHS and the community. In 2020/21, savings of £1.7M are proposed, by making best use of the extra staff to promote wellbeing and support people to live independently wherever possible.
Property/Other	
38.	No implications.
LEGAL IMPLICATIONS	

Statutory power to undertake proposals in the report:	
39.	Not applicable.
Other Legal Implications:	
40.	Not applicable.
RISK MANAGEMENT IMPLICATIONS	
41.	The approach to addressing the recommendations made in the Peer Challenge outlined in this paper, including through the Making Social Care Work Board and Adult Social Care Improvement Programme, will help to mitigate legal, financial and reputational risks.
POLICY FRAMEWORK IMPLICATIONS	
42.	This supports the council's objective of supporting people to live safe, healthy, independent lives and the council's priority to improve wellbeing as part of its 2025 investment programme.

KEY DECISION?	**~~Yes~~/No**
WARDS/COMMUNITIES AFFECTED:	**Not applicable.**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Adult Social Care Peer Challenge Report
2.	September Adult Social Care Monthly Performance Dataset
3.	Care Quality Commission Adult Social Care Profile – Older People's Pathway – Southampton

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?	**~~Yes~~/No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	**~~Yes~~/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	

Southampton City Council
Adult Social Care
Peer Challenge Report

May 2019

Final

Table of contents

Executive Summary

Southampton City Council (SCC) requested that the Local Government Association undertake an Adult Social Care Peer Challenge at the Council and with partners. The work was commissioned by Sandy Hopkins the Chief Executive and Richard Crouch, Chief Operating Officer at Southampton City Council. They were seeking an external view on the state of the adult social care service, which form of the Adults, Housing and Communities Department at Southampton City Council and intend to use the findings of this peer challenge as a marker on their improvement journey. The specific scope was to give a really clear base from which to reframe the work of the department, in particular:

- Is social work practice in line with delivering within the statutory requirements of the Care Act?
- Do we have sufficient capacity and capability within the workforce?
- Is the budget set at the correct levels?
- Does the council have the right strategy and governance arrangements in place to deliver its adult social care objectives?

It was clear to the peer team from the pre-reading and the conversations we engaged in whilst onsite in Southampton that senior leaders from across the Council, both members and officers see a significant opportunity to transform the Council. The adult social care management team were commendably honest about the position of the service in the self-assessment for this work. Throughout the onsite work there were few things of which they were unaware. If peer challenge is, in part, an assessment of self-awareness it is to their credit that very few things we discussed with them were a surprise. Being in this position makes it easier to improve.

The key changes that need to be made at SCC are fully understood by the leadership in that the strategic resources review needs to be agreed and fully implemented. As part of this there will be the appointment of a permanent Director of Adult Social Services (DASS) with statutory responsibility for both commissioning and delivery of adult social care which should ensure that there are clear lines of accountability, responsibility and reporting to members, partners and staff. This will provide the stability adult social care requires.

Through this process in adult social care it needs to be ensured that there is sufficient leadership and capacity at all levels to deliver the service from the DASS, through the Assistant Director level, middle and frontline managers. When this structure is put in place, consider how to ensure there is a good understanding of social work practice and safeguarding at a senior level. So that when decisions about frontline service delivery are made they are informed by this knowledge, with senior colleagues and Elected Members fully appraised of risk when advice and guidance is given.

The service needs to create a base budget for adult social care based on need and then a strategy to deliver the service within these resources. Then use this understanding of what is required to negotiate with colleagues both inside and outside SCC about what good adult social care delivery looks like. This process should create clarity and confidence for adult social care at all levels. Thus it should be possible to address the culture of anxiety and the capacity issues that presently bedevil the service and hinder its ability to work really well for people.

New lead members are dedicated to working with adult social care staff to provide good leadership and direction and it is a positive position to be in that there are good partnership relationships across the City. There are strong relationships with health to deliver integration as well as the good work of the Joint Commissioning Board and the Integrated Commissioning Unit. The ICU's focus is on transformation and creating system change of which Adult Social Care is a key element.

Senior managers recognise the need to strengthen the approach to communicating the new vision and strategy for Southampton across adult social care and its partners, so that staff are clear about the way forward and how they can play their part in it. In order to contribute to this transformation staff will need more support in managing changing cultures and ways of working. The details of these and other issues are outlined and discussed in the body of the report.

Report
Background

1. Southampton City Council (SCC) requested that the Local Government Association undertake an Adult Social Care Peer Challenge at the Council and with partners. The work was commissioned by Sandy Hopkins the Chief Executive and Richard Crouch, Chief Operating Officer at Southampton City Council. They were seeking an external view on the state of the adult social care service, which form of the Adults, Housing and Communities Department at Southampton City Council and intend to use the findings of this peer challenge as a marker on their improvement journey. The specific scope was to give a really clear base from which to reframe the work of the department, in particular:

Scope	Key areas of focus
Is social work practice in line with delivering within the statutory requirements of the Care Act?	Outcomes for people Service delivery & effective practice
Do we have sufficient capacity and capability within the workforce?	Resource & workforce management
Is the budget set at the correct levels?	Resource & workforce management
Does the council have the right strategy and governance arrangements in place to deliver its adult social care objectives?	Vision, strategy & leadership

2. A peer challenge is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer challenge is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends' with no surprises. All information was collected on a non-attributable basis in order to promote an open and honest dialogue.

3. The benchmark for this peer challenge was the Adult Social Care Key Areas of Focus Tool (Appendix 1). Prior to the peer challenge exercise SCC completed a self-assessment to give the peer challenge team a view with which to compare what they read, heard and saw whilst onsite.

4. The members of the peer challenge team were:

- **Moira Wilson**, Care and Health Improvement Adviser, Yorkshire and the Humber, Local Government Association
- **Amy Cross**, Executive Member for Reducing Health Inequalities and Adult Safeguarding, Blackpool Borough Council
- **Jamaila Tausif**, Associate Director of Commissioning, NHS South Cheshire CCG & NHS Vale Royal CCG
- **Scott Woodhouse**, Strategic Commissioning Manager, Adults, North Tyneside Council
- **Grace Hanley**, Assistant Director Health and Social Care, Brighton and Hove City Council
- **Michaela Pinchard**, Independent Adult Social Care Consultant
- **Marcus Coulson**, Challenge Manager, LGA

5. The team were on-site from 14th – 17th May 2019. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

    - interviews and discussions with councillors, officers and partners
    - focus groups with managers, practitioners, frontline staff and people using services and carers
    - reading documents provided by the Council, including an independent case file audit and a self-assessment of areas of strength and challenges
    - taking into account the report of an in-depth finance review completed in advance by the Local Government Association's Care and Health Improvement Adviser for Finance and Risks

6. The peer challenge team would like to thank councillors, staff, people who use services, carers, partners and providers for their open and constructive responses during the challenge process. All information was collected on a non-attributable basis. The team was made very welcome and would in particular like to thank Sharon Stewart, Adult Social Care Service Lead and Nash Gwaze, Executive Personal Assistant at Southampton City Council for their invaluable assistance for the onsite support to the team in planning and undertaking this peer challenge which was well organised and administered.

7. Prior to being on-site the team considered eighty-nine documents including a self-assessment. Whilst on-site the team had forty-two meetings with at least seventy-three different people. The peer challenge team have spent about 336 hours with Southampton City Council and its documentation, the equivalent of 42 working days.

8. Our feedback to the Council on the last day of the challenge gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the peer challenge.

Context

9. To understand the present context that Southampton City Council Adult Social Care finds itself in it is important to realise the recent history of the organisation. In January 2019 Sandy Hopkins took up the post of Chief Executive and is bringing stability to the organisation after a period of change, that change included an interim Chief Executive and over the past five years five Directors of Adult Social Services.

10. Ms Hopkins has instigated a review of strategic resources that will include a revised strategic management structure with altered responsibilities and reporting lines. As well as the new Chief Executive the peer team spoke with a wide variety of people at all levels in the organisation who expressed a desire to improve the Council as well as the delivery of services in adult social care.

11. The relationships between partners across the City appears to be good and this is evidenced through some effective integrated working. The partnership landscape across the City will change further and there is an opportunity for the new Chief Executives at Southampton City Council, University Hospitals Southampton Foundation Trust and a change in leadership at Southampton Clinical Commissioning Group to forge yet stronger ties between themselves and with other key partners in the City such as the wider business community. To drive this there is recognition of the need for SCC to be more outward facing.

12. Within adult social care it was clear that staff and councillors are committed to those they serve and work hard to deliver positive outcomes for them. This is despite the capacity issues the department is experiencing. As with all adults services across the country significant cuts in funding have required a reduction in the number of staff. This has got to a point in Southampton where in essence there appear to be too few staff to deal with the demands to deliver a safe, effective service. Several groups of staff are experiencing severe stressors due to high workloads with fewer colleagues to complete tasks yet with still the same desire to do a good job. The changes in the department have not been restricted to frontline staff but also includes senior management. The present leadership is split between an operational lead and a commissioning lead, both of whom report to a Chief Operating Officer. This results in some people both within the organisation and outside being unclear how the responsibilities for different aspects of adult social care business are allocated and unsure of to whom to speak to about issues, this may also create risk in decision-making. The individuals in these posts, however, take responsibility and work hard to try to reduce any apparent confusion and manage the inherent risks involved.

13. Added to the issue of limited capacity is that of culture. The present tone of the culture, within the adult social care department is one of anxiety. This inhibits staff decision-making and their ability to prioritise, leading to accounts of anxiety and exhaustion. The positive response by a number of staff at the frontline and at team manager level was impressive as they have organised themselves into peer support groups to protect themselves and their well-being. This needs to change for the better.

Key Messages

- Agree and implement the strategic resources review
- Appoint a permanent DASS and ensure there are clear lines of accountability, responsibility and reporting to members, partners and staff
- In adult social care ensure there is sufficient leadership and capacity at all levels to deliver the service
- Consider how to ensure understanding of social work practice and safeguarding is represented at a senior level
- Create a base budget for ASC based on need and then a strategy to deliver the service within these resources
- Use this understanding of what is required deliver the ASC service to negotiate with colleagues both inside and outside SCC about what good service delivery looks like
- You are doing some really good work in the:
    - Senior Practitioner Support Group
    - Extra Care Housing
    - Community Independence Service
    - Integrated Commissioning Unit
    - Integrated Discharge Bureau
    - Joint Commissioning Board
    - Joined up Better Care Fund
    - Total Integration Case Study
    - Support and engagement from key partners
- But you need to focus on the basics in a caring manner:
    - Information & advice for people to help themselves in their communities
    - How people access services
    - Person centred needs assessment
    - Managing risk
    - Delivering personalised care and support plans
- Workforce capacity is an issue across adult social care resulting in delays in response times, multiple hand-offs and increasing pressure on frontline staff and managers for example at the Front door and the Social Wellbeing Teams.

15. The key changes that need to be made at SCC are fully understood by the leadership in that the strategic resources review needs to be agreed and fully implemented. As part of this there will be the appointment of a permanent Director of Adult Social Services with statutory responsibility for both

commissioning and delivery of adult social care which should ensure that there are clear lines of accountability, responsibility and reporting to members, partners and staff. This will provide the stability adult social care requires.

16. Through this process in adult social care it needs to be ensured that there is sufficient leadership and capacity at all levels to deliver the service from the DASS, through the Assistant Director level, middle and frontline managers. When this structure is put in place, consider how to ensure there is a good understanding of social work practice and safeguarding at a senior level. This should ensure that when decisions about frontline service delivery are made they are informed by this knowledge, with senior colleagues and Elected Members fully appraised of risk when advice and guidance is given.

17. The service needs to create a base budget for adult social care based on need and then a strategy to deliver the service within these resources. Then use this understanding of what is required to negotiate with colleagues both inside and outside SCC about what good adult social care delivery looks like. This process should create clarity and confidence for adult social care at all levels. Thus it should be possible to address the culture of anxiety and the capacity issues that presently bedevil the service and hinder its ability to work really well for people.

18. The peer team had the privilege to hear about some really good work in the:

    a. Senior Practitioner Support Group, enabling staff to work effectively across adult social care.

    b. Extra Care Housing is part of the Adult Social Care priorities for 2019/20 and the service the peer team visited at Erskine House provides a positive and effective offer for its residents.

    c. The Community Independence Service, is an integrated team with Solent NHS Trust, the community health provider, with social work practitioners and occupational therapists working as three locality teams aligned to Better Care clusters, delivering assessment and a reablement plan, supporting people with long term care and support arrangements in straightforward cases where goals cannot be reached with reablement and an individual's own strengths and networks. This service is an exemplar of integration and rated outstanding. Those who use the service are satisfied with the service, saying that it helps them regain independence, that staff listen to them and that they feel safer following support.

    d. The development of an Integrated Commissioning Unit (ICU) in 2014 demonstrates a joint commitment to further strengthening integration with arrangements underpinned by Section 75 and Section 113 agreements and relevant governance and delegation. This includes a shared ambition for change. The ICU covers commissioning for Adults, Children and Public Health in the Council and a large element of the CCG budget. The ICU as an integrated commissioning team, is integral to delivering the City's Health and Care Strategy and has supported significant change across the City. The quality team within the ICU has a specific focus on improving quality in commissioned services and managing safeguarding concerns. The team is a mix of health and social care practitioners with differing areas of expertise. They support care homes and home care providers

through a range of activities including quality assurance visits, review of local intelligence and quality data, providing access to training and support through the Learning and Development VIP programme, providing bespoke training and facilitating access to specialists such as medicines management pharmacists, infection prevention and control and clinical nursing practice.

e. The Integrated Discharge Bureau includes the Complex Care and Hospital Discharge Team who support people to be discharged safely from an acute or community hospital, with a focus on delivering the enhanced discharge pathway.

f. The Joint Commissioning Board acts as a single health and wellbeing commissioning body for the City of Southampton with members having delegated authority to make decisions. The City's Joint Commissioning Board allows for integrated governance arrangements. The Board is comprised of Council Cabinet Members and members of the Southampton Clinical Commissioning Group Governing Body, enabling truly joined up decisions to be made.

g. The Joined up Better Care Fund. There is oversight of the Better Care Programme and the associated pooled resources from both the CCG and Local Authority to support the delivery of the Better Care Programme. In 2018/19 this totalled £111.5M (£74.5m from the CCG and £37m from the Council), making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement of £16.177m, which demonstrates its commitment to integrating health and social care at scale. The closer working has delivered progress in reducing Delayed Transfers of Care (DToC). The data to February 2019 shows a reduction in the overall rate of DToC (as a percentage of total available occupied bed nights) over the last 3 years, although the national target of 3.5% is not being achieved.

h. Total Integration Case Study: Southampton (under the banner of Better Care Southampton) are one of the 5 case studies featured in the 2017 SCIE Report 'Integration 2020: Scoping research Report to the Department of Health'. The report presents findings from a programme of scoping research and engagement to better understand what excellent integrated health and social care should look like in 2020; to test out the Integration Standard with national stakeholders and local areas; and to provide feedback and support for further development of the standard.

i. Support and engagement from key partners within the Council, with wider health commissioners and providers, and with voluntary and community sector partners.

19. Whilst there are areas adult social care does well it is recognised that there needs to be a focus on the basics of service delivery in a caring manner in such areas as:

    a. Information & advice for people to help themselves in their communities

    b. How people access services

c. Person centred needs assessment
d. Managing risk
e. Delivering personalised care and support plans

20. Adult social care senior staff are aware that workforce capacity is an issue that results in delays in response times, multiple hand-offs and increasing pressure on frontline staff and managers. There were significant examples of these pressures in the work at the Front door and with the Social Wellbeing Teams that the peer team spoke with.

21. There is also the well-known issue of the culture of the department that is probably also present in other areas of the Council. Staff report that the culture is infused with anxiety as everything is a priority and must be completed to a high degree of accuracy even though there have been significant cuts to the number of posts. A smaller number of clearer priorities, with other things de-prioritised and an increase in capacity would remedy these issues. To achieve this the department needs clear and consistent leadership that sends and reinforces these messages over a period of time so that staff will believe them and see the differences.

Political recommendations

22. For the politicians who lead Southampton City Council, and in light of the issues adult social care is working with in terms of capacity and workforce, it is key for all members to understand the pressures that staff experience between fulfilling their role as advocates for the community and also acting as a gatekeeper to the diminishing resources that are available.

23. It would be useful to decide on 2 or 3 political priorities that all strategies can work towards to give clear direction to the officer group to achieve. This gives clear political leadership and a message that is recognised by residents. This allows for clear decision making criteria for offices to follow. All strategies and major policy decisions can be checked against these priorities. If residents understand the message from political leaders they are more likely to understand what the Council is trying to achieve. Examples of priorities are usually, i) To grow the local economy and support existing businesses, and, ii). To improve the lives of people, living, working and visiting the City.

24. Consider how to brief the portfolio holder and other members using options appraisals in a timely way that allows for debate, policy development and the management of risk. This would promote the development of political understanding and discourse about adult social care and the challenges it faces.

25. Adult social care should implement a system for managing member enquires to ensure there is a timely and appropriate response to queries and clear lines of responsibility for requests and replies.

26. The Council may wish to revisit the issue of all out elections to provide certainty for staff and continuity of political leadership for elected members.

27. It would be possible to seek to use the Overview and Scrutiny function more effectively for the development of policy, inform decision-making, scrutinise key aspects of adult social care delivery and help cross party working through the use of pre-decision scrutiny.

28. Use informal Cabinet to have policy discussions and support Cabinet Members in decision-making.

29. Consider the offer of political support and development opportunities for all members, such as attendance at the National Children's and Adult Conference (https://www.local.gov.uk/NCASC-2019) and the LGAs member development programmes the webpage for which can be found here: https://www.local.gov.uk/our-support/highlighting-political-leadership

    Other LGA Member Development Programmes are:

    - The Leader's Programme: https://www.local.gov.uk/our-support/highlighting-political-leadership/lga-leadership-development-leaders-programme
    - Next Generation: https://www.local.gov.uk/our-support/highlighting-political-leadership/next-generation
    - Leadership Essentials Programmes: https://www.local.gov.uk/our-support/highlighting-political-leadership/leadership-essentials

30. Training for all Cabinet Members should include further developing a more in-depth understanding of the budget and how to influence the budget setting process as it progresses each year.

Outcomes for people to improve independence and wellbeing

31. It was clear to the peer challenge team that partners respect adult social care delivery teams, have good relationships with them and there are some good integrated working arrangements in place. For example the Community Independence Service, the Integrated Learning Disability Team and the good links with the CCG and the Accident and Emergency Delivery Board. The respect of staff working together in the Urgent Response and Community Independence Service had for each other and their respective roles was evident in their dedication and commitment towards achieving the best outcomes for people using the service. Successes described included; the transfer of health and social care pathways into a single pathway, multi-disciplinary working with staff upskilling in each other's areas and reducing unnecessary referrals and hand offs.

32. There is a clear understanding of Deprivation of Liberty Safeguards (DoLS) risk within the Council both at the strategic and operational levels and a good audit tool to manage the risk. A potential development to consider would be to highlight this on the Corporate Risk Register so it can be manged further.

33. The Shared Lives Service is delivering really good outcomes. In addition there are two residential care homes, with a total of 67 beds and it is these services that are rated as "Good" by the Care Quality Commission.

34. Adult social care senior managers recognise that co-production with people who use services and family carers' needs to take place. The medium term adult social care strategy has a commitment to the co-production of a longer term strategy and the department is learning from the way that it approaches decisions to close services such as residential care. A care service for people living with a learning disability has also highlighted the need for a genuine co-production approach. It is proposed to establish a "Making Social Care Work" Board with broad representation, including people with lived experience, to oversee this process. There was also good evidence of this within the Extra Care Service redesign. The peer team recognise that the service is self-aware and has a clear desire to learn.

35. The commissioners of the Learning Disability Service are working with operational staff to change the offer. The joint appointment with the CCG of an Integrated Service Manager for Learning Disability in November 2018, has brought much needed additional senior leadership capacity and has enabled a clear focus on practice and service improvements. There is significant service user involvement in the Learning Disability Partnership Board and Carers of people with learning disabilities were consulted as part of the Learning Disability Market Position Statement. Action is planned as a result of their feedback. The Choices Advocacy survey and focus group of service users with learning

disability collected information on their views and stakeholder meetings have also been held with voluntary organisations and carers of people with learning disability.

36. There is a new social work manager in place to support social work supervision with the mental health teams. This is adding capacity and oversight through effective supervision which in turn is leading to better case management and team support. It is likely that it will also reduce staff absence and sickness rates.

37. You recognise there is more work to be done on complaints and compliments. You recognise that learning from complaints will help you to improve outcomes for those who access services and you also recognise that feedback from users and carers needs to be collected and then used to inform strategy and change service delivery.

38. During the past twelve months changes had taken place in the safeguarding service. This involved a move from a central specialist safeguarding team to a front door triage system at Social Care Connect, the relocation of safeguarding social work staff to the local social wellbeing teams, and retaining a central quality assurance hub.

39. The Quality Assurance Team are working well with care providers on safeguarding issues. The Quality Assurance Team (part of the Integrated Commissioning Unit) have a proactive approach to working with and alongside care providers. This can be through the open and trusting relationship they have already or by responding to safeguarding or quality issues brought to the attention of the team. This approach has seen an overall improvement in the quality of provision and ratings by CQC over the last five years.

40. The peer team considered that the new safeguarding system was not fully embedded as it was difficult for managers to have a joined up view of the whole safeguarding system, and backlogs were reported at different stages. We advise that you undertake a joint review of the safeguarding pathway with partners and quality assurance system to report to the Safeguarding Adults Board, to include:
    a. the timeliness of assessments on customer safeguarding pathway
    b. managing risk and the allocation of cases
    c. quality assurance of case flow in real time

41. It is also important reconsider how to ensure a line of sight between operational social workers doing safeguarding and the Southampton Safeguarding Adults Board. Under the Care Act the SAB has a key role in holding all partners to account for the effectiveness of safeguarding arrangements. As part of the review of the safeguarding pathway the Council with its partners should consider how best to ensure there is a line of sight on safeguarding practice to the SAB.

42. The peer team suggest the department look at the capacity for operational and commissioning staff to work even more closely together. At present there is a desire from both sides to communicate on commissioning intentions and the operational issues that inform them. However this intent is sometimes

scuppered by a lack of capacity for operational staff to be able to respond in a timely manner.

43. Adult social care recognises that there is insufficient capacity to carry out timely social care assessments and reviews (including those required to support service transformation) and similarly there is the awareness of the need to assure yourselves of the status and workflow of reviews and assessments across all service areas.

44. Address the capacity issues in the MCA/DoLS team and provide training on Mental Capacity Act/DoLS and assurance and monitor it through supervision. Consider a further audit to complement the two completed in 2017 and 2018 to check on progress, manage risk and ensure that senior adult social care management and the portfolio holder are advised of the potential risk of community DoLS risk. Following the case audit that was completed in 2018 it states that there were 61 uncompleted assessments, however the staff involved suggested they had over 300.

Vision, Strategy and Leadership

45. It was clear to the peer team from the pre-reading and the conversations we engaged in whilst onsite in Southampton that senior leaders from across the Council, both members and officers see a significant opportunity to transform the Council. That would involve, in part, addressing the capacity and cultural issues prevalent in adult social care.

46. The Adult Social Care and Integrated Commissioning Unit Leadership Team were commendably honest about the position of the service in the self-assessment for this work. It was interesting to note that throughout the onsite work in the peer team's developing understanding of the department and in our ongoing discussions with them there were few things of which they were unaware. If peer challenge is, in part, an assessment of self-awareness it is to their credit that very few things we discussed with them were a surprise. Being in this position makes it easier to improve.

47. New lead members are dedicated to working with adult social care staff to provide good leadership and direction and it is a positive position to be in that there are good partnership relationships across the City. Examples the peer team heard about where that Better Care Southampton gives a clear strategy for the next five years developing integrated services and the Southampton Place is recognised in the Hampshire and the Isle of Wight Sustainability and Transformation Partnership plan.

48. There are strong relationships with health to deliver integration as well as the good work of the Joint Commissioning Board and the Integrated Commissioning Unit.

49. Senior managers recognise the need to strengthen the approach to communicating the new vision and strategy for Southampton across adult social care and its partners, so that staff are clear about the way forward and how they can play their part in it. In order to contribute to this transformation staff will need more support in managing changing cultures and ways of working.

Working together

50. The corporate policy and projects management functions provide much needed capacity to deal with change. They can add value and be useful enablers of transformation in adult social care. The challenge for the department is for adult social care to find the capacity to engage and respond to requests in a timely and effective way.

51. There are good working relationships between operational and commissioning teams and between commissioning and Home Care providers and voluntary and community sector colleagues who are seen as equal partners. The Joint Commissioning Board works well, in part, due to the high levels of trust in place to develop joint commissioning arrangements, also SCC and CCG work well together in the pooling of budgets. In 2018/19 this totalled £111.5M (£74.5M from the CCG and £37M from the Council), making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which is £16.177M, and demonstrating its commitment to integrating health and social care at scale.

52. The peer team saw some good integrated services and front line teams working together. Examples were the Total Integration Team, the Learning Disability Team and the Community Independence Service.

53. The work on Transitions with Children's Services department is an example of good joint working, thoughtful training and development and engagement with young people and their families. Transition to Adulthood pathways have been developed by health and social care staff working together and in partnership with stakeholders. A guidance document has been developed as a collaborative piece of work and there have been implementation workshops for front line staff.

54. Whilst onsite in Southampton the peer team had the privilege of meeting with frontline staff from adult social care and health and their managers from a range of settings across the City. As a group they came across as resilient, hard-working and thoughtful with a clearly stated desire to deliver positive outcomes for the people who used the services as well as the carers of those people. It was typical that they were able to identify opportunities to improve their services which is a very positive position for the service to build on.

55. Better Care Southampton gives a clear direction for health and care over the next five years. It could consider how to engage and communicate this to public and staff so that teams feel greater ownership and understand how it fits into the day-to-day business of their teams.

56. The department may wish to consider how to provide effective and timely feedback to internal and external stakeholders about what is happening and ensure learning is put in practice with regards to areas such as the complaints procedures and safeguarding. There was evidence to suggest that different people involved in these areas did not always feel as well informed as they would like.

57. As has been mentioned previously there needs to be a more effective level of communication with staff on a range of issues. This could be widened to include

teams involved important service developments such as the insight and intelligence teams.

Resource and Workforce Management

58. The recruitment of the new Principal Social Worker is seen by all as a welcome development. Members of the peer team met with the person concerned and were impressed by her understanding of the challenges, her ideas and approaches to address them. The note of caution we would like to sound is that given the current context, the post holder will need to be properly supported by the organisation and her colleagues to ensure that any improvements are sustained and effective.

59. Southampton's new Chief Executive is supportive of staff and their Continuing Professional Development and their personal learning through investment in people to achieve organisational learning. This welcome focus should seek to play its part in bringing the present culture to a positive place for staff as well as those who use services.

60. The adult social care department at Southampton appears to this peer team to have somewhat lost its focus on delivering its core business well due to competing priorities and capacity issues over the recent past and is now seeking to recover its position and focus. The commissioning of this peer challenge is an example of that intent to improve. The peer team heard about a strong network of peer support that adult social care staff use to maintain their wellbeing and we suspect the prevalence of this approach is, in part, due to a perceived absence of care by the department for its staff. There is also a growing recognition in the service of the need to change current practice that is seen by some as old fashioned and traditional, towards an approach which is focussed on delivering personalised care and support which helps people to maintain their independence and community networks.

61. The senior managers in adult social care are aware that there is a lack of staff capacity in the service to do the job well, which is a legacy of the recent cuts. This was further highlighted by the recent report from John Jackson the Local Government Association, Care and Health Improvement Adviser for Finance and Risks. You are also aware that funding some social worker posts from the temporary IBCF monies is a short term measure. Therefore you know you need to address the issue through the recruitment of social work staff to move towards your comparator average of 2.6 adult social care workers per 1000 65+ population and further develop support to retain the current workforce.

62. Related to the above point the service needs to make sure there is an appropriate level of investment in staff training and development so that staff report they feel guided and supported by the organisation so they can do their work well. With this in mind there need to be clear systems and management oversight to ensure consistency on a range of issues such as staff attendance, supervision and Personal Development Reviews.

63. The experienced staff in the department work hard to guide and support their newly qualified colleagues and there is significant good will towards their work and colleagues.

64. The peer team heard about the introduction of a new information technology system for adult social care. Along with the understanding of the need for

genuine co-production with those who use services and their carers it is an opportunity for the department to involve operational teams in the scope, design and delivery of this new system so they feel involved and listened to.

65. Review the current panel process to ensure good outcomes for people and that decision-making is as close to the customer as possible and enables greater budget control. All care package funding at present needs to be agreed by a panel which is an administrative burden and difficult to manage. Adult social care should seek to move to a system of delegated responsibility where staff have greater scope and flexibility to agree packages at team leader, team manager and service manager levels. The aim would be to give staff greater ownership for the funding and ensuring that it is more aligned to the outcomes to be achieved by the client.

66. In the recent report by John Jackson the LGA CHIA the comment was made that “Your Market Position Statements contain some useful information but there is more work to be done”, the peer team concur with this statement.

Service delivery & effective practice

67. The Public Health function at Southampton City Council are engaged with the prevention agenda and are clear how they can contribute to the priorities of the Council as a whole and the adult social care department.

68. The teams that are integrated with health are making good progress delivering positive outcomes for people and there is a desire by staff to get it right. This was the case with the Community Independence Service (CIS) which is an integrated team with Solent NHS Trust, the community health provider, with social work practitioners and occupational therapists working as three locality teams aligned to Better Care clusters, delivering assessment and a reablement plan, supporting people with long term care and support arrangements in straightforward cases where goals cannot be reached with reablement and an individual’s own strengths and networks. The Urgent Response Service has an Outstanding Care Quality Commission rating and is an example of successful integration and investment with health and social care teams working together as one to deliver a seamless service.

69. There has been an improvement in the quality of CQC rating of both internal and commissioned services. The focus over the last 18 months for the quality assurance meeting has been on ensuring the CQC regulated services (Kentish Road, Shared Lives, Urgent Response Service, Glen Lee and Holcroft) meet the requirements of registration. Extensive action plans have been in place particularly in relation to Kentish Road, Glen Lee and Holcroft to support them in achieving a rating of good when inspected by the CQC. Current ratings are good for all services with the Urgent Response Service rated outstanding.

70. The Extra Care housing at Erskine Court that builds on the success of the earlier pilot at Manston Court, is a great service with resident led groups and activities.

71. The peer team agree with the recent staff conference work held with expert speakers, including Lyn Romeo, the Chief Social Worker for Adults. This focused work with the Learning Disability Team to reduce workloads, investing in senior social workers' development and is appointing champions for key areas such as safeguarding and mental capacity.

72. During the self-assessment phase for this work senior adult social care leaders initiated a number of staff focus groups to hear about the staff experience of working for SCC and better understand the challenges faced, this itself is commendable. The list of issues that staff felt needed to be addressed included: better communication, a lack of staff and resources leading to a reactive, crisis management approach rather than preventative work, the service being reliant on staff working extra hours, long waiting lists of cases to be assessed and receive services, a lack of clarity of what the service's overall strategy is, variability in access to training and the need for effective support from information technology, administrative support and the human resources function to deliver their roles. The peer team endorses the intention to deal with these issues to further enable staff to be more able to deliver good services.

73. As you move to focusing on fewer key priorities consider how the Target Operating Model works to achieve these objectives and manages risk. You state in your self-assessment that the target operating model was designed to support the transition from a traditional, care management, deficit-based approach to one that supports self-management and a strengths-based approach. You are well aware that the implementation of the new model has been hindered by not being able to receive accurate and dynamic management information reports thus making it difficult to know the effectiveness of this new approach. As you move forward with a more concise focus it would be well worth re-visiting the model to see how this revised focus relates to it.

74. Ensure service users and staff understand personal budgets and how they should be used in personalised ways to meet needs and improve outcomes.

75. The insourcing of the Capita contract is an opportunity to improve the joint working across all service areas such as the Financial Assessment and Benefits team, the Debtors team and the Contact Centre.

76. The senior staff in adult social care are aware of the challenges with the ongoing changes to the information technology system and are seeking to ensure it adds value to staff tasks. As an aspect of this some consideration should be given to introducing a dashboard at the frontline that allows for all staff to see the costs and progress of packages through the care system. This would enable staff to see the impact of their decisions with both service users and their management colleagues and could be a tool to generate greater responsibility and ownership of the finance issues involved for all.

Immediate next steps

We appreciate the senior political and managerial leadership will want to reflect on these findings and suggestions in order to determine how the organisation wishes to take things forward.

As part of the peer challenge process, there is an offer of further activity to support this. The LGA is well placed to provide additional support, advice and guidance on a number of the areas for development and improvement and we would be happy to discuss this. There are two LGA colleagues with which to discuss future developments:

Sarah Mitchell, Care and Health Improvement Adviser for the South East is the main contact for adult social care issues between you and the Local Government Association. Her contact details are, email: sarah.mitchell@local.gov.uk Telephone: 07769 302051.

Will Brooks, Principal Adviser is the main contact between your authority and the Local Government Association for all other issues. His contact details are, email: william.brooks@local.gov.uk, Telephone: 07949 054421.

In the meantime we are keen to continue the relationship we have formed with the Council throughout the peer challenge. We will endeavour to provide signposting to examples of practice and further information and guidance about the issues we have raised in this report to help inform ongoing consideration.

Contact details

For more information about the Adult Social Care Peer Challenge at Southampton City Council please contact:

Marcus Coulson
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For more information on adults peer challenges and peer reviews or the work of the Local Government Association please see our website https://www.local.gov.uk/our-support/peer-challenges/peer-challenges-we-offer/safeguarding-adults-and-adult-social-care

Read the Adults Peer Reports: https://www.local.gov.uk/our-support/peer-challenges/peer-challenges-we-offer/safeguarding-adults-and-adult-social-care-0

Appendix 1 – Key Areas of Focus benchmark questions

This is the Key Areas of Focus for peer challenges in adult social care that was used as the benchmark for this peer challenge. It was used as it covers a wide range of areas of business and thereby enabled to peer team to ensure they covered all relevant areas for this work.

The peer challenge process aims to help local government to help itself to respond to the changing agenda for adult social care. Undertaken from the viewpoint of a friend, albeit a 'critical friend', a peer challenge allows a team of people who understand the pressures of running a local authority to review the council's practices in a challenging but supportive way. A peer challenge includes an assessment of current achievements and provides recommendations of how further improvements can be made. It is a constructive, collaborative and supportive process with has the central aim of helping councils improve. It is not an inspection, nor does it award any form of rating category.

The following sections set out the key areas of focus for peer challenges in adult social care. They have been tested with the sector. The key areas of focus also can be used as a means of self-assessment.

They are centred on the following key themes:

1. Outcomes for people who need care and support to improve independence and wellbeing

2. Participation

3. Vision, Strategy and Leadership

4. Working Together

5. Resource and Workforce Management

6. Service Delivery and Effective Practice

7. Commissioning and Market Shaping

8. Improvement and Innovation demonstrating notable practice

Every council and partnership is different and the challenge team will ensure the challenge is individually tailored to the needs and priorities of each local authority. The intention is not to cover all the questions as they appear below. Instead scoping would be done with the individual authority to select the areas most appropriate to them. The full Key Areas of Focus document can be downloaded from the LGA website here: https://www.local.gov.uk/our-support/peer-challenges/peer-challenges-we-offer/safeguarding-adults-and-adult-social-care.

Adults - Social Care

Sep-19 **Monthly dataset**

Qualitative measures:			Key to direction of travel:		
Positive	Similar	Negative	Increase 10% or more ⇧	Similar ⇨	Decrease 10% or more ⇩

																Analytics					Target		Benchmarking	
No.	Indicator	Owner	Reporter	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	% change from	% change from same	DoT*	*12-mnth avg.*	*12-mnth max value*	*2018-19*	*2019-20*	CIPFA Group	England
CNTC-1	Percentage of enquiries resolved at first contact	S. Stewart	A. Hill	86.3%	84.6%	87.3%	85.3%	85.3%	83.5%	87.0%	85.7%	86.8%	84.6%	83.8%	84.4%	85.2%	⇨ 1%	⇨ -1%	▲	85.4%	87.3%	90.0%	90.0%	*Local*	*Local*
REFL-1	Number of referrals of all types received	S. Stewart	A. Hill	1,167	1,415	1,279	1,052	1,321	1,168	1,213	1,307	1,278	1,179	1,379	1,315	1,201	⇨ -9%	⇨ 3%		1,252	1,415			*Local*	*Local*
REFL-3	Number of Adult safeguarding alerts received	S. Stewart	E. Smith	168	272	217	147	199	187	183	170	173	259	318	384	348	⇨ -9%	⇧ 107%		233	384			*Local*	*Local*
ASST-1	Number of people with a completed assessment or review	L. Slater	A. Hamilton	350	416	374	292	342	371	347	340	366	328	417	326	367	⇧ 13%	⇨ 5%	▲	357	417			*Local*	*Local*
ASST-2	Percentage of people with eligible long term services reviewed during the past year	L. Slater	S. Till	63.0%	63.7%	62.0%	62.2%	60.3%	54.2%	51.6%	51.6%	47.1%	46.2%	48.6%	49.0%	51.2%	⇨ 4%	⇩ -19%	▲	54.7%	63.7%	90.0%	95.0%	*Local*	*Local*
CARE-0	Number of social care clients	P. Juan	S. Stewart	2,587	2,584	2,601	2,611	2,573	2,572	2,577	2,550	2,534	2,521	2,509	2,514	2,546	⇨ 1%	⇨ -2%		2,560	2,611			*5,116*	*4,308*
CARE-0b	Rate of social care clients per **10,000** 18+ year olds	P. Juan	S. Stewart	126.6	127.9	128.7	129.2	127.3	127.3	127.5	126.2	125.4	124.8	124.2	124.4	126.0	⇨ 1%	⇨ 0%		127	129			*164.1*	*150.6*
CARE-2	Number of **new** social care clients	P. Juan	S. Stewart	54	55	52	46	34	76	84	52	60	59	56	87	84	⇨ -3%	⇧ 56%		61	87			*tbc*	*tbc*
CARE-1	Percentage of people with eligible needs supported to live independently	P. Juan	L Slater	75.1%	74.4%	74.6%	74.7%	75.2%	75.1%	75.5%	75.3%	75.8%	75.8%	75.9%	76.4%	76.6%	⇨ 0%	⇨ 2%	▲	75.4%	76.6%	80.0%		*68.4%*	*68.4%*
CARE-3	Numbers of residential placements	P. Juan	S. Stewart	487	497	496	485	485	485	482	474	469	464	469	467	463	⇨ -1%	⇨ -5%	▼	479	497			*782*	*947*
CARE-4	Numbers of nursing placements	P. Juan	S. Stewart	315	321	321	317	311	320	318	313	310	312	310	310	313	⇨ 1%	⇨ -1%	▼	315	321			*330*	*362*
CARE-5	Numbers of home care	P. Juan	S. Stewart	1,392	1,396	1,393	1,381	1,396	1,401	1,395	1,366	1,403	1,374	1,371	1,402	1,397	⇨ 0%	⇨ 0%	▼	1,390	1,403			*Local*	*Local*
CARE-6	Number of Connected Care users	J. Brown	C. Kendall	1,003	1,002	1,038	1,060	1,095	1,110	1,133	1,137	1,147	1,160	1,170	1,185	1,215	⇨ 3%	⇧ 21%	▲	1112	1215	1,306	1,330	*Local*	*Local*
CARE-6a	Number of referrals to Connected Care	Lee Tillyer	C. Kendall	65	93	100	73	71	74	89	71	79	66	82	81	58	⇩ -28%	⇩ -11%	▲	77	100			*Local*	*Local*
CARE-6b	Number of Connected Care installs	L. Tillyer	C. Kendall	34	42	56	42	49	45	38	28	33	16	23	20	19	⇨ -5%	⇩ -44%	▲	34	56			*Local*	*Local*
CARE-6c	Conversion rate for Connected Care referrals to installs	L. Tillyer	C. Kendall	52.3%	45.2%	56.0%	57.5%	69.0%	60.8%	42.7%	39.4%	41.8%	24.2%	28.0%	24.7%	32.8%	⇧ 33%	⇩ -37%	▲	44.2%	69.0%			*Local*	*Local*
CARE-17n	Number of clients using care technology	P. Juan	S. Stewart	1,182	1,179	1,213	1,237	1,277	1,283	1,303	1,293	1,294	1,303	1,318	1,330	1,357	⇨ 2%	⇧ 15%	▲	1,275	1,357	1,306	1,330	*Local*	*Local*
CARE-17	Percentage of clients using care technology	P. Juan	S. Stewart	45.7%	45.6%	46.6%	47.4%	49.6%	49.9%	50.6%	50.7%	51.1%	51.7%	52.5%	52.9%	53.3%	⇨ 1%	⇧ 17%	▲	49.8%	53.3%			*Local*	*Local*
CARE-8	Number of Shared Lives service users	D. Samber	C. Roberts	46	45	45	45	46	46	46	46	47	46	47	45	45	⇨ 0%	⇨ -2%	▲	46	47			*Local*	*Local*
CARE-10	Number of Direct Payment users	P. Juan	L Slater	359	354	352	349	342	333	326	319	309	311	313	311	312	⇨ 0%	⇩ -13%	▲	330	359			*661*	*836*
CARE-11	Percentage of Direct payment users of all eligible service users	P. Juan	L. Slater	19.5%	19.3%	19.0%	19.1%	18.6%	18.3%	17.9%	17.9%	17.0%	17.5%	17.3%	17.3%	17.2%	⇨ -1%	⇩ -12%	▲	18.1%	19.5%	32.5%	39.0%	*24.7%*	*28.1%*
CARE-10n	Number of new Direct Payments	P. Juan	L. Slater	3	3	1	2	0	0	1	1	1	7	2	4	4	⇨ 0%	⇧ 33%	▲	2	7				
CARE-10c	Number of ceasing Direct Payments	P. Juan	L. Slater	7	4	7	5	4	2	5	4	7	2	9	1	2	⇧ 100%	⇩ -71%	▼	5	9				
CARE-10a	Total number of users eligible for Direct Payments	P. Juan	L. Slater	1,819	1,821	1,812	1,797	1,815	1,803	1,799	1,757	1,772	1,768	1,759	1,790	1,807	⇨ 1%	⇨ -1%		1,794	1,821				
CARE-12	Number of carers who have a Direct Payment	P. Juan	L. Slater	543	549	562	571	589	609	616	630	624	635	657	680	677	⇨ 0%	⇧ 25%	▲	611	680			*381*	*539*
CARE-12%	Percentage of carers who have a Direct Payment	P. Juan	L. Slater	91.8%	91.9%	92.3%	91.9%	92.1%	92.2%	89.4%	88.7%	88.2%	88.0%	88.3%	88.1%	87.7%	⇨ 0%	⇨ -4%	▲	90.0%	92.3%	85.0%	90.0%	*55.8%*	*67.4%*
CARE-13	Average cost of care package	P. Juan	C. Pelletier	£463.81	£465.84	£466.75	£473.22	£468.95	£457.47	£471.30	£477.49	£485.97	£490.19	£497.40	£497.94	£493.07	⇨ -1%	⇨ 6%	▼	£477.65	£497.94			*n/a*	*£658*
CARE-14	Average cost of care package of nursing placements	P. Juan	C. Pelletier	£757.38	£763.70	£762.86	£766.81	£776.02	£758.31	£766.42	£778.62	£778.80	£775.39	£778.71	£784.75	£790.57	⇨ 1%	⇨ 4%	▼	£772.18	£790.57			*n/a*	*£562.96*

No.	Indicator	Owner	Reporter	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	% change from	% change from same	DoT*	*12-mnth avg.*	*12-mnth max value*	*2018-19*	*2019-20*	CIPFA Group	England
CARE-13B	Average cost of non-residential services to clients with learning disabilities (all ages)	P. Juan	C. Pelletier	£624.56	£607.58	£614.63	£616.48	£616.13	£612.42	£621.42	£622.12	£656.25	£664.18	£662.97	£658.68	£651.51	→ -1%	→ 4%	▼	£632.99	£664.18			*Local*	*Local*
CARE-13A	Average cost of non-residential services to clients excluding learning disabilities (all ages)	P. Juan	C. Pelletier	£228.67	£229.63	£236.74	£245.15	£234.65	£237.11	£240.50	£247.03	£251.25	£262.20	£262.71	£262.27	£263.55	→ 0%	↑ 15%	▼	£246.27	£263.55			*Local*	*Local*
CARE-15A	Average cost of residential services to clients excluding learning disabilities (all ages)	P. Juan	C. Pelletier	£634.04	£645.18	£648.28	£653.59	£655.69	£653.32	£655.01	£668.73	£671.15	£682.51	£680.24	£688.49	£689.36	→ 0%	→ 9%	▼	£663.51	£689.36			*n/a*	*£539.72*
CARE-15B	Average cost of residential services to clients with learning disabilities (all ages)	P. Juan	C. Pelletier	£1,328.06	£1,322.30	£1,326.53	£1,321.03	£1,322.07	£1,305.20	£1,312.50	£1,331.81	£1,335.51	£1,330.47	£1,363.99	£1,376.98	£1,358.82	→ -1%	→ 2%	▼	£1,333.48	£1,376.98			*n/a*	*£1,256.9*
DTOC-1	Number of DToC per month bed days - Total	P. Juan	S. Stewart	44	40	37	28	39	36	33	29	29	38	37	39	-	- n/a	- n/a	▼	36	44	tbc	tbc	*n/a*	*n/a*
DTOC-2	Total number of Delayed Transfers of Care (DToC) per month (days)	P. Juan	S. Stewart	1,334	1,229	1,120	880	1,196	1,019	1,015	855	912	1,154	1,143	1,212	-	- n/a	- n/a	▼	1,089	1,334	tbc	tbc	*1,192*	*1,235*
DTOC-3	Number of DToC per month bed days - Social Care	P. Juan	S. Stewart	17	14	12	9	15	15	15	12	12	15	16	18	-	- n/a	- n/a	▼	14	18	tbc	tbc	*Local*	*Local*
DTOC-4	Social care - Delayed Transfers of Care (DToC) per month (days)	P. Juan	S. Stewart	516	444	348	284	465	409	453	363	384	447	499	549	-	- n/a	- n/a	▼	430	549	tbc	tbc	*280*	*382*
DTOC-1 rate	Rate per 100,000 of DToC per month bed days - Total	P. Juan	S. Stewart	21.8	19.8	18.3	13.9	19.3	17.8	16.2	14.4	14.4	18.8	18.3	19.3	-	- n/a	- n/a	▼	18	22	tbc	tbc	*tbc*	*tbc*
DTOC-3 rate	Rate per 100,000 of DToC per month bed days - Social Care	P. Juan	S. Stewart	8.4	6.9	5.9	4.5	7.4	7.4	7.4	5.9	5.9	7.4	7.9	8.9	-	- n/a	- n/a	▼	7	9	tbc	tbc	*n/a*	*15*
DOLS-1	Total number of DOLS applications received	S. Stewart	E. Berry	49	63	77	67	77	76	51	68	61	68	77	67	67	→ 0%	↑ 37%		67	77			*113*	*107*
DOLS-2	Total number of DOLS authorisations	S. Stewart	E. Berry	21	50	32	8	40	36	28	29	30	5	13	19	36	↑ 89%	↑ 71%		27	50			*79*	*51*
CARE-9a	Total number of SCC Extra Care units	P. Juan	L. Slater	136	136	136	136	136	136	136	135	135	135	151	151	151	→ 0%	↑ 11%		139	151			*Local*	*Local*
CARE-9	Number of SCC Extra Care units taken up in the month	P. Juan	L. Slater	0	0	3	2	1	3	2	2	1	3	3	2	4	↑ 100%	- n/a	▲	2	4	50	50	*Local*	*Local*
CARE-9b	Total number of occupied SCC Extra Care units	P. Juan	L. Slater	126	125	125	127	126	131	132	130	127	129	144	143	145	→ 1%	↑ 15%		132	145			*Local*	*Local*
CARE-9c	Occupancy rate for SCC Extra Care units (of total 151 units)	P. Juan	L. Slater	92.7%	91.9%	91.9%	93.4%	92.7%	96.3%	97.1%	96.3%	94.1%	95.6%	95.4%	94.7%	96.0%	→ 1%	→ 4%	▲	94.5%	97.1%	95.0%	95.0%	*Local*	*Local*
1C(1A)	Percentage of people using social care who receive self-directed support	P. Juan	L. Slater	73.9%	73.7%	73.4%	73.4%	72.7%	72.3%	72.1%	72.1%	70.8%	71.1%	70.3%	76.5%	75.8%	→ -1%	→ 3%	▲	72.9%	76.5%			*88.7%*	*86.9%*
2A(2)	Number of long term admissions to residential and nursing care homes (rate per 100,000 population over 65+)	P. Juan	S. Stewart	67.4	67.4	70.5	49.0	46.0	73.5	58.2	61.3	58.2	52.1	64.3	64.3	27.6	↓ -57%	↓ -59%	▼	58	74	63.8	51.7	*784*	*628*
2A(2) (number)	Number of long term admissions to residential and nursing care homes	P. Juan	S. Stewart	22	22	23	16	15	24	19	20	19	17	25	26	9	↓ -65%	↓ -59%	▼	20	26	20.8	20.8	*Local*	*Local*

* Preferred Direction of Travel

LA area data profile: Older people's pathway

Southampton

Date produced: 18 July 2019

Contact: arealevelanalytics@cqc.org.uk

Context and demographics

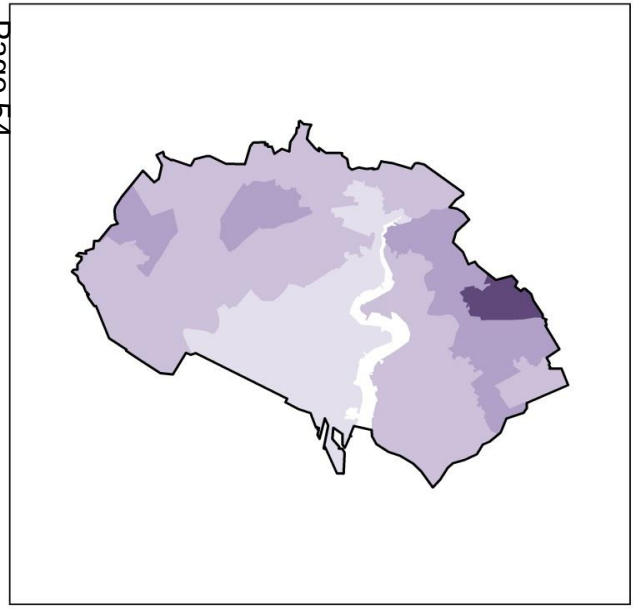
Context

This data profile uses analysis to help identify issues within health and care systems in local authority areas. It is focused on care for older people (aged 65+), however some indicators are for the whole adult population. Full information about the analysis can be found in the technical

Link to technical appendix

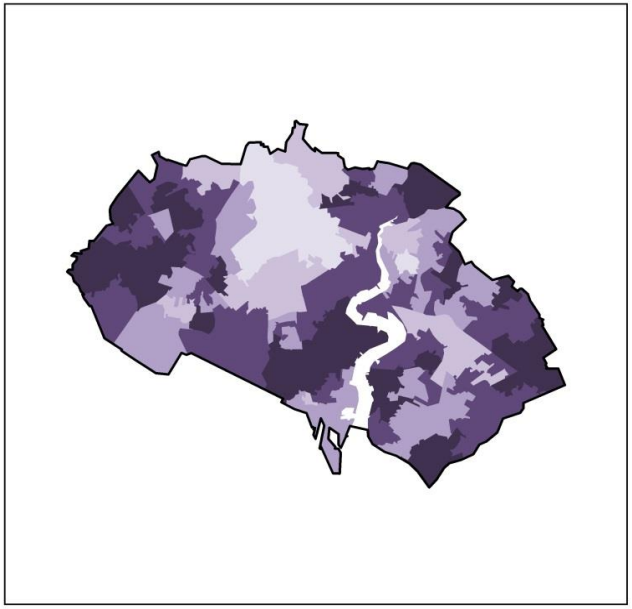
Demographic map- Age

20% most elderly — 20% least elderly



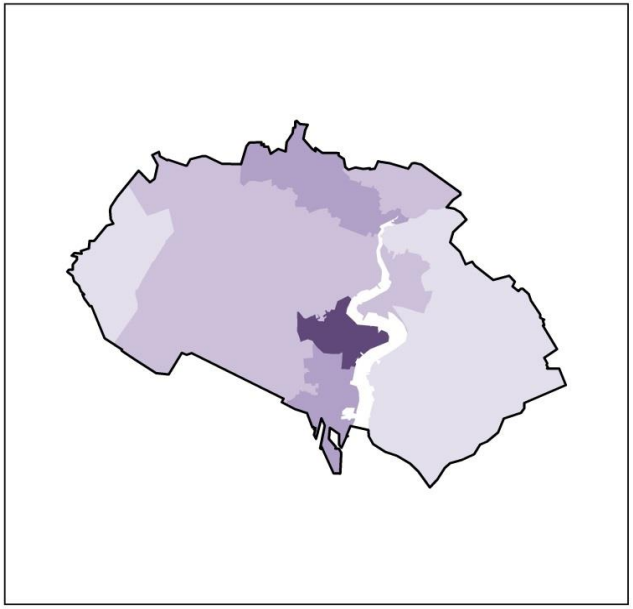
Demographic map- Deprivation

20% most deprived — 20% least deprived



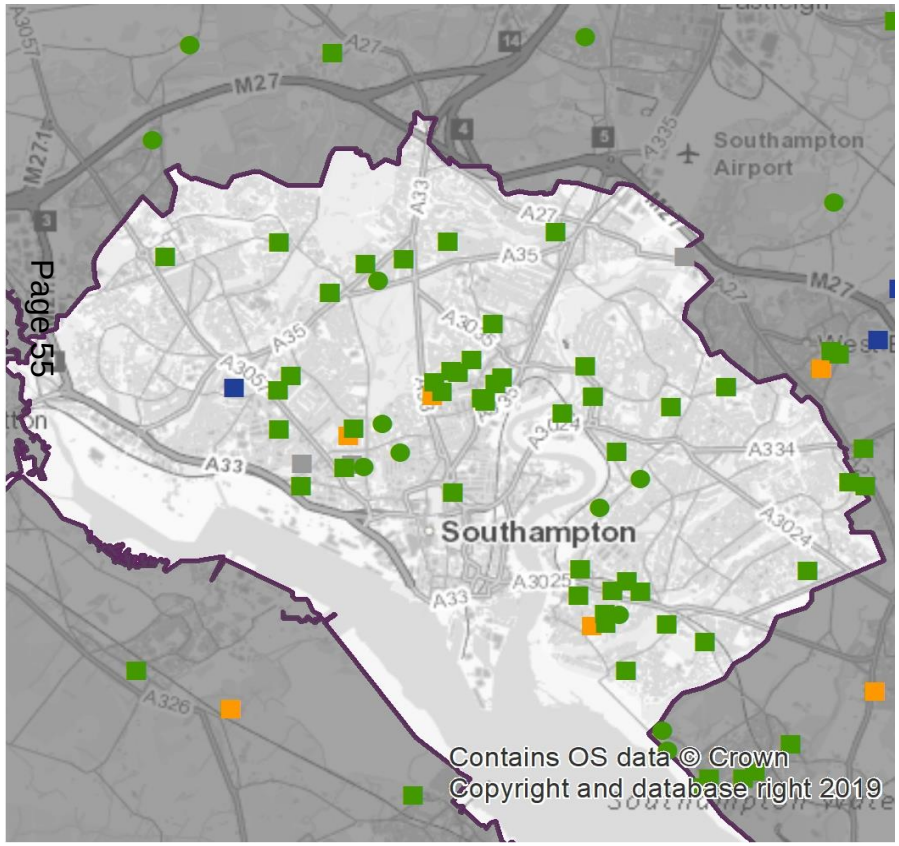
Demographic map- Ethnicity

20% most BME — 20% least BME



Ratings – adult social care

This map shows the overall ratings of active adult social care locations in Southampton.
There may be multiple locations in one position so not all locations may be visible.



Nursing homes - see circles on map

	Inadequate	R.I.*	Good	Outstanding	Unrated
This LA	0% (0)	0% (0)	100% (10)	0% (0)	0% (0)
Comparators	0%	22%	72%	2%	3%
England	2%	21%	68%	4%	4%

Residential care homes - see squares on map

	Inadequate	R.I.*	Good	Outstanding	Unrated
This LA	0% (0)	8% (4)	87% (46)	2% (1)	4% (2)
Comparators	1%	12%	78%	4%	4%
England	1%	13%	79%	3%	4%

Domiciliary care agencies - not shown on map

	Inadequate	R.I.*	Good	Outstanding	Unrated
This LA	0% (0)	6% (2)	71% (25)	3% (1)	20% (7)
Comparators	0%	12%	61%	4%	23%
England	1%	10%	65%	3%	21%

Community care services - not shown on map

	Inadequate	R.I.*	Good	Outstanding	Unrated
This LA	0% (0)	0% (0)	33% (2)	0% (0)	67% (4)
Comparators	0%	7%	79%	3%	11%
England	0%	5%	69%	4%	22%

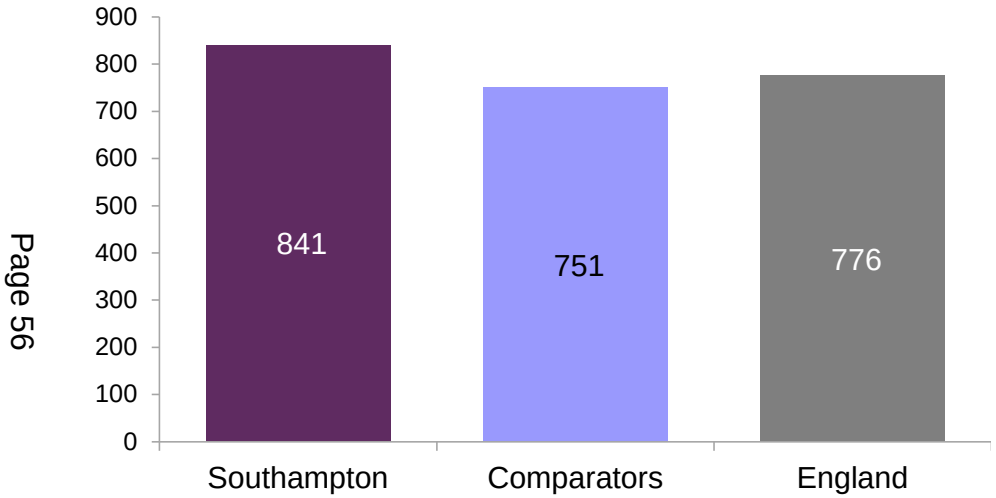
*R.I. = requires improvement

Numbers in brackets are the number of locations.

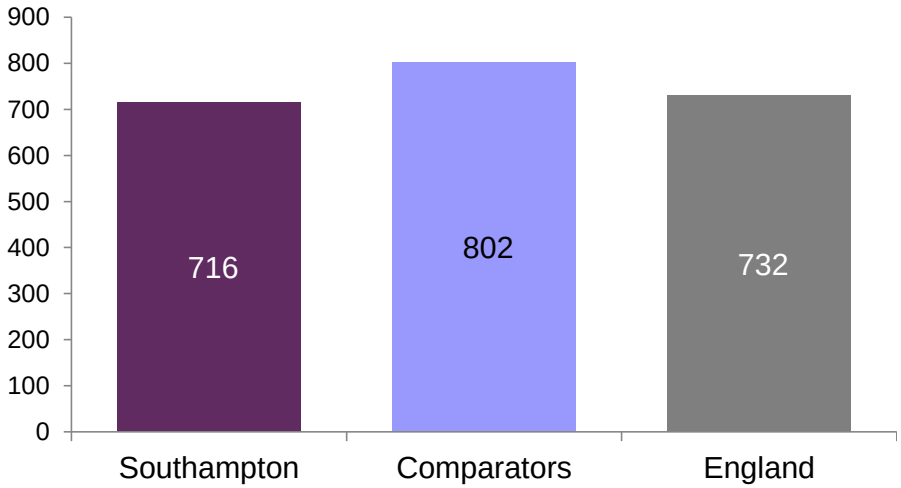
CQC data accessed on 18/07/19.

Service provision – adult social care service provision

Residential care beds per LA population (65+)



Nursing care beds per LA population (65+)

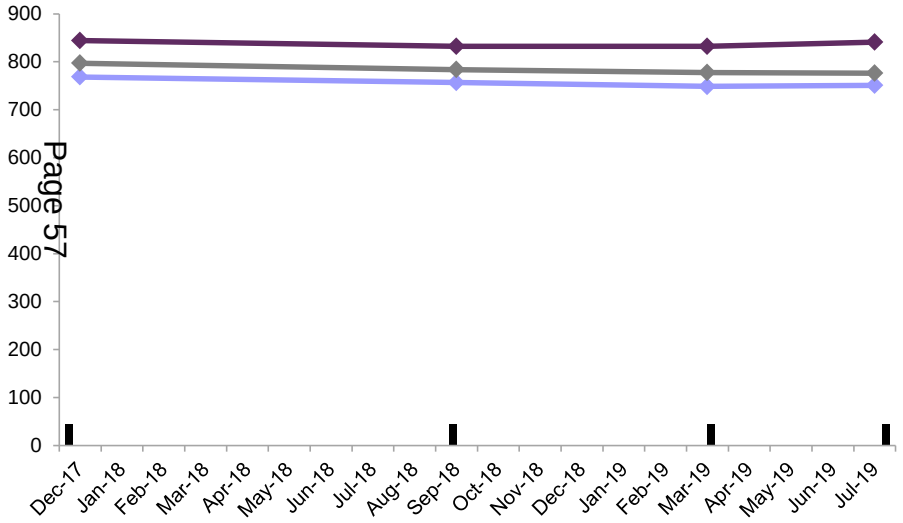


This slide shows the number of residential and nursing care home beds for the population of Southampton LA as at 18/07/19. The comparator group and England bars represent the number of care home beds available across those areas if their older populations were scaled to the same size as Southampton's older population. Population figures are ONS mid year estimates published for 2017.

Service provision – change in care bed numbers

This slide shows change in residential and nursing care home beds per population aged 65+ between each iteration of this profile. The data points shown in the charts below correspond with the dates previous area profiles were produced and are also marked along the bottom of the charts.

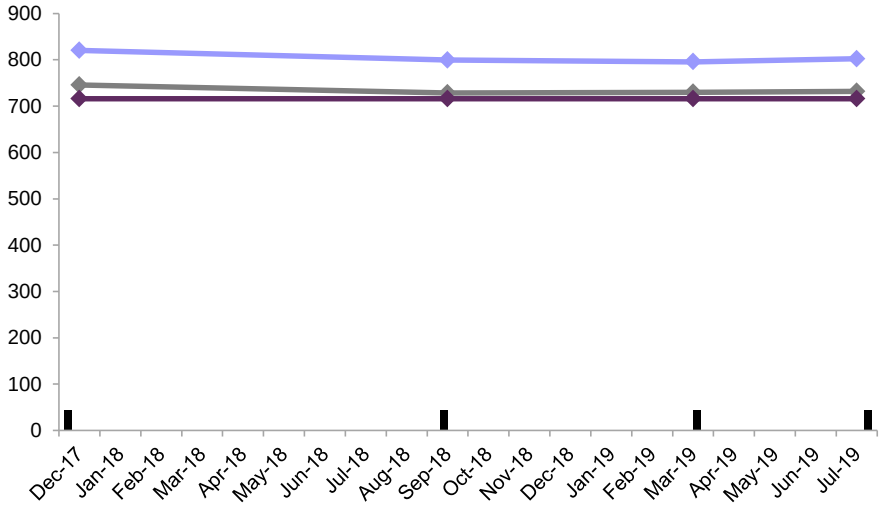
Weighted provision of residential home beds over time



Change in residential home beds between the profile published in December 2017 and this current profile:

Southampton	-0.4%
Comparators	-2.3%
England	-2.7%

Weighted provision of nursing home beds over time



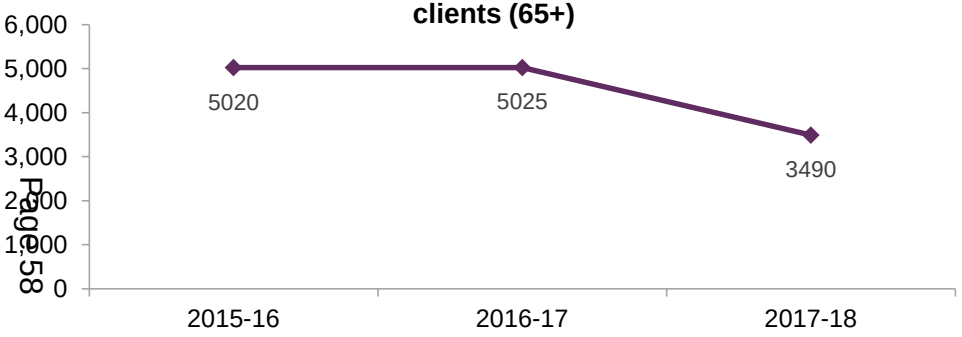
Change in nursing home beds between the profile published in December 2017 and this current profile:

Southampton	0.0%
Comparators	-2.2%
England	-1.9%

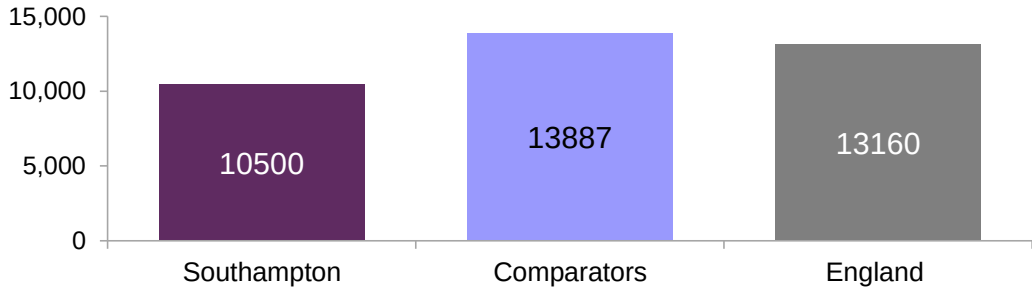
Service provision – requests for ASC support

This slide shows the number of requests for adult social care support from new clients aged 65+ received by the selected local authority over the last 3 years and the rate of requests per 100,000 population in 2017/18 in the selected local authority compared to the average across comparator areas and England. This data was taken from the Adult Social Care Activity and Finance Report.

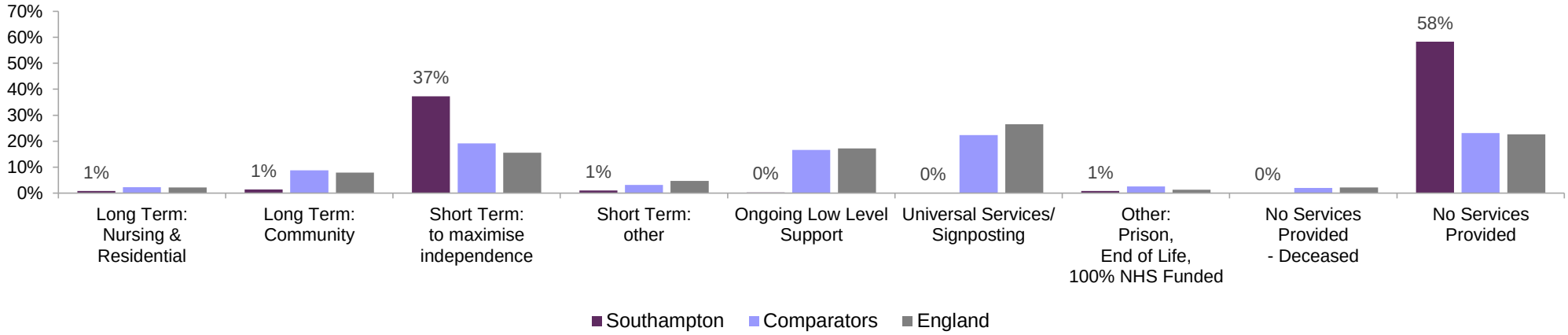
Number of requests for ASC support received from new clients (65+)



Requests for ASC support received from new clients (65+), per 100,000 population (65+) (2017/18)

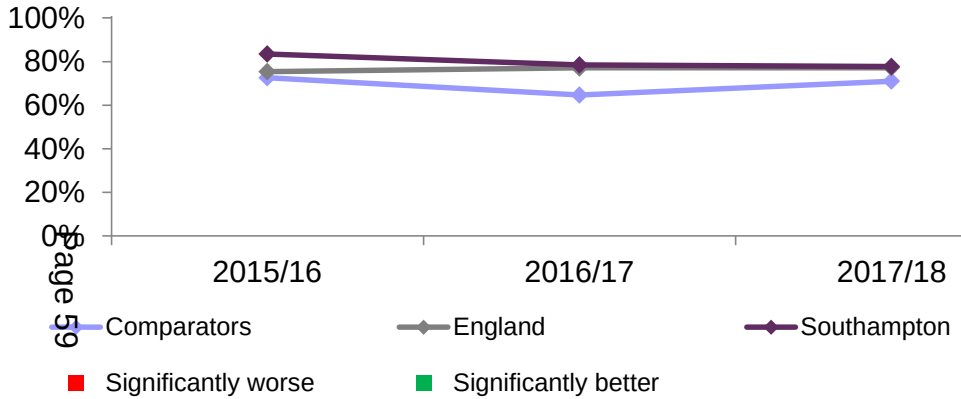


Services received by new clients (65+) requesting ASC support in 2017/18



Service provision – short-term treatment outcomes and long-term care home admissions

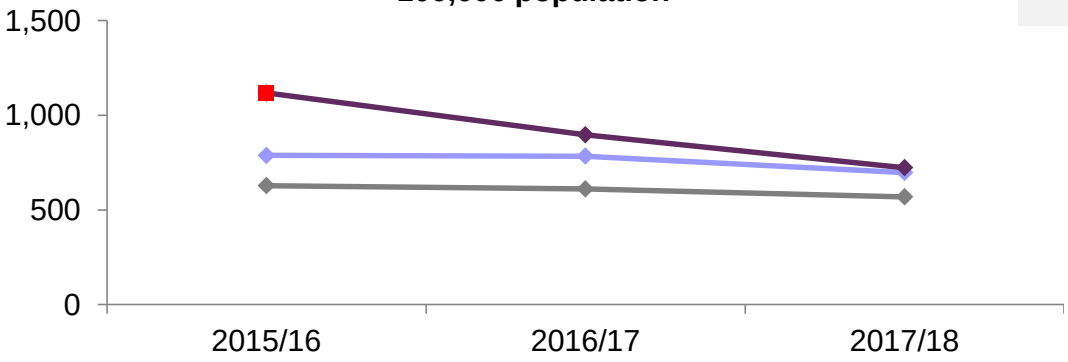
Proportion of new service users (65+) who received a short term service to maximise independence who then required no ongoing support or support of a lower level



	15/16	16/17	17/18
Southampton	**83%**	**78%**	**78%**
Comparators	73%	65%	71%
England	75%	77%	77%

This chart and table shows the proportion of older people (65+) who requested adult social care support from their local authority as a new service user and received a short term service to maximise their independence and who then went on to require no further ongoing support or support at a lower level. This data is taken from the Adult Social Care Outcomes Framework (ASCOF).

Long-term support needs of older adults (65+) met by admission to residential and nursing care homes, per 100,000 population

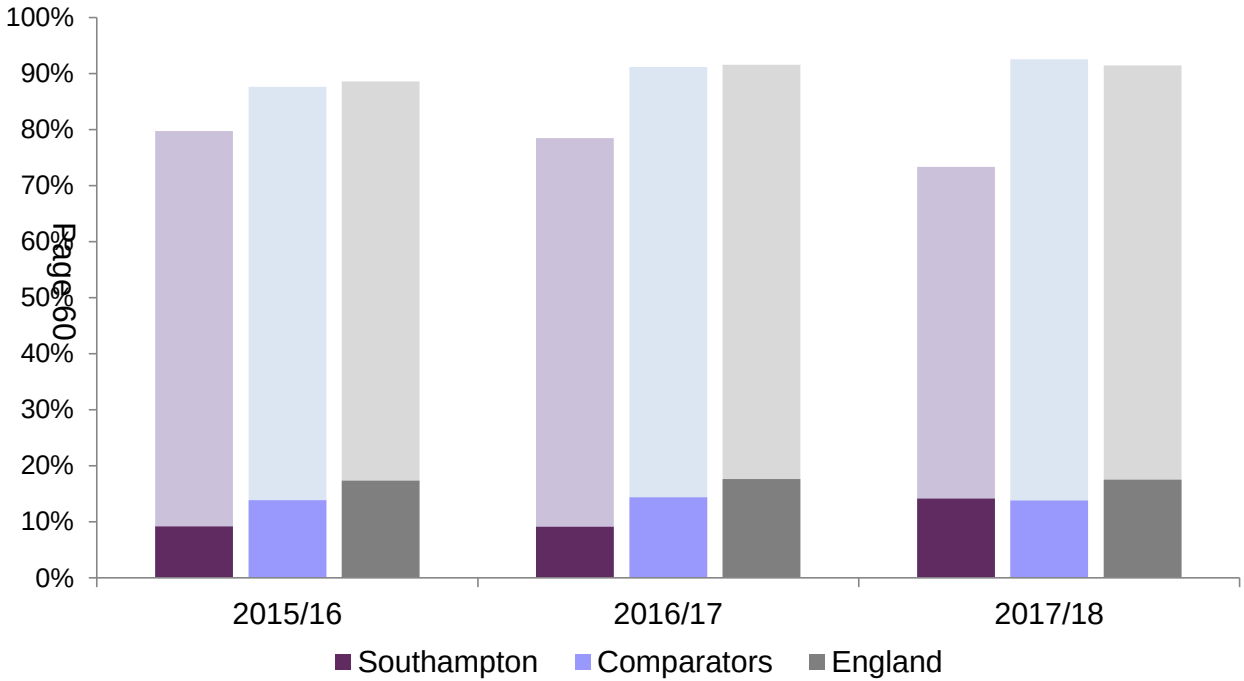


	15/16	16/17	17/18
Southampton	**1117**	**897**	**723**
Comparators	788	784	698
England	628	611	568

This chart and table shows the rate of council-supported older people (65+) whose long-term support needs were met by a change of setting to residential or nursing care during the year per 100,000 population. This data is taken from the Adult Social Care Outcomes Framework (ASCOF).

Service provision – self directed support and direct payments for ASC

Percentage of ASC service users (65+) who receive a direct payment
(Plus percentage receiving any other self-directed support)



Percentage of ASC service users aged 65+ who received any self-directed support (including direct payments)

	15/16	16/17	17/18
Southampton	**79.7%**	**78.5%**	**73.3%**
Comparators	87.6%	91.2%	92.5%
England	88.6%	91.6%	91.4%

Percentage of ASC service users aged 65+ who received direct payments

	15/16	16/17	17/18
Southampton	**9.2%**	**9.1%**	**14.2%**
Comparators	13.9%	14.4%	13.8%
England	17.3%	17.6%	17.5%

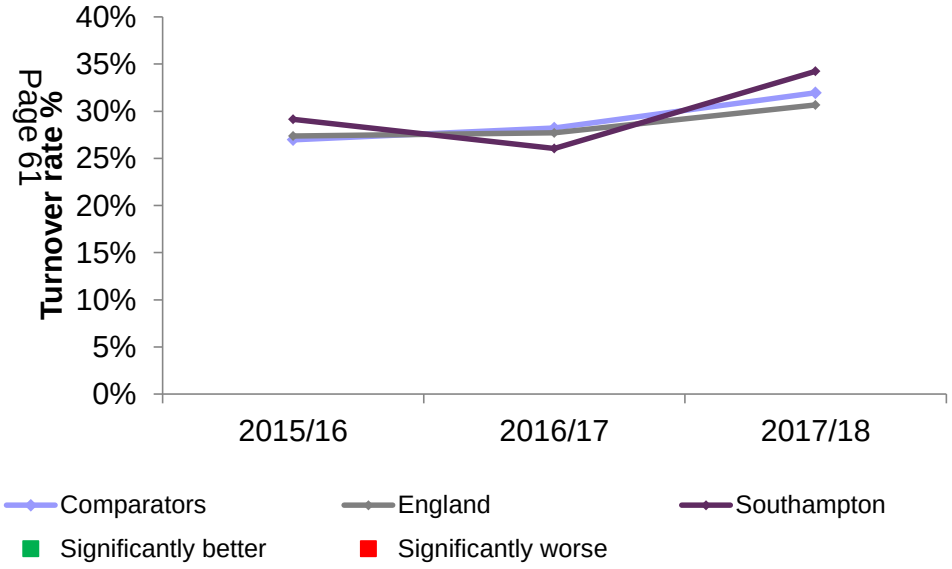
The bold-coloured bars on the chart show the percentage of people aged 65+ who were accessing long-term adult social care support at the end of March of each year who were receiving direct payments. The lighter shaded area of each bar represents the percentage who have a council-managed Personal Budget in place (another kind of self-directed support).

Staffing – adult social care turnover and vacancy

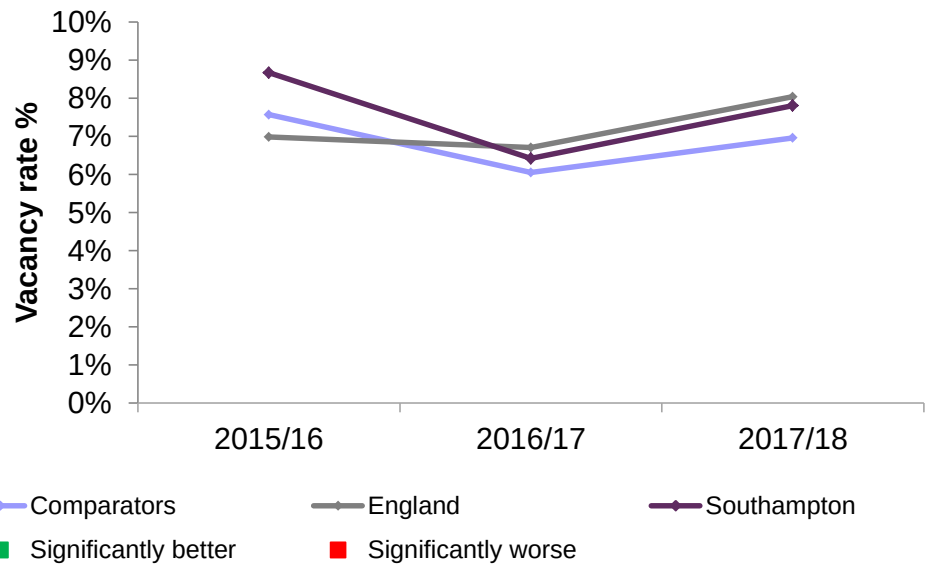
	Turnover rates		
Area	**15/16**	**16/17**	**17/18**
Southampton	**29.1%**	**26.0%**	**34.2%**
Comparators	27.0%	28.2%	31.9%
England	27.4%	27.7%	30.7%

	Vacancy rates		
Area	**15/16**	**16/17**	**17/18**
Southampton	**8.7%**	**6.4%**	**7.8%**
Comparators	7.6%	6.1%	7.0%
England	7.0%	6.7%	8.0%

ASC staff turnover rates 2015 - 2018

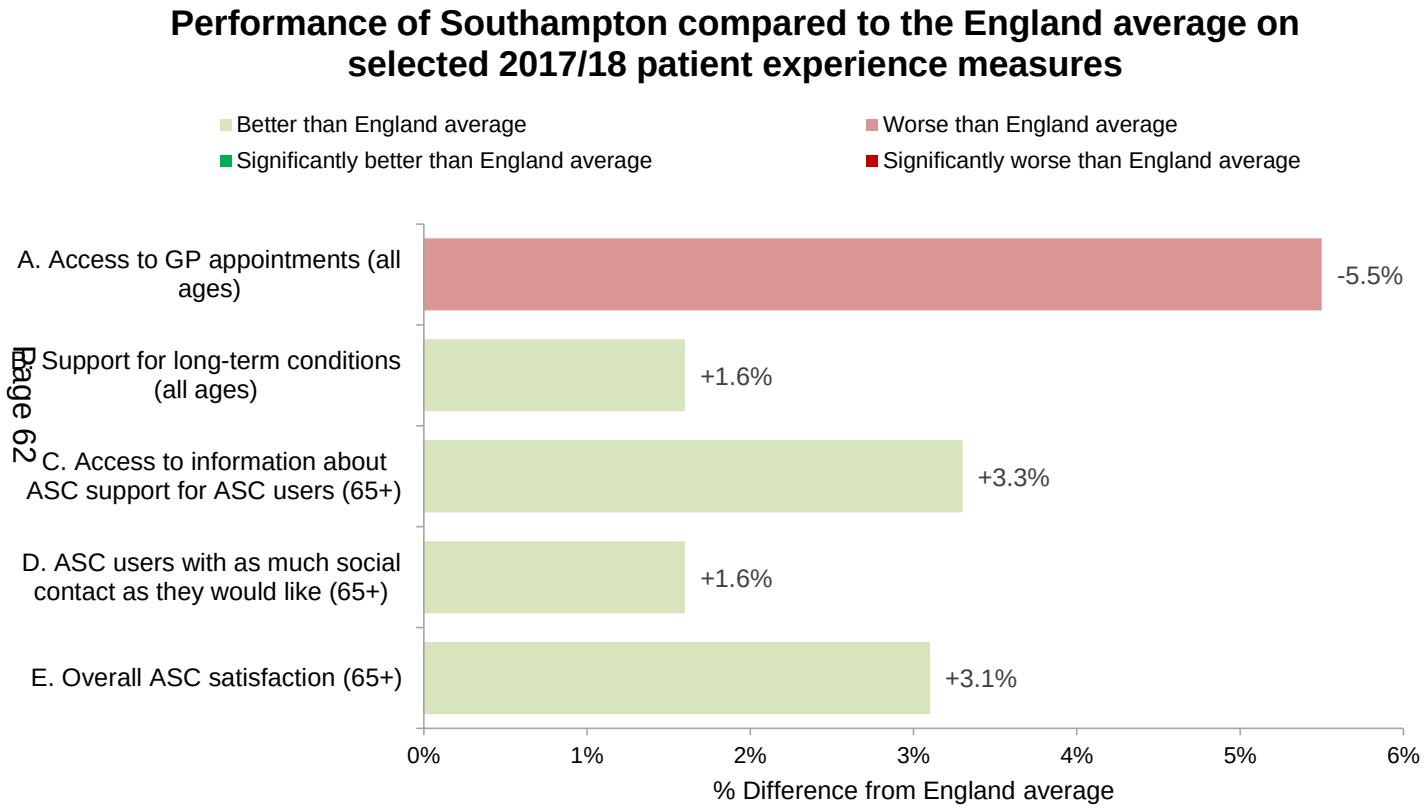


ASC staff vacancy rates 2015 - 2018



This slide provides information on estimated levels of staff turnover and vacancies within adult social care services in recent years. These estimates are developed by the Workforce Intelligence team at Skills for Care using data supplied by adult social care organisations. Data may be subject to data quality and completeness issues. Data supplied directly to CQC by Skills for Care in July 2018.

Service user experience measures



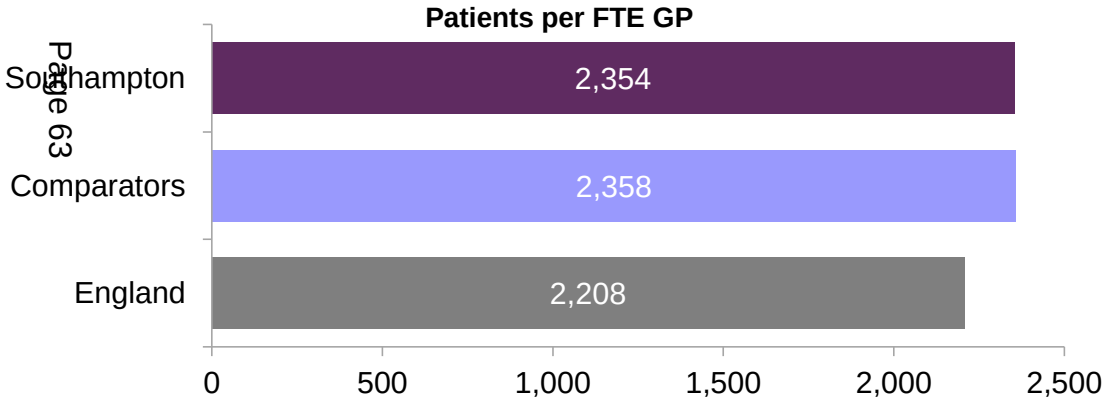
Measure	Southampton	England
A	**63.2%**	68.7%
B	**61.2%**	59.6%
C	**78.3%**	75.0%
D	**45.6%**	44.0%
E	**66.0%**	62.9%

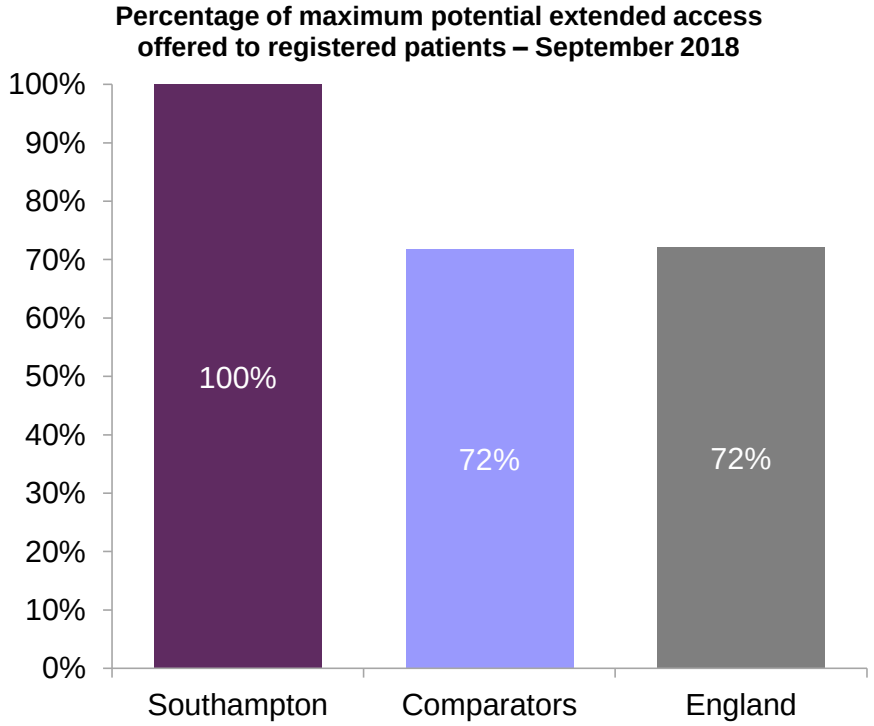
The chart above shows the performance of Southampton compared to the England average for selected service user experience measures. Measures where Southampton is performing better than the England average are in green and measures where it is performing worse than the England average are in red. Bolder colours mean performance is significantly better or worse. The actual values for each measure are detailed in the table on the right. Details of the source and time period of each measure is detailed in the technical appendix.

Service provision – GP ratings, extended access and workforce

	GP ratings as at 18/07/19				
	Inadequate	R.I.*	Good	Outstanding	Unrated
This LA	0% (0)	0% (0)	100% (24)	0% (0)	0% (0)
Comparators	2%	5%	86%	4%	3%
England	1%	4%	86%	4%	5%

	Provision by GP practice			
	Full	Partial	None	*No Data*
Southampton	**100%**	**0%**	**0%**	**0%**
Comparators	53%	34%	9%	4%
England	54%	34%	8%	5%





The table at the top left of this slide shows CQC overall ratings of GP surgeries physically located within the LA.
The chart above shows the number of registered patients for each full time equivalent GP working in surgeries located within the LA and across comparator areas at March 2019.

The table and chart on the right show the provision of extended access to GP appointments as at September 2018. NHS England set a target for CCGs to provide extended access for 100% of their population by 1 October 2018.

Main community, mental health and combined provider(s)

The following provider(s) have been identified as serving Southampton based upon data on non-acute delayed transfers of care. This is a proxy measure and some providers may be missing, see technical appendix for further details. CQC data accessed 18/07/19

Trust code	Trust name	Primary inspection category	Overall Rating
R1C	Solent NHS Trust	Community health - NHS & Independent	Good
RW1	Southern Health NHS Foundation Trust	Mental health - community & residential - NHS	Requires improvement

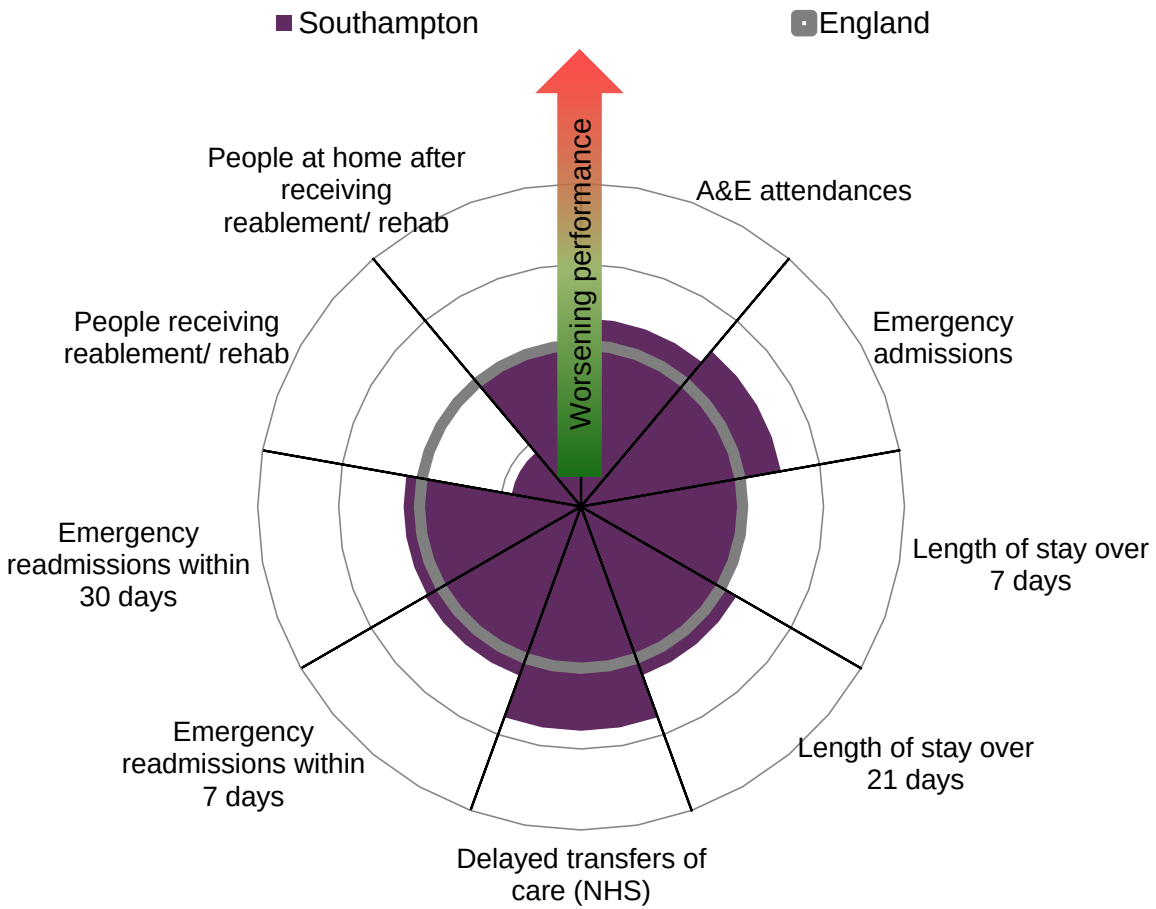
Community and MH core services relevant to older people	R1C	RW1
Community health inpatient services		
Community health services for adults		
Community health (sexual health services)		
Community dental services		
Community end of life care		
Urgent care services		
Mental health crisis services and health-based places of safety		
Wards for older people with mental health problems		
Community-based mental health services for older people		
Community mental health services for people with learning disabilities or autism		
Forensic inpatient/secure wards		

Activity – acute hospital pathway overview

Dartboard for all hospital attendees/admissions aged 65+

The shaded purple area in the dartboards represents the LA's performance relative to the average performance across England, which is denoted by the bold grey line. If the LA performance extends beyond the bold grey line then the performance of the LA is worse than the England average. Moving clockwise around the dartboards represents elements of an acute hospital pathway, through A&E attendance, to admission, discharge and readmission.

Time periods differ between indicators. Full details can be found in the technical appendix (linked in slide 2)



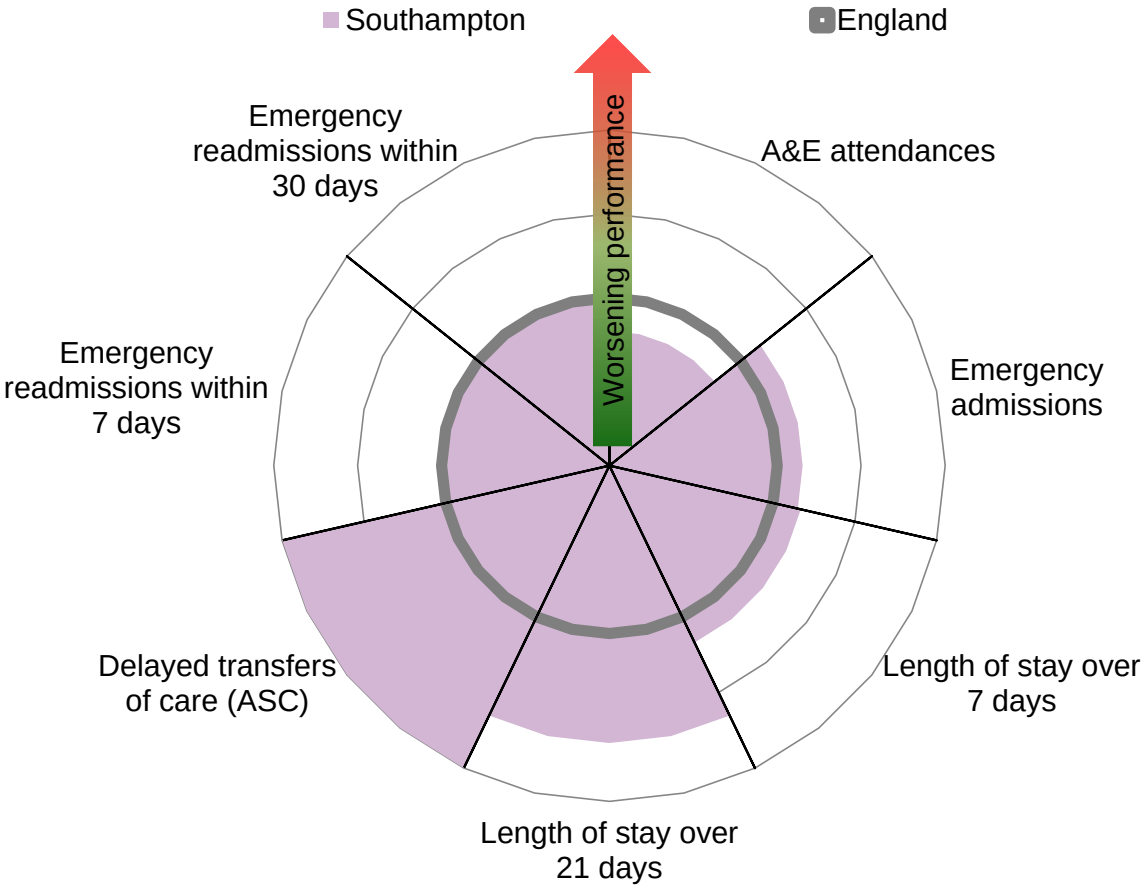
Activity – acute hospital pathway overview (from care homes)

Dartboard for hospital attendees/admissions aged 65+ coming from care homes

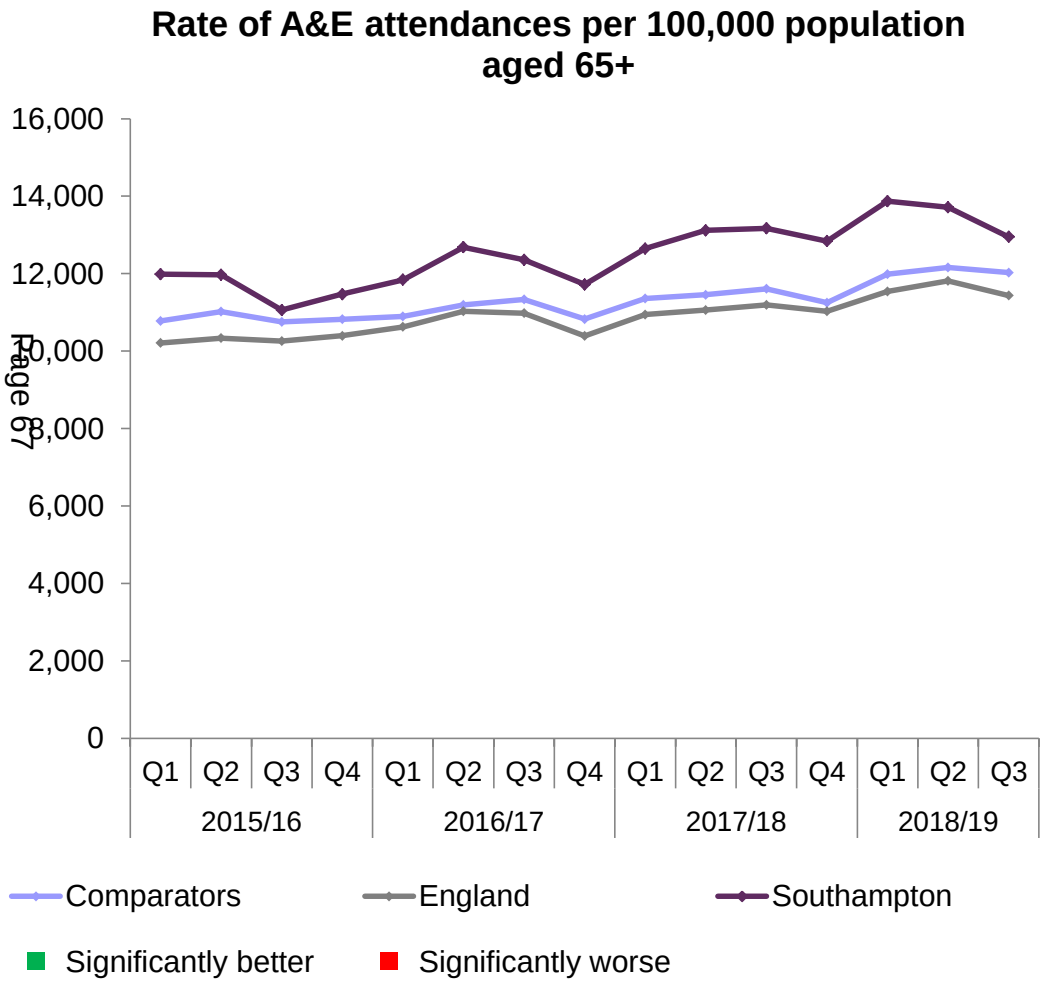
The shaded purple area in the dartboards represents the LA's performance relative to the average performance across England, which is denoted by the bold grey line. If the LA performance extends beyond the bold grey line then the performance of the LA is worse than the England average. Moving clockwise around the dartboards represents elements of an acute hospital pathway, through A&E attendance, to admission, discharge and readmission.

The analysis uses postcode of residence to identify activity from care homes. As such, it may include data pertaining to other addresses within the same postcode and overestimate activity from care homes.

Time periods differ between indicators. Full details can be found in the technical appendix (linked in slide 2)



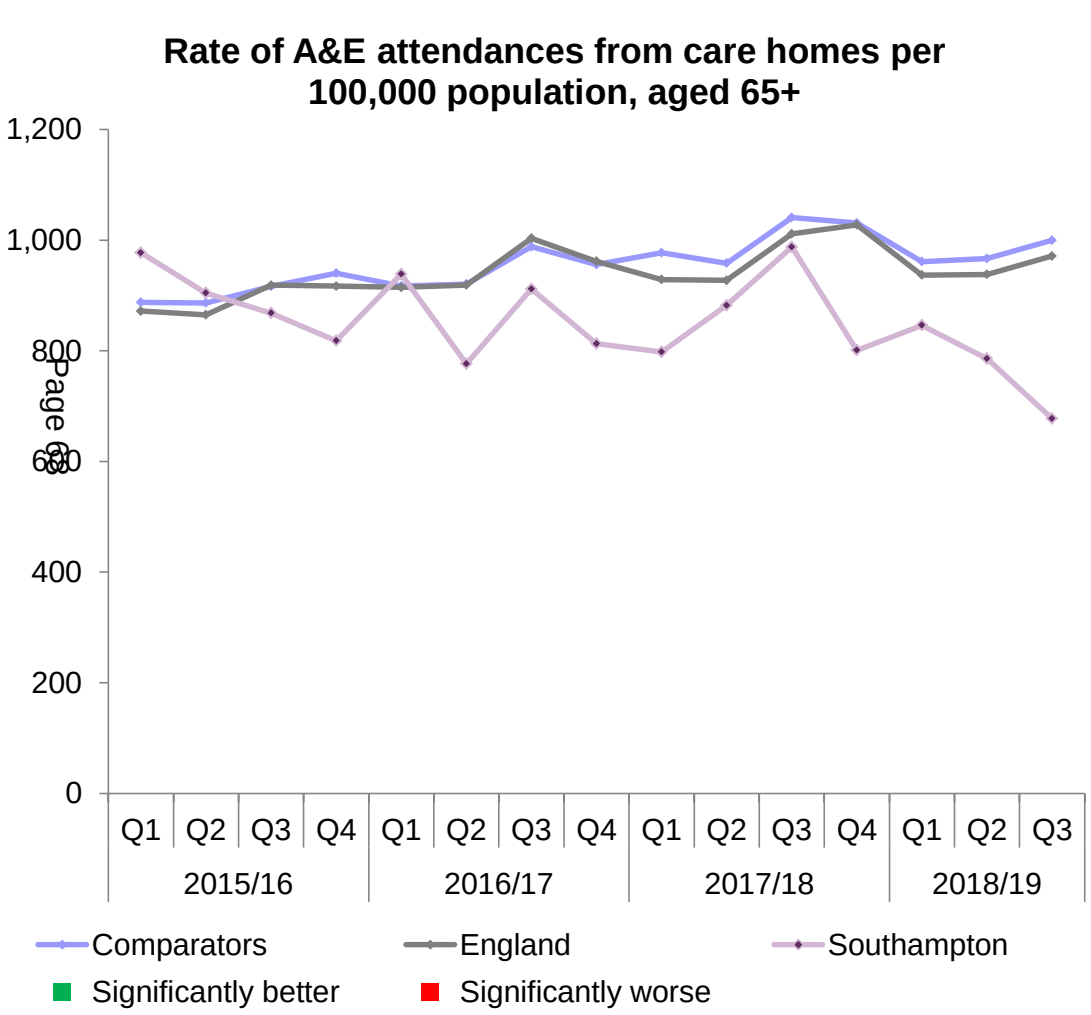
Activity – A&E attendances aged 65+



This slide shows analysis of A&E attendance rates for people aged 65+. High rates of A&E attendance may indicate problems in system working and access to primary or community care. This is based on Hospital Episodes Statistics (HES) data from April 2015 - December 2018.

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**12,841**	**13,868**	**13,717**	**12,949**
Comparators	11,248	11,983	12,161	12,025
England	11,025	11,537	11,810	11,436

Activity – A&E attendances from care homes aged 65+

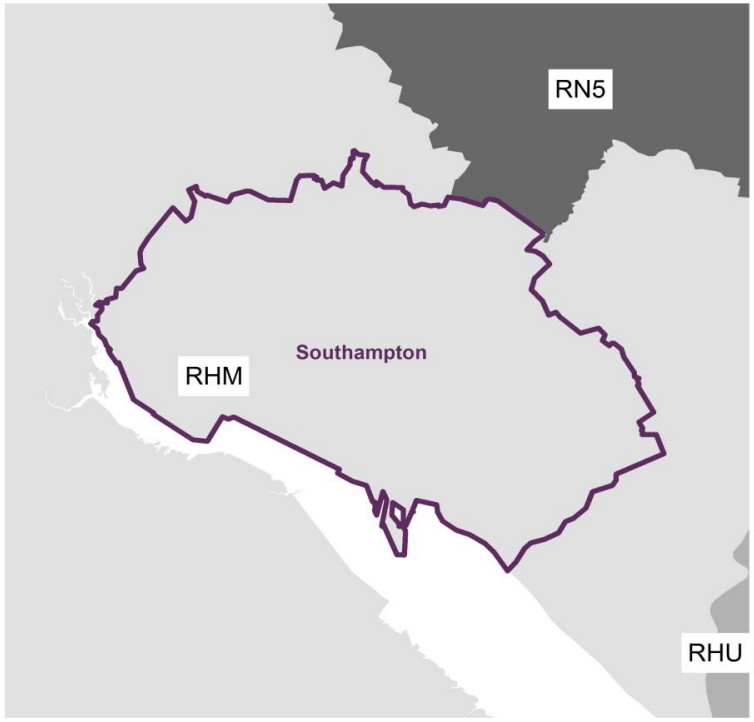


This slide shows analysis of A&E attendance rates for people aged 65+ coming from care homes. This is based on Hospital Episodes Statistics (HES) data from April 2015 - December 2018. The analysis uses postcode of residence to identify activity from care homes. As such, it may include data pertaining to other addresses within the same postcode and overestimate activity from care homes.

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**801**	**846**	**786**	**677**
Comparators	1,031	961	967	1,000
England	1,028	937	938	971

Ratings – main acute trust(s) by admissions

Trust code	Trust name	Rating	% of LA's admissions to trust	% of trust's admissions from LA
RHM	University Hospital Southampton NHS Foundation Trust	Good	96%	38%



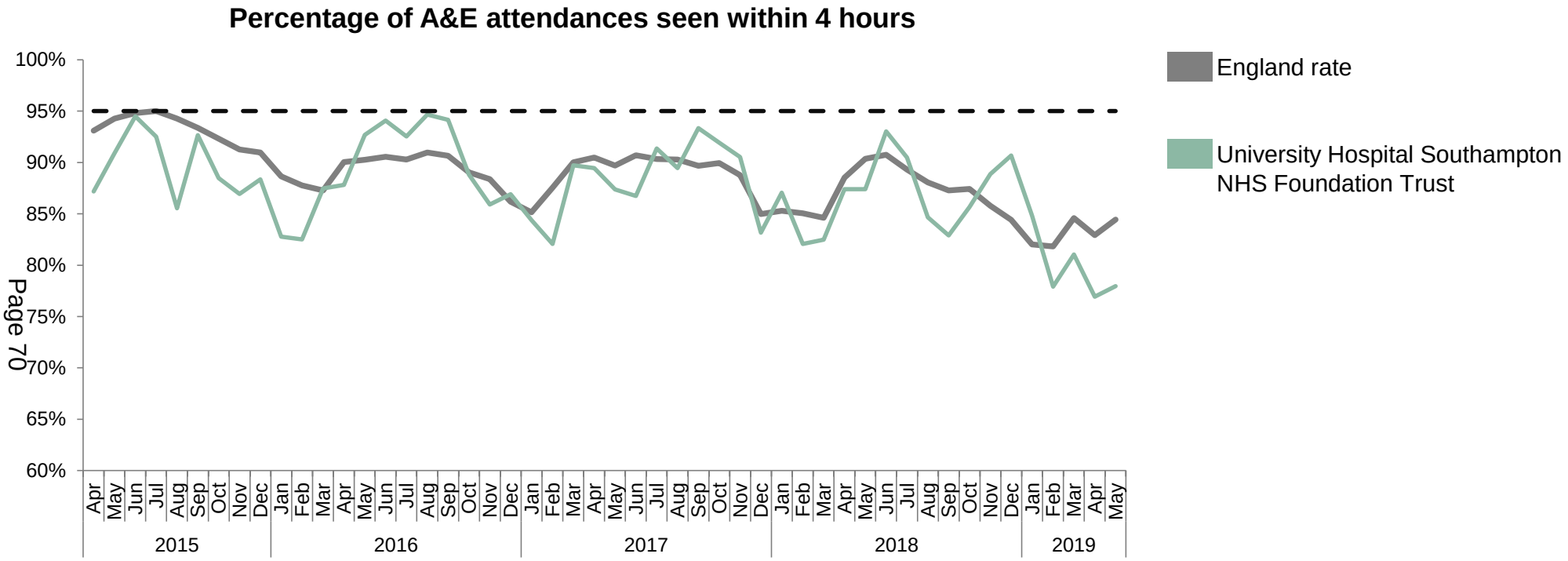
The table above shows the main acute hospital trust(s) serving the LA population. Trusts are included in this list if they receive more than 10% of the LA's admissions (based on Hospital Episode Statistics (HES) activity across 2017/18).

Overall trust ratings are accurate as of 18/07/19.

The map on the left shows the main trust(s) serving different parts of the LA (based on MSOA populations) as well as the surrounding area.

The trust boundaries are not to be seen as exclusive, rather the map serves more as a guide to which acute NHS trusts people residing in different parts of the LA are likely to access. The shading of the map does not indicate any value.

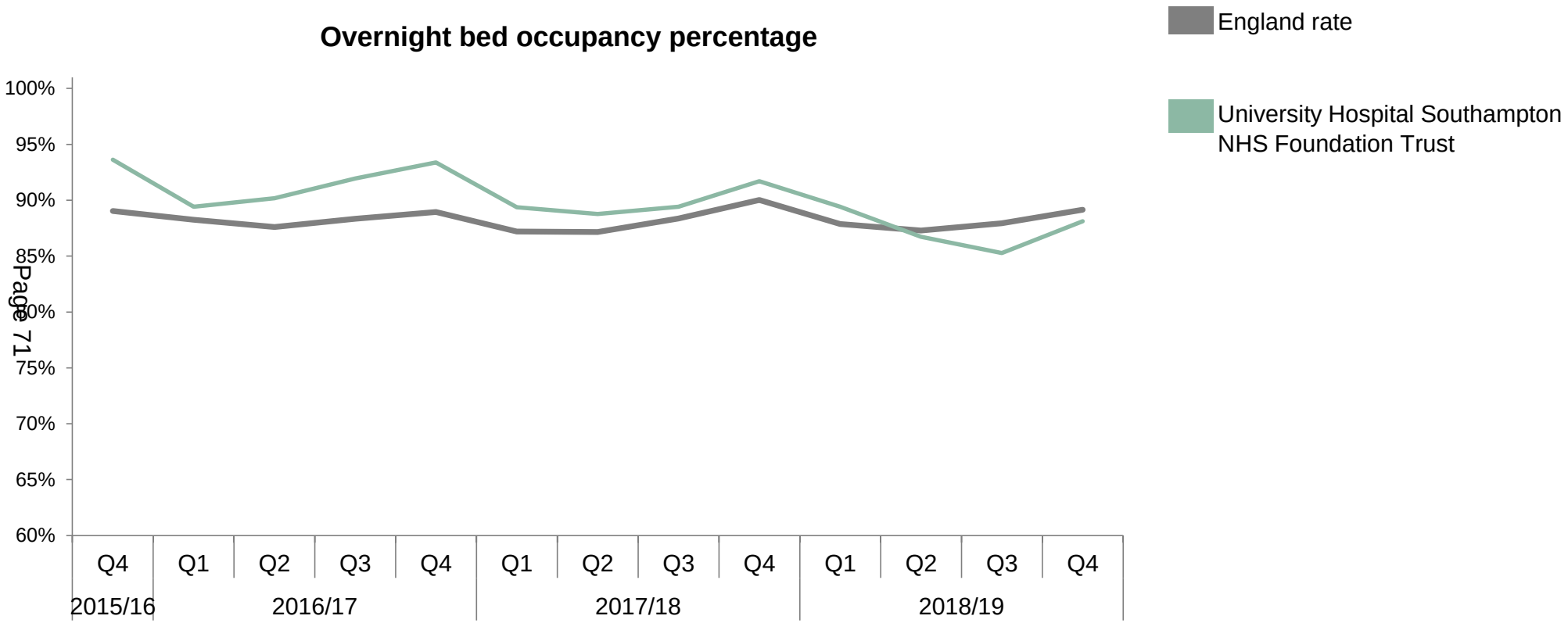
Activity – A&E four hour waits



The NHS Constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and then admitted or discharged in under four hours. A&E waiting times are often used as a barometer for overall performance of the NHS and social care system. This is because A&E waiting times can be affected by changing activity and pressures in other services such as the ambulance service, primary care, community-based care and social services.

Please note that as at May 2019, fourteen NHS acute trusts have agreed to work with national bodies to test proposed new standards for urgent and emergency care and, as such, they are not returning data against the four hour standard. This will impact on the national average. Please see the technical appendix for further information.

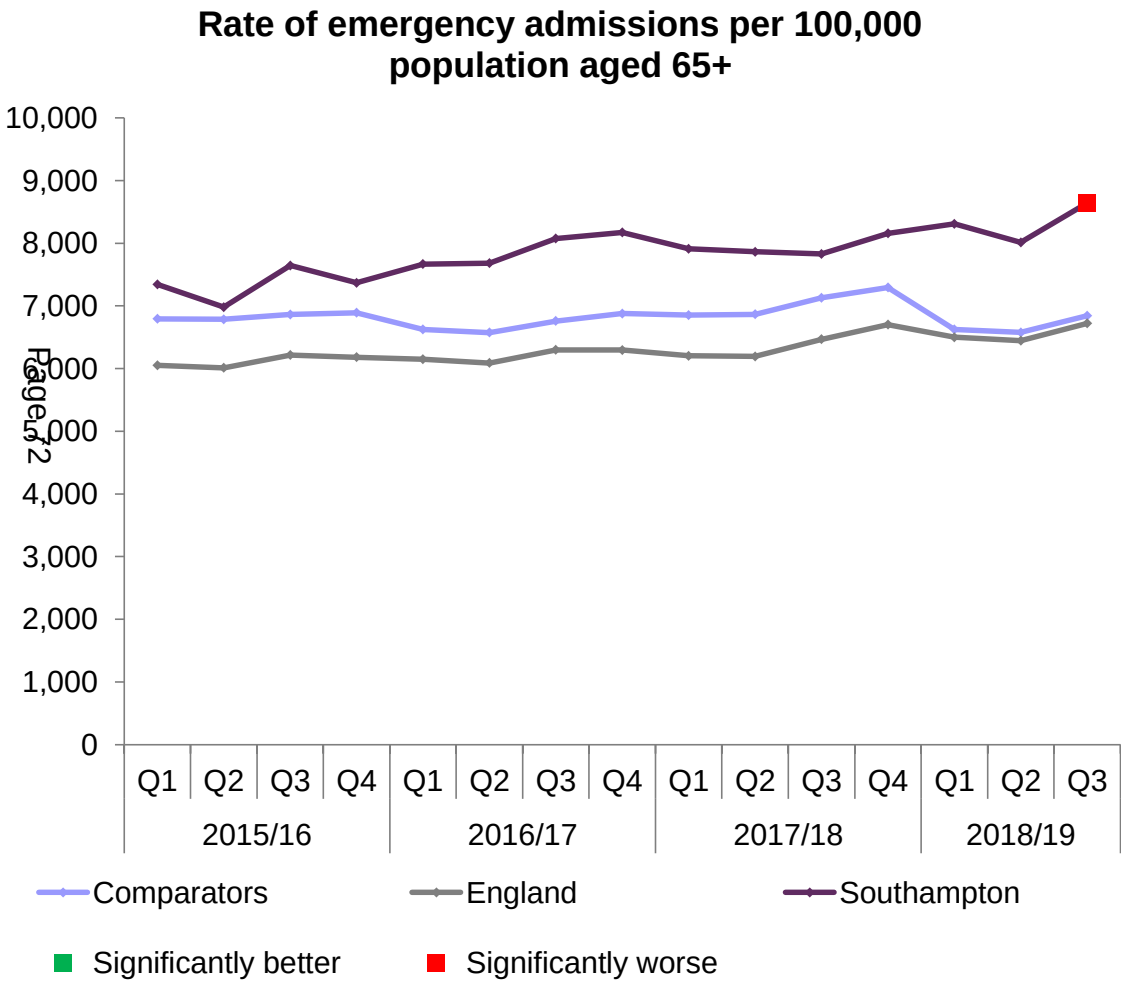
Service provision – acute bed occupancy



This slide shows the percentage of overnight beds that were occupied in the main trusts serving the LA in each quarter against England average figures for the quarter. Please note that England average figures for each quarter may be affected by missing data.

Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed-occupancy levels above 85% risk facing regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.

Activity – emergency admissions aged 65+

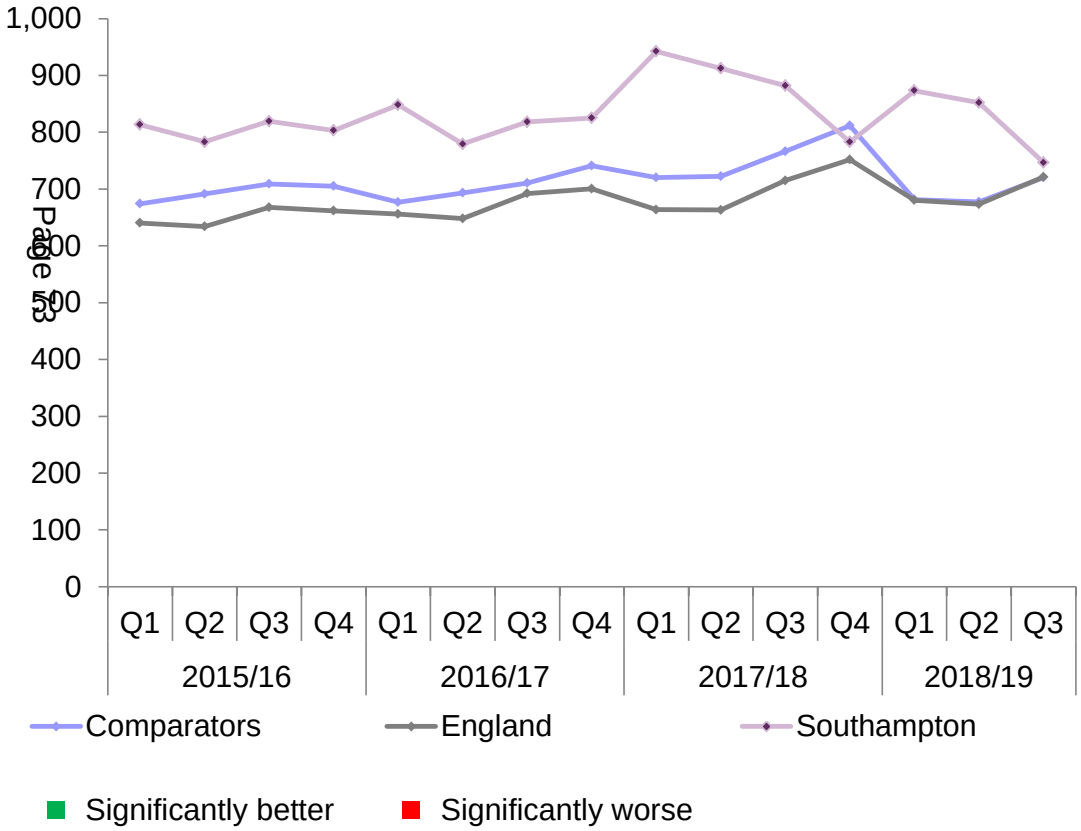


This slide shows analysis of emergency admission rates for people aged 65+. High rates of emergency admission may indicate problems with the wider health and social care system. This is based on Hospital Episodes Statistics (HES) data from April 2015 – December 2018

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**8,156**	**8,310**	**8,012**	**8,644**
Comparators	7,292	6,627	6,577	6,842
England	6,704	6,499	6,443	6,723

Activity – emergency admissions from care homes aged 65+

Rate of emergency admissions from care homes per 100,000 population aged 65+

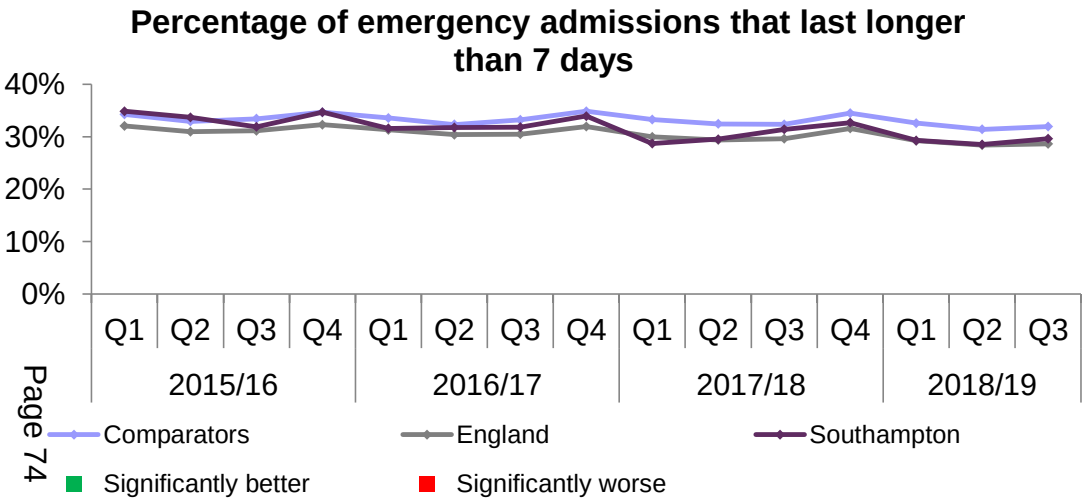


This slide shows analysis of emergency admission rates for people aged 65+ coming from care homes. This is based on Hospital Episodes Statistics (HES) data from April 2015 – December 2018.

Area	Financial year quarter			
	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
Southampton	**783**	**873**	**852**	**747**
Comparators	812	681	677	720
England	752	680	673	721

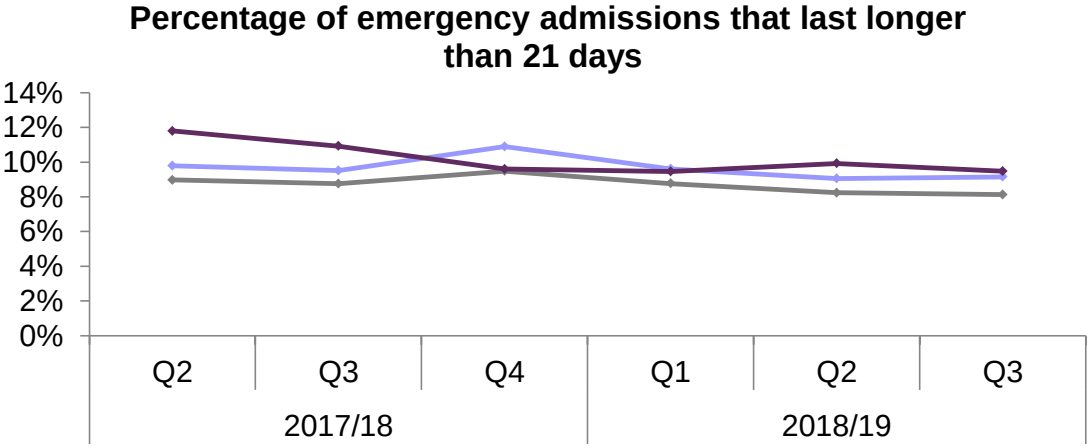
The analysis uses postcode of residence to identify activity from care homes. As such, it may include data pertaining to other addresses within the same postcode and overestimate activity from care homes.

Activity – length of hospital stay



Longer lengths of stay can act as a powerful proxy indicator of poor patient flow. CQC has looked at quarterly trends in emergency admissions for people aged 65+ that lasted longer than 7 days. This is based on Hospital Episodes Statistics (HES) data from April 2015 – December 2018.

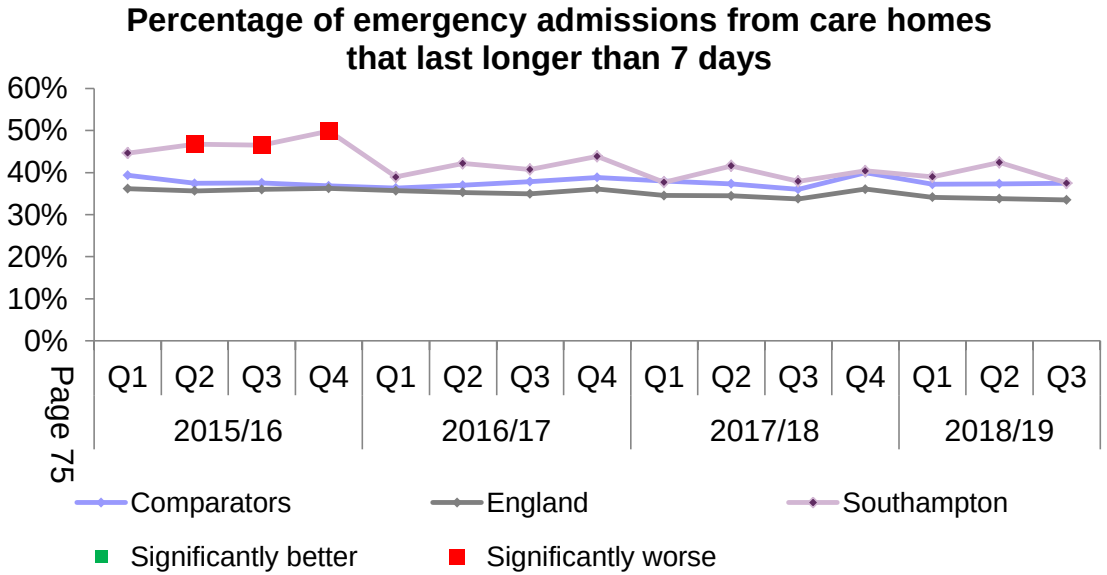
	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**33%**	**29%**	**29%**	**30%**
Comparators	34%	33%	31%	32%
England	32%	29%	28%	29%

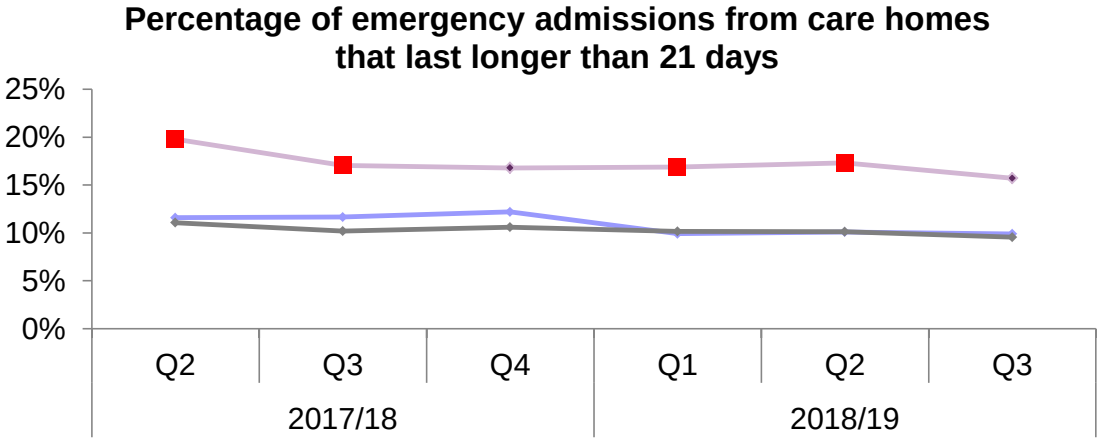


The 21 day measure is from July 2017 - December 2018. It follows a similar methodology to the measure above.

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**10%**	**9%**	**10%**	**9%**
Comparators	11%	10%	9%	9%
England	9%	9%	8%	8%

Activity – length of hospital stay - from care homes





CQC has also analysed emergency admissions for people aged 65+ coming from care homes that lasted longer than 7 days. This is based on Hospital Episodes Statistics (HES) data from April 2015 – December 2018.

It uses the postcode of residence to identify hospital activity from care homes and so may include data pertaining to other addresses within the same postcode and overestimate activity from care homes.

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**40%**	**39%**	**42%**	**38%**
Comparators	40%	37%	37%	37%
England	36%	34%	34%	34%

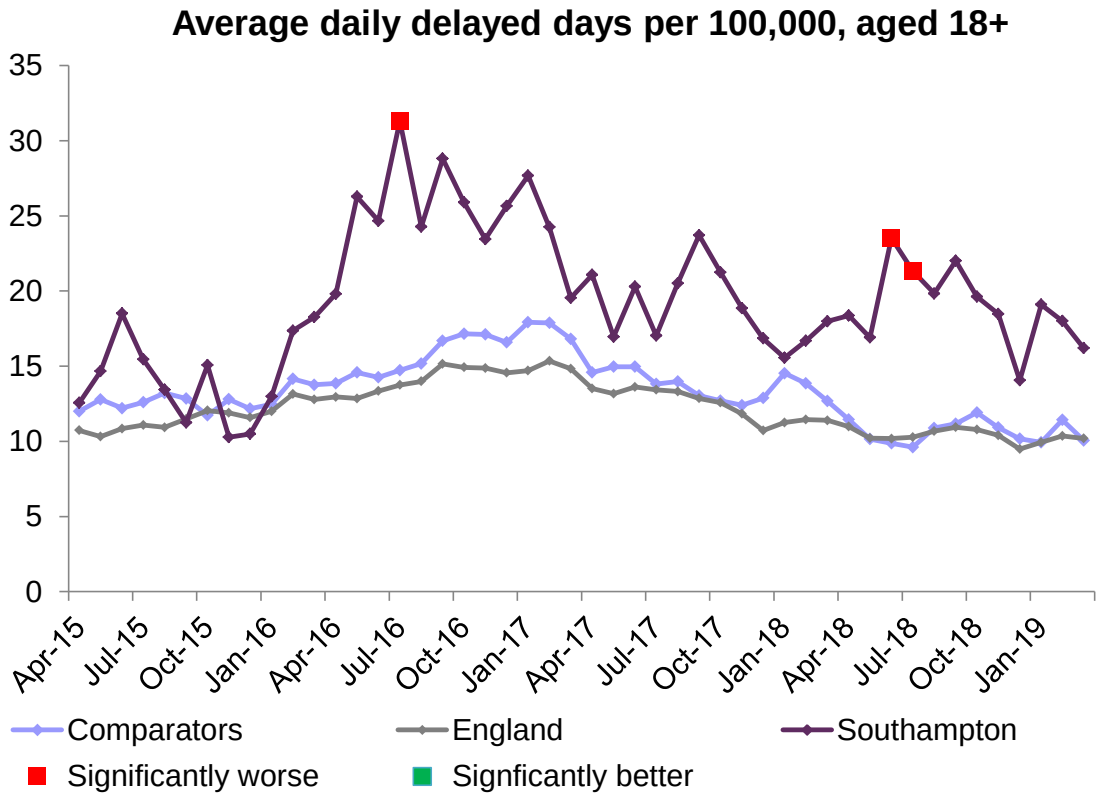
The 21 day measure is from July 2017 - December 2018. It follows a similar methodology to the measure above.

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**17%**	**17%**	**17%**	**16%**
Comparators	12%	10%	10%	10%
England	11%	10%	10%	10%

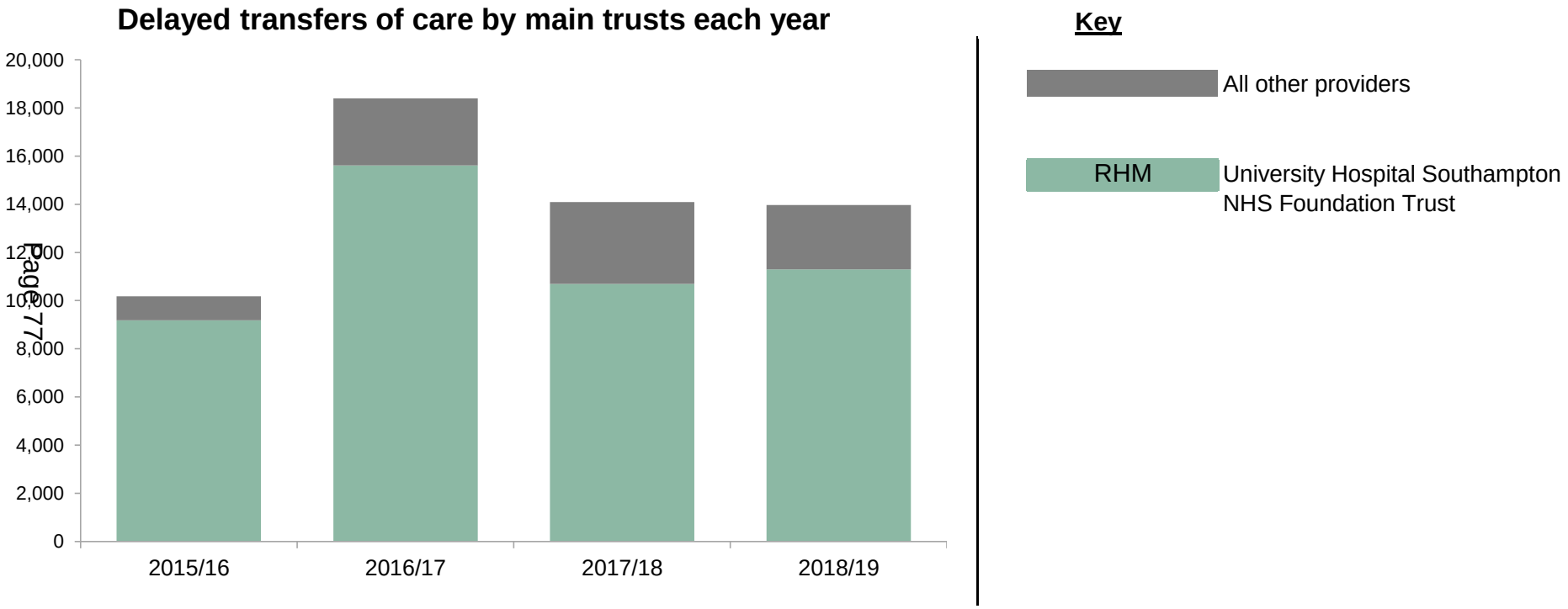
Activity – delayed transfers of care

This slide shows the daily average number of days transfers of care have been delayed as a rate per 100,000 population aged 18+ between April 2015 and March 2019. Delayed transfers of care reflect the ability of the system to ensure appropriate transfer from hospital to social care services for the entire adult population. It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Analysis is based on data from NHS England.

	Time period					
Area	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Southampton	**19.6**	**18.5**	**14.0**	**19.1**	**18.0**	**16.2**
Comparators	11.9	10.9	10.2	9.9	11.4	10.1
England	10.8	10.4	9.5	9.9	10.3	10.2



Activity – delayed transfers of care by main trust(s)

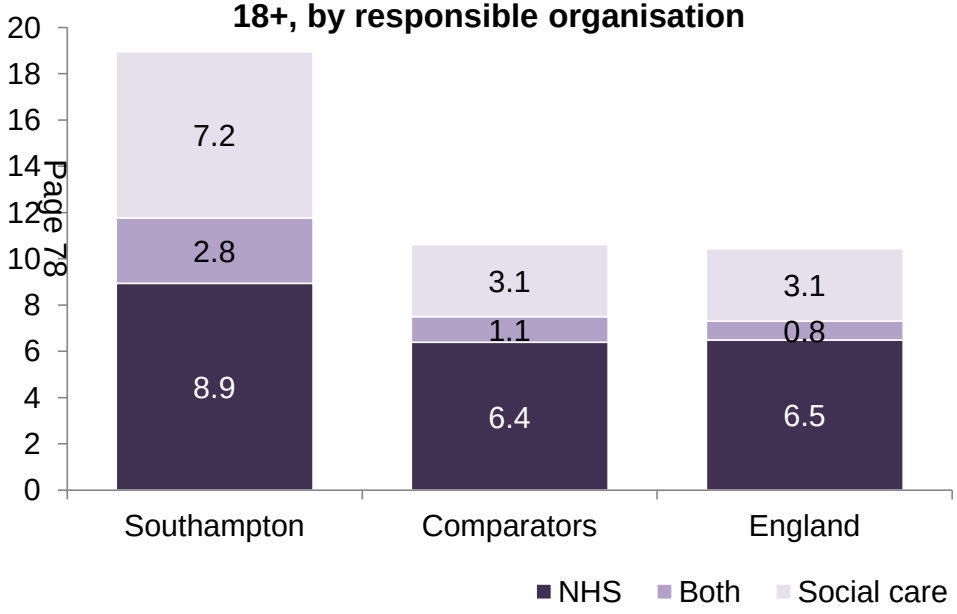


The chart shows delayed transfers of care within Southampton broken down by the trusts that those delays are coming from. Trusts are included if they have contributed more than 15% of DToCs in any year. As well as acute trusts, this slide may include DToCs from MH or community healthcare providers. Please note the main trusts contributing to delayed transfers of care in an area may not be the main providers in terms of volume of activity

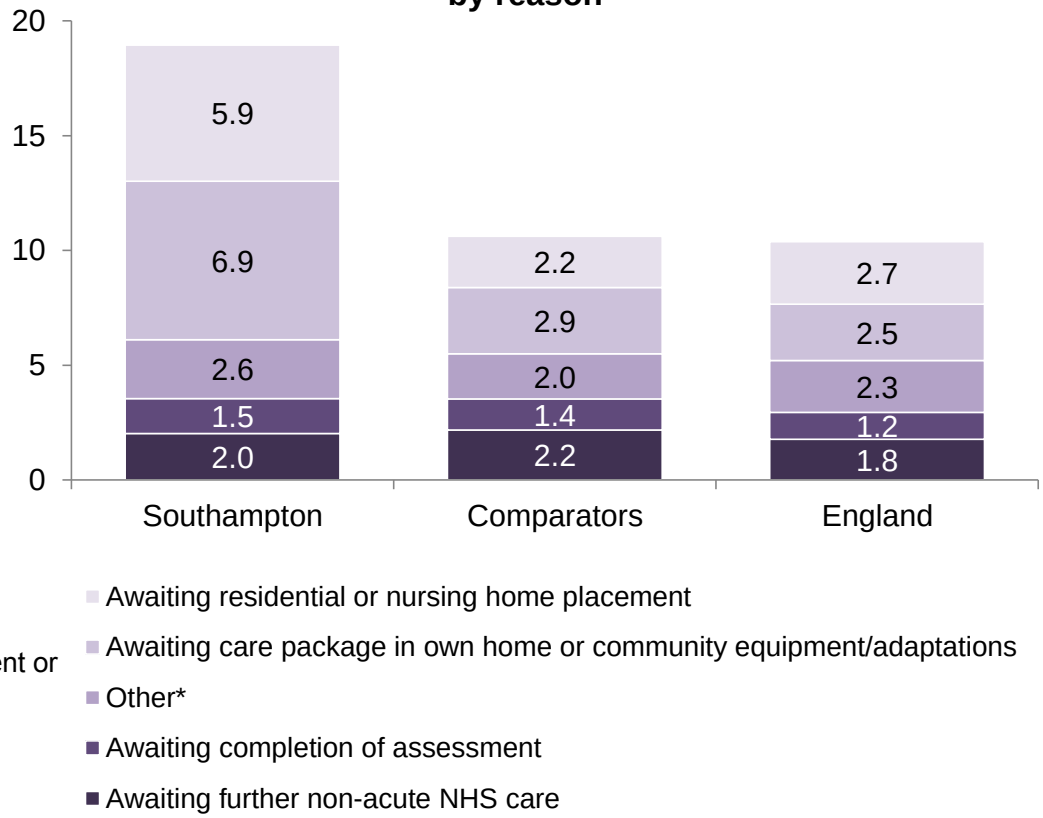
Actvity – delayed transfers of care by responsible organisation and reason

This slide shows the rate of delayed days per 100,000 population aged 18+ over the past year (April 2018 - March 2019), broken down to show the rate of delayed days attributed to the NHS against the rate attributed to social care and those attributed to a mix of both. The slide also shows the rate of delayed days according to the reason for delay. For the purpose of our analysis, some of the reasons have been grouped.

2018/19 average daily DToC per 100,000, aged 18+, by responsible organisation



2018/19 average daily DToC per 100,000, aged 18+, by reason

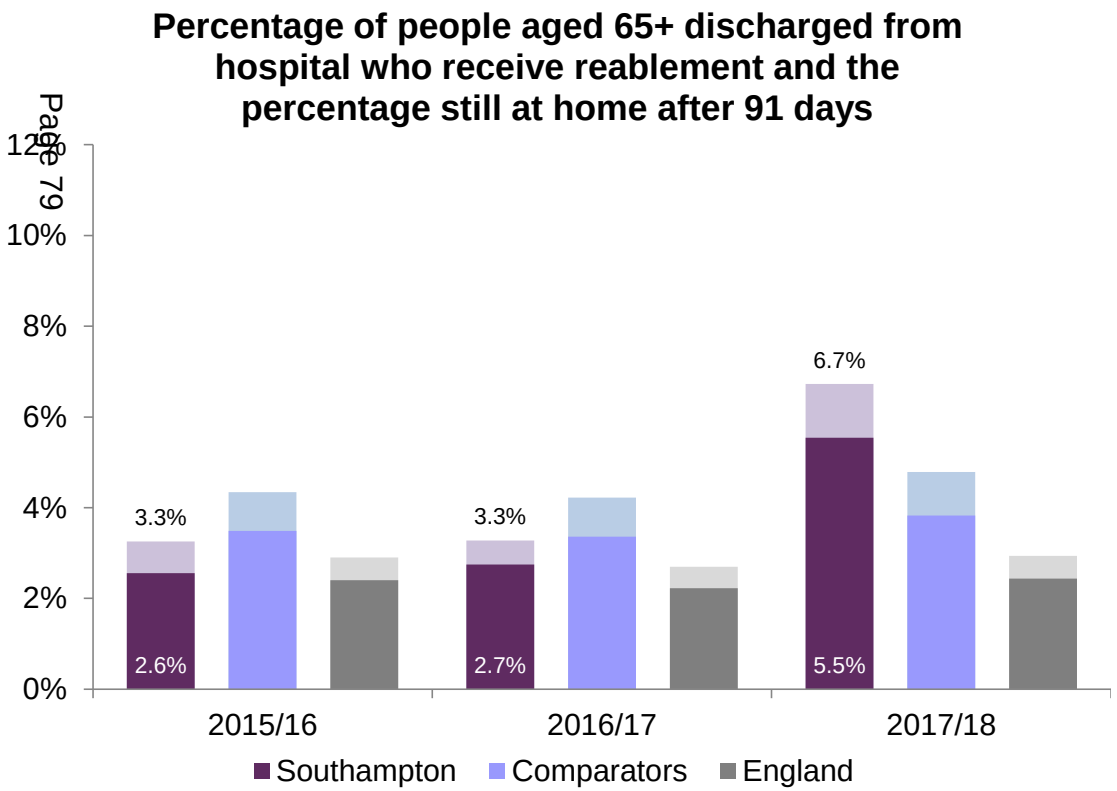


‘Further non-acute NHS care’ includes community and mental health care, intermediate care, rehabilitation services etc. ‘Other’ includes public funding, patient or family choice, disputes and housing. The categories are self-reported categories. Different LAs show a large variation in how frequently they report in the ‘Other’ category. For more information see:

DToC Guidance

Activity – reablement services

This slide shows the proportion of people aged 65+ discharged from hospital into reablement services, and the proportion still at home 91 days after discharge from hospital into reablement services. These measures are taken from the Adult Social Care Outcomes Framework (ASCOF). The chart provides a more nuanced view of the two ASCOF indicators by combining them to show the proportion of people aged 65+ who received reablement following discharge from hospital (lighter shaded bars) and, of all people aged 65+ discharged from hospital, the proportion that received reablement and were still at home 91 days later (bold shaded bars). The chart therefore shows the true volume of older people who benefitted from 'successful' reablement.



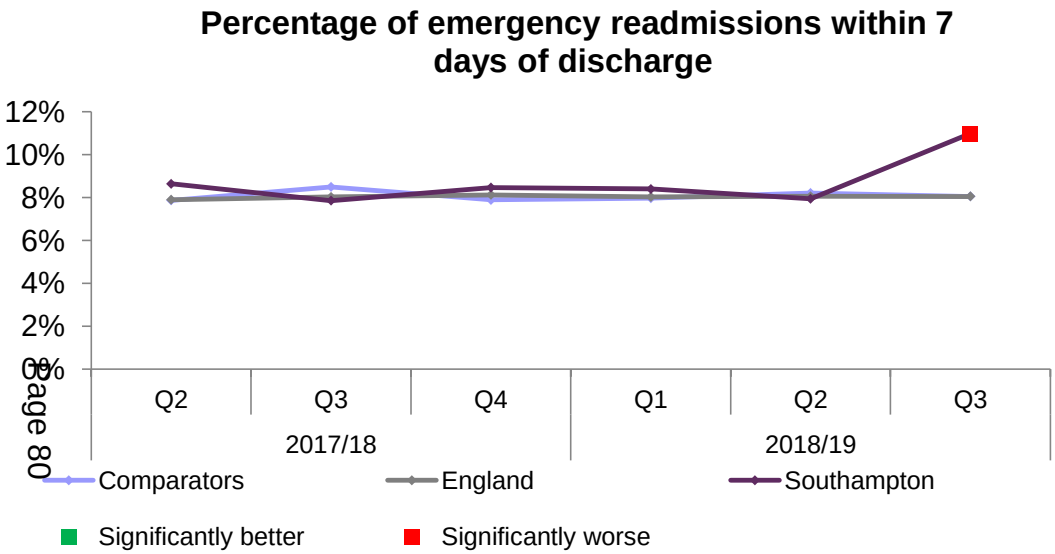
Percentage who received reablement

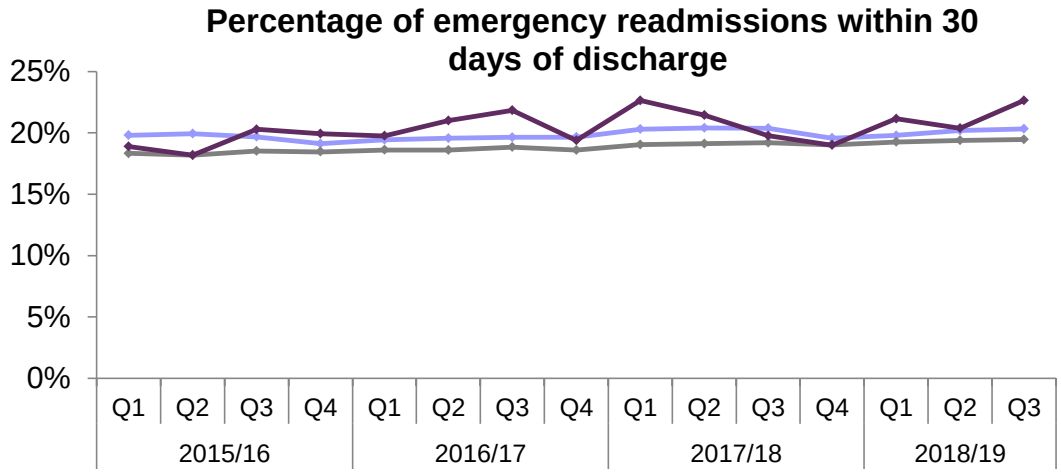
	2015/16	2016/17	2017/18
Southampton	**3.3%**	**3.3%**	**6.7%**
Comparators	4.3%	4.2%	4.8%
England	2.9%	2.7%	2.9%

Percentage who received reablement and were still at home 91 days following discharge

	2015/16	2016/17	2017/18
Southampton	**78.6%**	**83.9%**	**82.3%**
Comparators	80.4%	79.7%	80.0%
England	82.7%	82.5%	82.9%

Activity – emergency readmissions





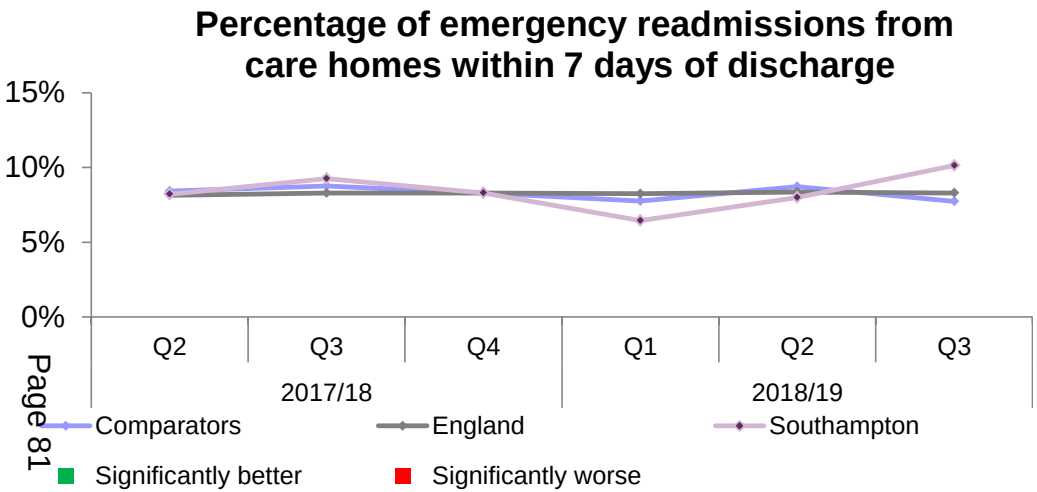
Emergency readmissions to hospital may reflect poor discharge planning and handover of care. CQC has looked at quarterly trends in emergency readmissions for people aged 65+ within 7 days of discharge. Analysis is based on Hospital Episodes Statistics (HES) data from June 2017 – December 2018.

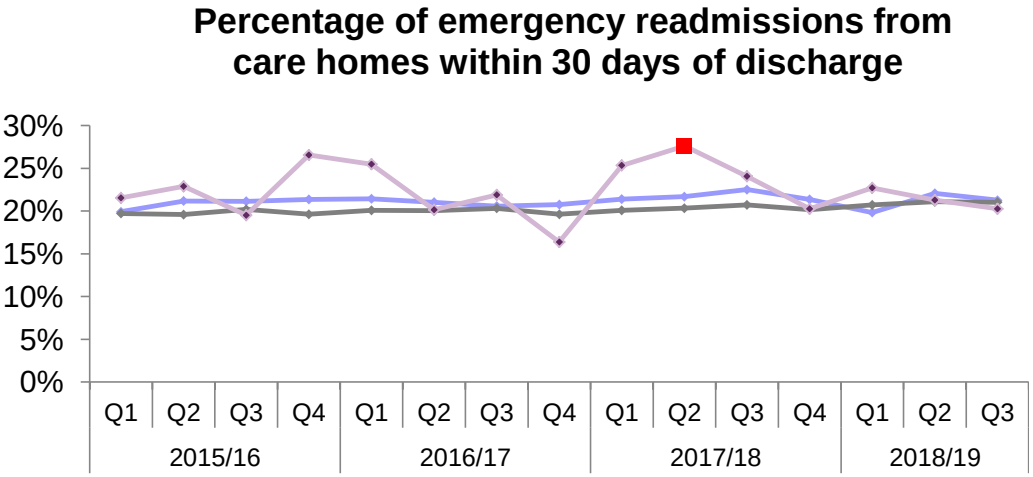
	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**8%**	**8%**	**8%**	**11%**
Comparators	8%	8%	8%	8%
England	8%	8%	8%	8%

The 30 day measure covers April 2015 - December 2018. It follows a similar methodology to the measure above.

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**19%**	**21%**	**20%**	**23%**
Comparators	20%	20%	20%	20%
England	19%	19%	19%	19%

Activity – emergency readmissions from care homes





CQC has looked at quarterly trends in emergency readmissions from care homes of people aged 65+ within 7 days. Analysis is based on Hospital Episodes Statistics (HES) data from July 2017 - December 2018. It uses the postcode of residence to identify hospital activity from care homes and so may include data pertaining to other addresses within the same postcode and overestimate activity from care homes.

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**8%**	**6%**	**8%**	**10%**
Comparators	8%	8%	9%	8%
England	8%	8%	8%	8%

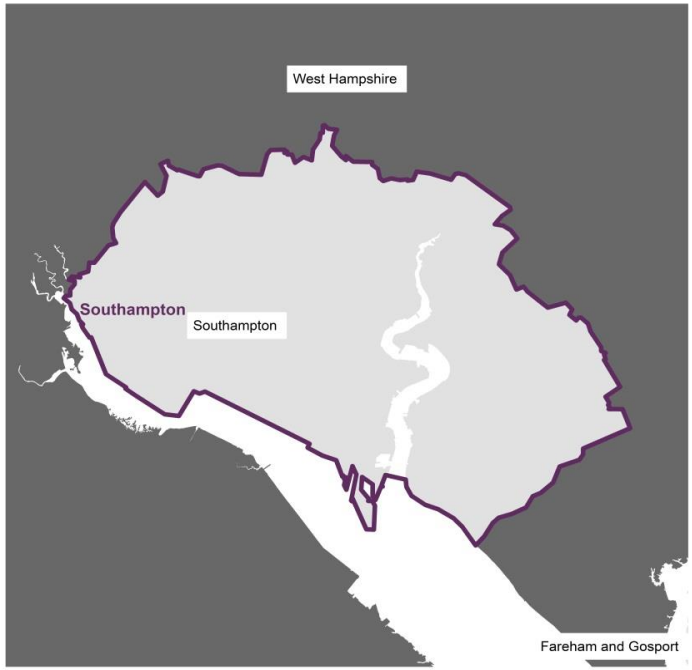
The 30 day measure covers April 2015 - December 2018. It follows a similar methodology to the measure above.

	Financial year quarter			
Area	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Southampton	**20%**	**23%**	**21%**	**20%**
Comparators	21%	20%	22%	21%
England	20%	21%	21%	21%

Local Authority to Clinical Commissioning Group mapping

The table below details the percentage of the LA population that is contained within the below CCGs as at Q3 18/19. It also shows the latest overall rating from NHS England's annual assessment of CCGs and the latest quarterly quality of leadership rating from the CCG Improvement and Assessment Framework. Mergers that happened at April 2019 are noted and represented in the map but not the table.

CCG code	CCG name	% of LA in CCG	% of CCG in LA	NHSE rating 2018/19	Quality of leadership rating 2018/19 Q3
10X	Southampton	100%	95%	Good	Requires improvement



The map on the left shows this LA outlined in purple with the latest post-April 2019 CCGs it covers underneath.

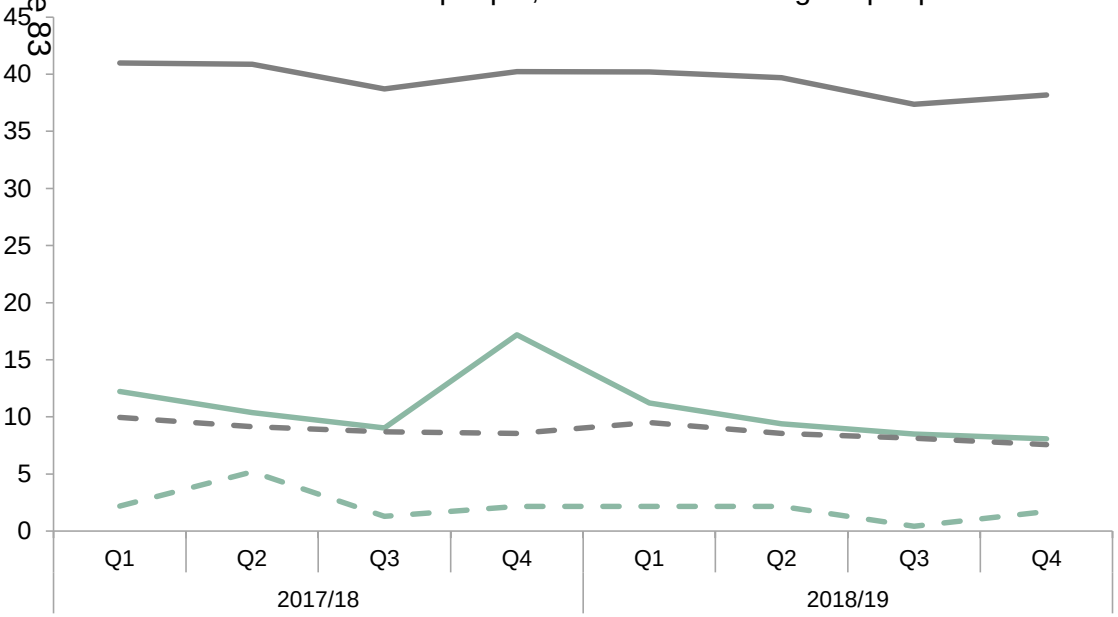
The CCG boundaries can be seen by the greyscale shapes which are labelled with the text in the white boxes. The shading of the CCGs on the map do not indicate any value.

Activity – NHS continuing healthcare (CHC)

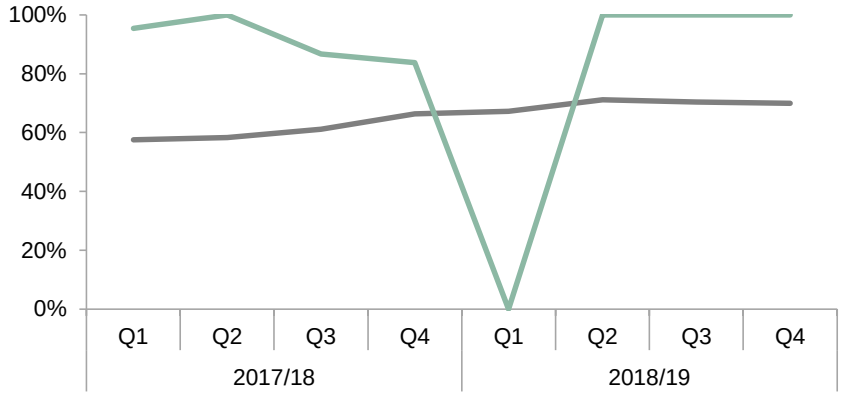
Key for all charts

England
NHS Southampton CCG

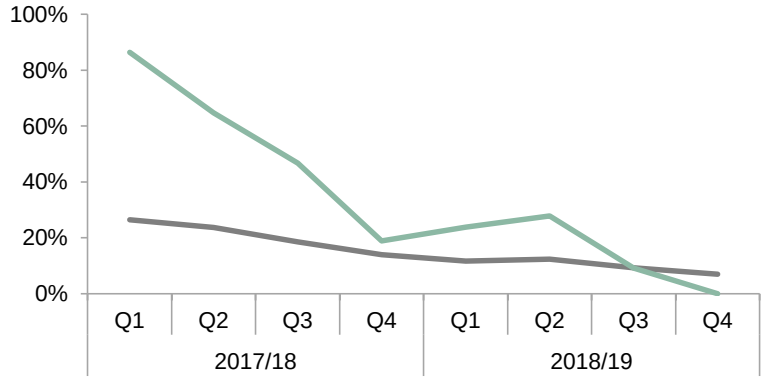
Number of new cases per 100,000 population aged 18+
Thick lines are referred people, dotted lines are eligible people



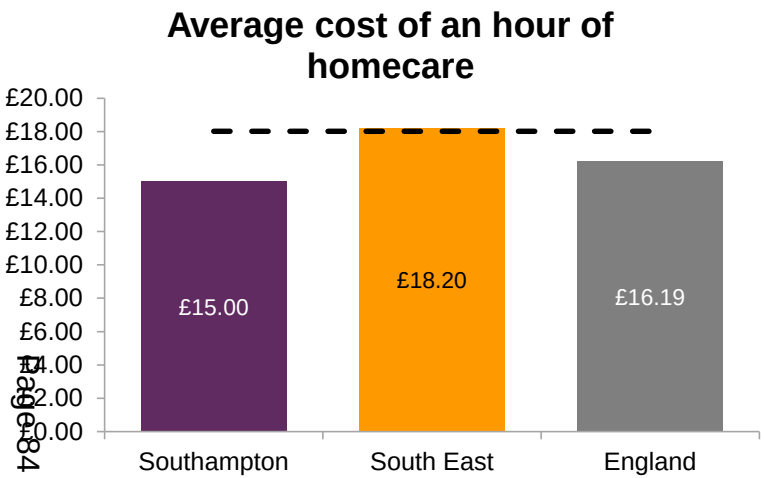
Percentage of CHC referrals completed within 28 days



Percentage of decision support tools completed in an acute setting



Funding – LA ASC costs

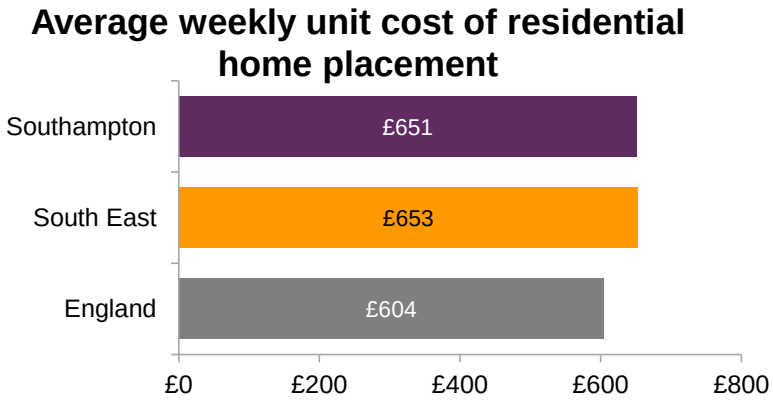


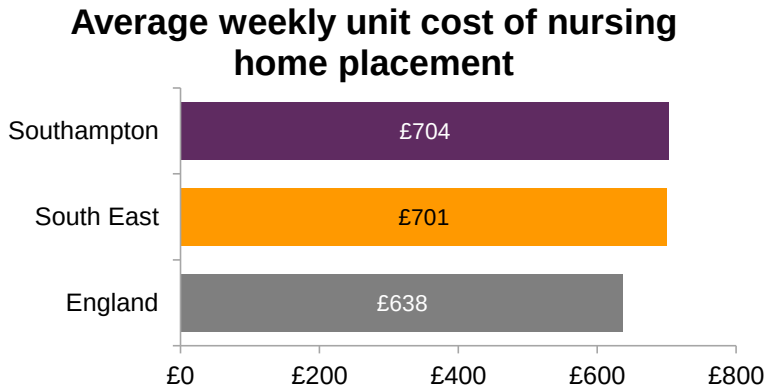
This chart uses figures from the 2018 UK Homecare Association report to show the average cost of an hour of homecare within the selected LA compared to the wider region and England. Data was collected via FoI requests submitted to each council for their average cost during a week in April 2018.

The UKHCA also calculated a **minimum price of £18.01 per hour of homecare,** represented as the dotted line on the chart. UKHCA's minimum price is designed to cover the cost of an hour of homecare commissioned by local authorities, while enabling providers to meet their legal obligations (including the National Minimum Wage) and the ability to run a sustainable business. The UKHCA have also set a minimum price of £18.93 for April 2019.

Link to UKHCA report

The charts below are taken from the 2017/18 Adult Social Care Finance Return (ASC-FR) and relate to people aged 65+





Progress against High Impact Changes

Implemention of the High Impact Change Model is designed to support system-wide improvements in transfers of care and is one of the four national conditions for the Better Care Fund plans for 2017-19.

The table below details the HWB's self-assessement of current and planned performance against each of the High Impact Changes for each quarter of 2018/19. The table at the bottom shows the national distribution of performance for the most recently published quarter.

Southampton		Early discharge planning	Systems to monitor patient flow	MDT/multi-agency discharge teams	Home first/ discharge to assess	Seven-day service	Trusted assessors	Focus on choice	Enhancing health in care homes	Red Bag scheme
Performance	**18/19 Q1**	**Established**	**Established**	**Mature**	**Mature**	**Plans in place**	**Established**	**Mature**	**Established**	**Plans in place**
Performance	**18/19 Q2**	**Established**	**Established**	**Mature**	**Mature**	**Plans in place**	**Established**	**Established**	**Established**	**Established**
Performance	**18/19 Q3**	**Established**	**Established**	**Mature**	**Mature**	**Plans in place**	**Not yet established**	**Mature**	**Established**	**Established**
Plans	*18/19 Q4*	Established	Established	Mature	Mature	Not yet established	Established	Mature	Mature	Established

National performance - 2018/19 Q3	Early discharge planning	Systems to monitor patient flow	MDT/multi-agency discharge teams	Home first/ discharge to assess	Seven-day service	Trusted assessors	Focus on choice	Enhancing health in care homes	Red Bag scheme
Not yet established	0%	0%	0%	0%	1%	1%	0%	0%	5%
Plans in place	13%	9%	5%	13%	31%	29%	7%	9%	21%
Established	65%	66%	61%	66%	55%	59%	71%	72%	57%
Mature	21%	24%	29%	18%	13%	11%	21%	17%	15%
Exemplary	1%	1%	4%	3%	1%	1%	1%	1%	1%

Appendix – comparators

Local authority comparator areas have been drawn from the Chartered Institute of Public Finance and Acccountancy's Nearest Neighbours model (data downloaded on 04/05/2017). This model identifies the 15 local authorities that are most similar to a selected LA, based on 39 variables that cover population size and density, age, gender and ethnicity make-up, deprivation, employment and housing. Local authorities are not compared to all other authorities in the country, but according to their categorisation into the following groups: London Boroughs, Metropolitan Districts and Unitary Authorities, and Counties.

The comparator group for Southampton LA is made up of the following local authorities, with the LA listed as number 1 being the most similar to Southampton.

1 Bristol, City of
2 Portsmouth
3 Plymouth
4 Newcastle upon Tyne
5 Coventry
6 Nottingham
7 Brighton and Hove
8 Salford
9 Sheffield
10 Derby
11 North Tyneside
12 Bolton
13 Swindon
14 Peterborough
15 Medway

Appendix – statistical analysis

Where we can transform the data into a standard normal distribution we have generated z-scores to measure how far the observed values of the selected LA deviate from the national average or 'mean'.

The z-scores reflect the number of standard deviations from the mean, after winsorising the data at the 10% level and controlling for over-dispersion.

Where an LA's z-score is greater than 2 or less than -2 it is said to be either 'significantly better' or 'significantly worse' than the national average.

Organisations are excluded from statistical analysis if their values are too low. This is represented by "-" in the accompanying table for the indicator.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:		HAMPSHIRE AND ISLE OF WIGHT LONG TERM PLAN
DATE OF DECISION:		24 OCTOBER 2019
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
In January 2019 NHS England published its Long Term Plan detailing circa 500 commitments. All health and care systems across the country have been asked to respond to the plan detailing how they will deliver on these commitments. The Hampshire and the Isle of Wight (HIOW) Long Term Plan details the local response to the national plan. Iterations of the plan, summarised in the attached document, are being received at Governing Bodies and Boards across the HIOW health and care system and describe the key themes of the plan.

RECOMMENDATIONS:		
	(i)	That the Panel notes and considers the priorities detailed in the plan, 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 priorities for 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 received a number of progress updates.
4.	The Panel agreed to review and monitor the development of the Partnership on a regular basis. Attached as Appendix 1 is a summary of HIOW Long Term Plan priorities.
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 Long Term Plan summary	
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 Long Term Strategic Delivery Plan

MOVING FORWARD TOGETHER

Introduction

- In January 2019 NHSE/I published their Long Term Plan for the NHS.
- Sustainability and Transformation Partnerships have been asked to develop their response to the 496 commitments made in the plan.
- We have discretion over the timing of some of the commitments.
- For the rest, targets and timescales are mandated
- We have split the commitments into nine themes and assigned clinical and executive leads for each.
- We have built upon existing engagement work to understand the views of our population and are currently undertaking additional engagement to test the themes of the plan with local people.
- The final version of the plan will be submitted mid Nov.

Themes of our plan

Long Term Plan priority areas

Clinical area

- Ageing well
- Cancer
- Cardiovascular disease
- Learning disabilities and autism
- Mental health
- Primary care
- Respiratory
- Stroke
- Starting well (maternity and paeds)

Other local priorities

- Urgent and emergency care
- Elective care

To be addressed through

A **new service model** for the 21st century based on:

1. High quality, proactive integrated care (removing the historic divide between primary and community care)
2. Networked care delivery
3. Improved access with capacity in the right place at the right time
4. Prevention programmes at scale and embedded in care pathways, targeted on reducing health inequalities

Supported by

5. Continuous quality and outcomes improvement
6. A high quality, supported workforce
7. Digital and data enabled services
8. Appropriate investment/finances
9. Our journey to ICS

SOURCE: Long Term Plan, HCW STP

A new service model - integrated care

Why is it important?

- Integrated care is essential to ensure that patients are treated in the right place at the right time, and in the most efficient way possible, having healthy independent lives
- The programmes support the development of seamless services that wherever possible aim to prevent admission to hospital
- The programmes are underpinned by a Population Health Management approach that aims to ensure that interventions made are effective and reach the right people
- Your Big Health Conversation saw 64% of the 2000 people asked say that the NHS must change and wanted a focus on community-based care

Our focus:

- Building a clear vision for community care
- Describing and rolling out a new integrated population health focussed care model
- Build a new workforce model including mental health specialists, pharmacists, physiotherapists
- Modernising the primary and community estate
- Investing in a digital programme to improve access to care and access to comprehensive patient records

A new service model - networked care

Why is it important?

- No provider organisation will be able to meet constitutional standards for access at present levels of demand and capacity – this situation could improve by establishing operational delivery networks.
- Local specialist services would benefit from more robust network engagement to become and remain comparable to national peers
- When thinking about hospital care, people told us that having the right level of expertise within the surgical team was the most important, followed closely by having access to a specialist team that operates a 24/7 rota. (Southern Hampshire Review of Vascular Services, 2016)

Our focus:

Supporting current networks and alliances whilst establishing networking as business as usual. Particular specialties of focus:

- Stroke
- Pathology
- Mental health – in particular out of area placements.
- Care for the population of the Isle of Wight
- Cancer

A new service model - access

Why is it important?

- Current performance indicates a mismatch of demand and capacity – this work is required to ensure the right capacity, in the right place, at the right time to meet demand and deliver operational, quality and financial outcomes
- Resources (financial, people, estate, equipment) are not limitless and should be deployed in the most efficient way to reduce unwarranted variation
- Mismatches in demand and capacity in one part of the system can have unintended consequences in others
- Local people tell us improving access should be one of our biggest priorities.

Our focus:

- Using data to identify opportunities to improve productivity
- Simplifying outpatients
- Mental health out of area placements
- Diagnostics
- Urgent access to primary care
- Ensuring people with learning disabilities have equity of access to care

A new service model - prevention

Why is it important?

- The ageing demographic in Hampshire and the Isle of Wight, with increasing frailty and multimorbidity, is a significant driver of health and social care needs.
- People living in deprived circumstances experience poorer health and, on average, die earlier than people in the more affluent areas.
- We need a radical approach to preventing ill health across the life course to manage future demand.

Our focus:

- Smoking and alcohol
- Reducing mortality for people with mental illness
- Behaviour change training for staff
- Diabetes prevention
- Prevention of cardio vascular disease
- Recognition of the importance of the wider determinants of health
- Increasing screening and immunisations
- Using data and intelligence to inform decision making

Quality and outcome improvements

Why is it important?

- To reduce unwarranted variation
- We are below national average on a number of specialties
- We must ensure the use of research and innovation to provide the best possible care

Our focus:

- Maternity, in particular a reduction in still births, maternal mortality and perinatal mental health
- Children and young people
- Learning disabilities and autism – with a particular focus on improving their physical health
- Reducing the number of people experiencing stroke, dementia and heart attacks
- Improvement against our diabetes targets
- Respiratory – improving access to care and better quality management of condition
- Delivering increasing levels of research and innovation

Workforce

Why is it important?

- Availability of workforce is the largest risk to all health and social care services.
- We are not attracting sufficient numbers of new staff. In Hampshire and the Isle of Wight, we are forecasting a decrease in our supply pipelines of 10.4% to 2024.
- Too many of our staff are leaving. We have a turnover rate of 14.2% against an England average of 9.1%.

Our focus:

- Making Hampshire and the Isle of Wight a great place to work
- Improving our leadership culture
- Tackling our workforce capacity issue – including recruitment and retention and collaborative bank
- Delivering 21st Century Care – including offering fulfilling flexible careers, increasing time to care, an new approach mental health workforce
- Delivering a new workforce operating model

Digital

Why is it important?

- Technology can help people take control of their health
- Better access to shared digital records helps us improve services and quality of care.
- Technology can help reduce inefficiencies and focus resources more appropriately.
- Rich and comprehensive data can help us plan and target services better and improve performance.
- Access to real-time data and intelligence can enable instant quality improvements
- People have told us that they want quick and easy access to clear information to help them make decisions about their health and care. (Healthwatch, 2019)

Our focus:

- Integrated health and care records
- Information governance
- Improving the digital maturity of our providers
- Intelligence and analytics
- Digital access and empowerment
- Public and clinical engagement

Moving to an Integrated Care System

Why is it important?

- It is fully recognised that an increasingly integrated system that delivers shared leadership and action is a key component of any plan that seeks to improve outcomes, reduce variation, deliver greater efficiencies and support financial sustainability.
- An ICS will enable local organisations to redesign care and improve population health. It is a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care

Our focus:

- Leadership, relationships, capability
- Vision and strategy
- Operational delivery
- Financial management
- Care delivery

Finances

Why is it important?

- By 2024 the financial allocation to the NHS in Hampshire and the Isle of Wight will have grown by £0.5 billion p.a. compared with 2019.
- We must understand how best to deploy this money in order to maximise the benefits for our local population.

Our focus:

- Work to agree the focus of this additional investment is ongoing and updates will be brought to partners as soon as they are available.

Involving local people

Long Term Plan Engagement drop in sessions from 4-7pm:

- Tuesday 8th October – The Pavilion Room, The Ark, Basingstoke
- Mon 14th October - The Atrium, Spark Building, Solent University, Southampton
- Wed 16th October – The Portsmouth Marriott, Portsmouth
- Thursday 17th October – The Sugar Store Events Centre, Cowes Harbour, Isle of Wight

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON CITY FIVE YEAR HEALTH AND CARE STRATEGY 2020-2025 UPDATE		
DATE OF DECISION:		24 OCTOBER 2019		
REPORT OF:		JAMES RIMMER, MANAGING DIRECTOR, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	Clare Young	**Tel:**	023 8029 6904
	E-mail:	clare.young4@nhs.net		
Director	**Name:**	James Rimmer	**Tel:**	023 8029 6904
	E-mail:	James.Rimmer3@nhs.net		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY This update sets out the priorities of the main programmes and workstreams for the city's five year health and care strategy, and timescales for completion.		
RECOMMENDATIONS: That the Panel		
	(i)	Notes the update.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To ensure the Health Overview and Scrutiny Panel has oversight of the progress being made to complete the five year strategic plan. The attached document follows previous updates to the panel in November 2018 and June 2019.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable.	
DETAIL (Including consultation carried out)		
3.	This draft document outlines the vision, goals and mission for the strategy, provides a high level overview of the draft priorities for each programme and workstream, and outlines expected timescales for completion.	
4.	The previous update to the Panel, in June 2019, outlined the challenges which require addressing. We have now proceeded, with support from partners, to incorporate further details on how those challenges will be addressed and how improvements will be delivered over the next five years into the final version of the strategy. Draft five year programme plans have now been developed for each programme. Each programme plan has focused on: • The current challenges in Southampton.	

	• The root causes of these challenges. • What we want to be different in five years' time. • How we are going to get there. • How we will know we're making a difference (KPIs).
5.	The plans are currently being reviewed and further refined. The governance structure for the strategy is in place. The Better Care Southampton Board will have oversight of delivery of the strategy.
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	Not applicable.
Property/Other	
7.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	Not applicable.
Other Legal Implications:	
9.	None.
RISK MANAGEMENT IMPLICATIONS	
10.	None.
POLICY FRAMEWORK IMPLICATIONS	
11.	Not applicable.

KEY DECISION?	No	
WARDS/COMMUNITIES AFFECTED:	ALL	
SUPPORTING DOCUMENTATION		
Appendices		
1.	SOUTHAMPTON CITY FIVE YEAR HEALTH AND CARE STRATEGY 2020-2025 (HOSP UPDATE)	
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)		
1.	None	

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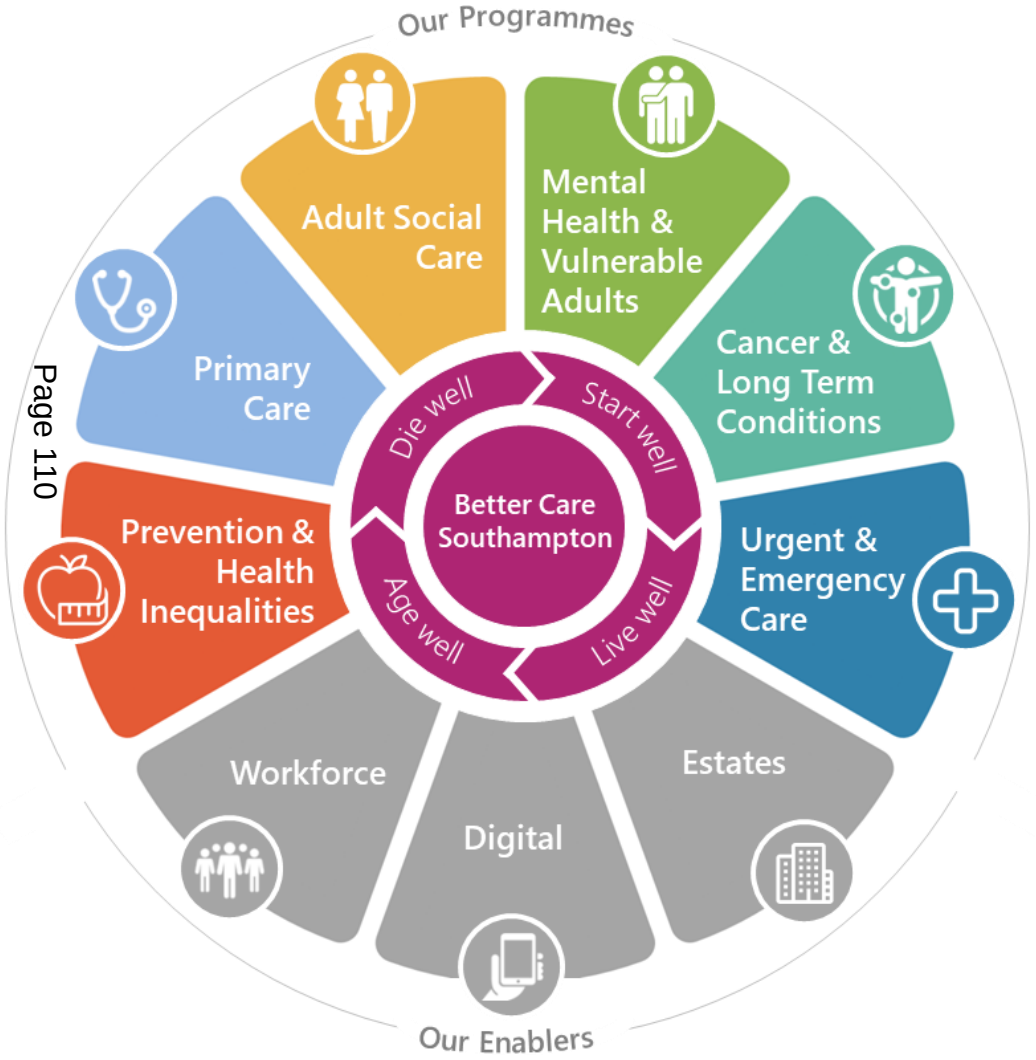
Southampton City Five Year Health and Care Strategy

2020-2025

HOSP Update

Southampton City Five Year Health and Care Strategy 2020-2025



Our Vision

One city, our city, a healthy Southampton where everyone thrives

Our Goals

- Reduce **health inequalities** and confront deprivation
- Give **children and young** people a strong start in life
- Tackle the city's '**three big killers**': Cancer, Cardiovascular and Respiratory
- Improve **whole-person** care
- Improve **mental and emotional** wellbeing
- Build resourceful **communities**
- Reduce variation in **quality and productivity**

Our Mission

Effective system partnerships delivering safe, sustainable, coordinated care with the people of Southampton

Our Health & Care Partners

NHS Southampton City Clinical Commissioning Group
SOUTHAMPTON CITY COUNCIL
Southampton Voluntary Services
NHS Solent NHS Trust
NHS Southern Health NHS Foundation Trust
NHS University Hospital Southampton NHS Foundation Trust
Southampton Primary Care Ltd.

DRAFT

Our Programmes & Workstreams

Start Well

- Child Friendly Southampton
- City-Wide integrated specialist services
- Maternity
- Extended Early Help Locality Teams
- Children with SEND
- Managing acute childhood illness outside of hospital

Age Well

- Supporting people to stay well into older age
- Reactive care, recovery & reablement through integrated intermediate care provision
- Falls prevention
- Proactive care and support through integrated locality teams
- Enhanced Health in Care Homes
- Improving hospital discharge

Die Well

- Supporting people to die in their preferred place of death
- Robust Fast-Track Processes
- Personalisation
- Continuity of care
- Bereavement care

Prevention & Health Inequalities

- Encourage people to stop smoking
- Promote healthy weight and physical activity
- Encourage people to stop drinking too much alcohol
- Make Every Contact Count (MECC)
- Health in all policies
- Planning for health
- Tackle health inequalities
- Healthy settings

Primary Care

- Improve access to primary care
- Improve the quality and sustainability of services
- Digitally-enabling primary care
- Population health
- Integrated, networked primary care
- Workforce & skills
- Fit-for-purpose, modern estate

Adult Social Care

- Supporting people to help themselves
- Creating stronger communities for Southampton to be a city that supports greater wellbeing
- Meeting peoples' ongoing needs through high-quality, good value personalised support
- Training & IT

Mental Health & Vulnerable Adults

Mental Health:

- Perinatal Mental Health
- Common Mental Illnesses
- Serious Mental Illnesses
- Crisis Care & Liaison
- Suicide Reduction
- Older People's Mental Health
- Inpatient Care
- Rough sleepers support

Vulnerable Adults:

- Homelessness
- Substance Misuse
- Sex Workers
- Domestic & Sexual Abuse
- Modern Slavery
- Hoarders

Learning Disabilities & Autism

Cancer & Long Term Conditions

Cancer

- Increasing Screening
- Earlier Diagnosis
- Improving Cancer Pathways

Long Term Conditions

- Cardiovascular Disease
- Respiratory Disease
- Diabetes

Urgent & Emergency Care

Pre-Hospital Urgent Care

- Public communications & engagement
- Integrated Urgent Care, including NHS111
- Enhanced and Urgent access to Primary Care Services and Urgent Treatment Centre

Hospital Emergency Care

- Same Day Emergency Care
- Internal A&E processes
- Improving flow
- Ambulance Pathways

Workforce

- Planning the workforce needs of tomorrow, today
- Creating a great place to work
- Attracting and developing talent
- Developing an employment experience which works
- Developing empowering leaders

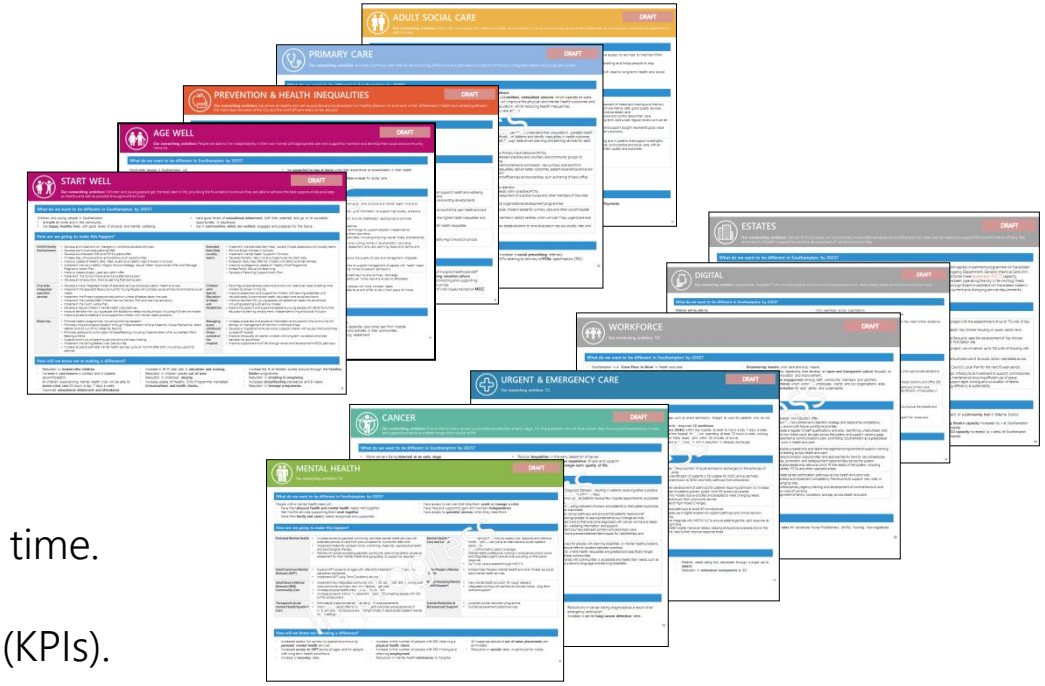
Digital

- Making best of new technologies
- Making best use of population health analytics
- Exchange and use of data and information
- Improving infrastructure

Estates

- RSH & WCH Campus Optimisation
- Locality Hubs & Primary Care Estate Optimisation
- Housing with Care
- Key Worker Housing
- Provider Trust Estate Strategies
- One Public Estate & Local Plan Development

Where are we now?



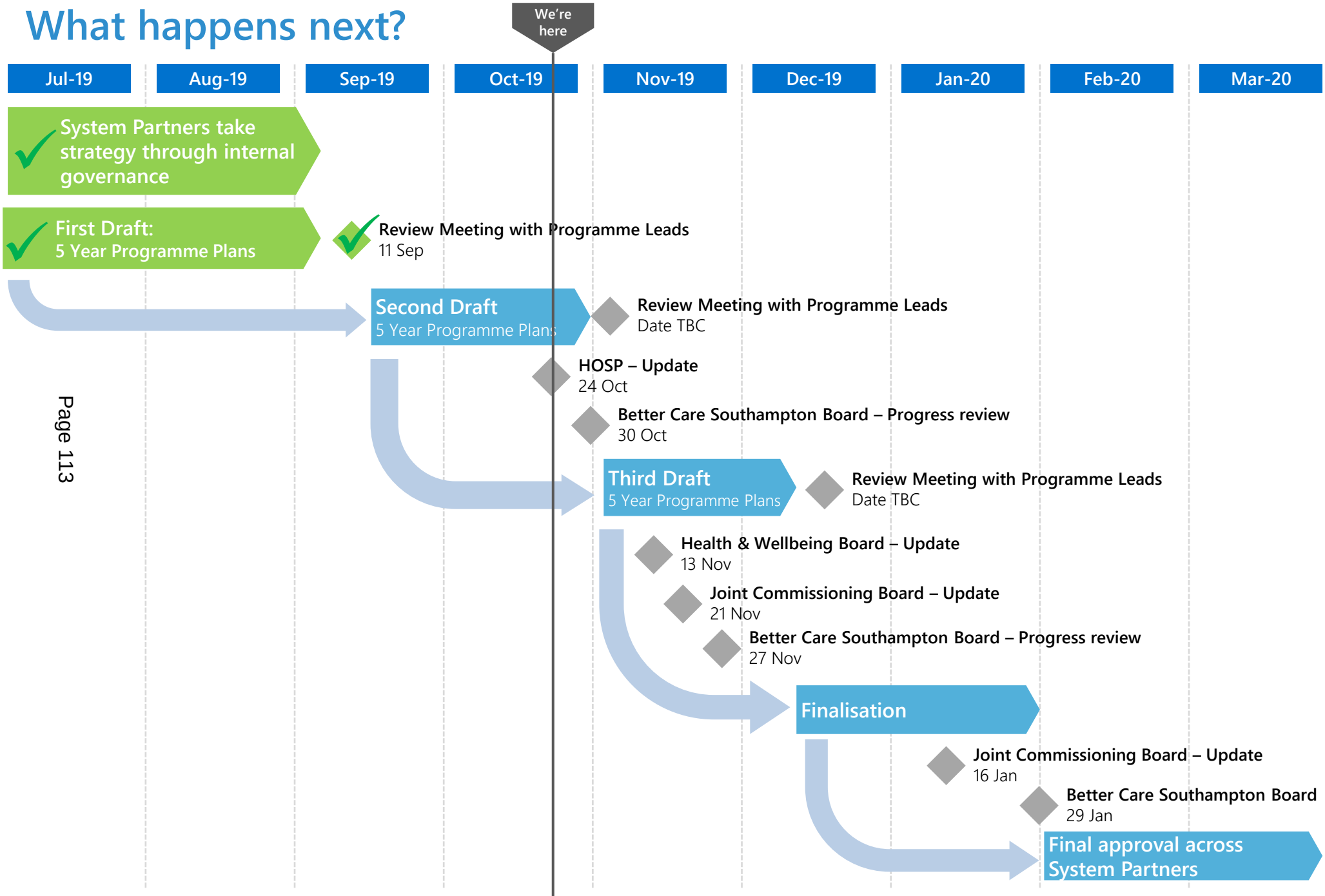
- **Draft five year plans** have now been developed for each programme.

- Each programme plan has focused on:
  - The **current challenges** in Southampton.
  - The **root causes** of these challenges.
  - What we want to be **different** in five year's time.
  - **How** we're going to get there.
  - How we'll **know** we're making a difference (KPIs).

- The plans are currently being reviewed and further refined.

- The **governance structure** for the strategy is in place. The Better Care Southampton Board will have oversight of delivery of the strategy. Subgroups (new and existing) are in place for each of programme, which are responsible for developing and implementing the five year programme plans. The subgroups will regularly report progress into the Better Care Southampton Board.

What happens next?



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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MONITORING SCRUTINY RECOMMENDATIONS		
DATE OF DECISION:		24 OCTOBER 2019		
REPORT OF:		DIRECTOR - LEGAL AND GOVERNANCE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		
Director	**Name:**	**Richard Ivory**	**Tel:**	**023 8083 2794**
	E-mail:	**Richard.ivory@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
This item enables the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.		
RECOMMENDATIONS:		
	(i)	That the Panel considers the responses to recommendations from previous meetings and provides feedback.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To assist the Panel in assessing the impact and consequence of recommendations made at previous meetings.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	Appendix 1 of the report sets out the recommendations made at previous meetings of the Health Overview and Scrutiny Panel. It also contains summaries of any action taken in response to the recommendations.	
4.	The progress status for each recommendation is indicated and if the Health Overview and Scrutiny Panel confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Panel does not accept the matter has been adequately completed, it will be kept on the list and reported back to the next meeting. It will remain on the list until such time as the Panel accepts the recommendation as completed. Rejected recommendations will only be removed from the list after being reported to the Health Overview and Scrutiny Panel.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	None.	

Property/Other		
6.	None.	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.	
Other Legal Implications:		
8.	None	
RISK MANAGEMENT IMPLICATIONS		
9.	None.	
POLICY FRAMEWORK IMPLICATIONS		
10.	None	
KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Monitoring Scrutiny Recommendations – 24 October 2019	
2.	Continuing Healthcare Benchmarking	
3.	GP data	
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	

Health Overview and Scrutiny Panel (HOSP)

Scrutiny Monitoring – 24 October 2019

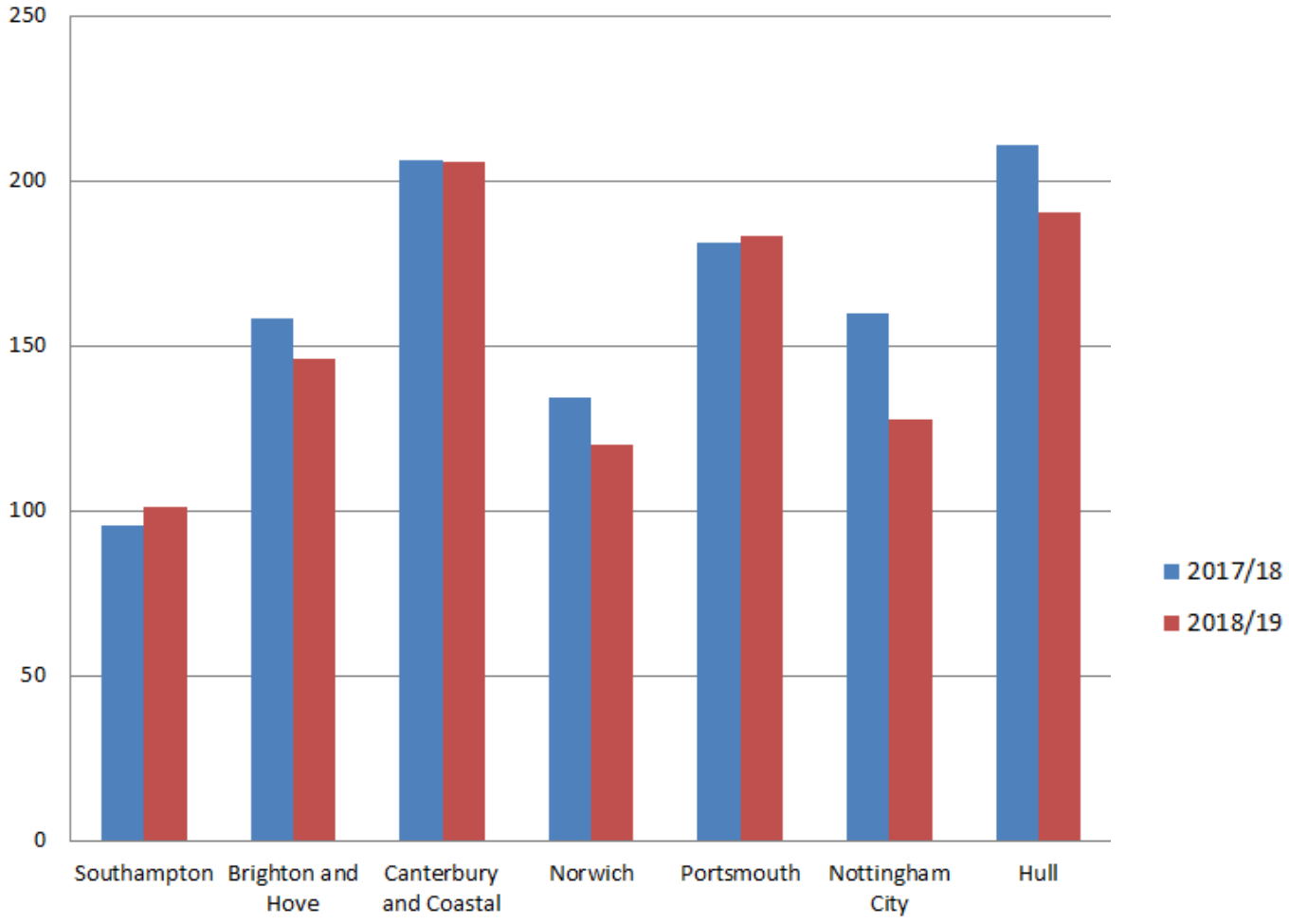
Date	Title	Action proposed	Action Taken	Progress Status
29/08/19	Continuing Healthcare	1) That NHS Southampton City CCG undertake analysis for the Panel of the variation between the number of Continuing Healthcare assessments and those determined to be eligible for Continuing Healthcare from Quarter 3 in 2017/18 to quarter 1 in 2018/19.	We have interrogated the archive data that we have for this period. This shows that the majority of referrals at this time were from the acute hospital trust. At this time there was a significant amount of staffing instability in the hospital discharge team due to sickness, staff turnover and vacancies which impacted on availability of staff with an understanding of CHC. This team submitted a large number of referrals during this time – hence the spike in referrals. The lack of experienced CHC staff in the hospital meant that positive checklists were completed for patients for whom there was not enough evidence that they were likely to meet the criteria for CHC. As a result of the positive checklists, the hospital staff had to go on to complete Decision Support Tools (DST) and Multidisciplinary Team Meetings for these individuals. Once this process was completed a considerable number of these patients were identified as not eligible for CHC funding, hence the discrepancy between the number of referrals and eligible patients. What have we done since this time to address this situation? • There has been a re-focus of the CHC training programme run by the CCG CHC team to support colleagues in acute and community settings in understanding the CHC process and in particular use of the checklist and DST.	Completed

Date	Title	Action proposed	Action Taken	Progress Status
			• The CHC training moved from being provided on an ad-hoc basis (generally 2 sessions per year) to quarterly from March 2018 with training dates for the whole year planned and published, and the events well attended. • The Discharge to Assess (D2A) programme started in December 2017 and grew in momentum through Q4 of 2017/18 to be established as 'normal practice' from Q2 2018/19. The D2A programme enables patients to be discharged from the acute trust when they are medically stable into an interim placement. This allows for a more accurate view of the individual's long term needs in a community setting to be established which in turn ensures that appropriate checklists are completed.	
		2) That the Panel are provided with a suite of benchmarked performance metrics to enable the Panel to compare performance in Southampton, as it relates to Continuing Healthcare, with other areas of the country.	Information enclosed as Appendix 2: 1. Number of people eligible in year per 50k population 2. Number of CHC eligible individuals in years 3. Number of clients referred, assessed and eligible for CHC Quarter 1 2019/20 4. CHC average conversation rate Q1 2017/18 to Q1 2019/20 - Referral to Eligible 5. Conversion rate - percentage of people referred who were eligible by standard CHC pathway and fast track pathway Comparison data provided for Brighton and Hove, Canterbury & Coastal, Norwich, Portsmouth, Nottingham City and Hull. Note: Comparing numbers across comparator groups does not always show the clear picture. The CCG funds a range of packages, including CHC adult fully funded care, Adult Joint Funded Packages of care, CHC Adult fully funded personal	Completed

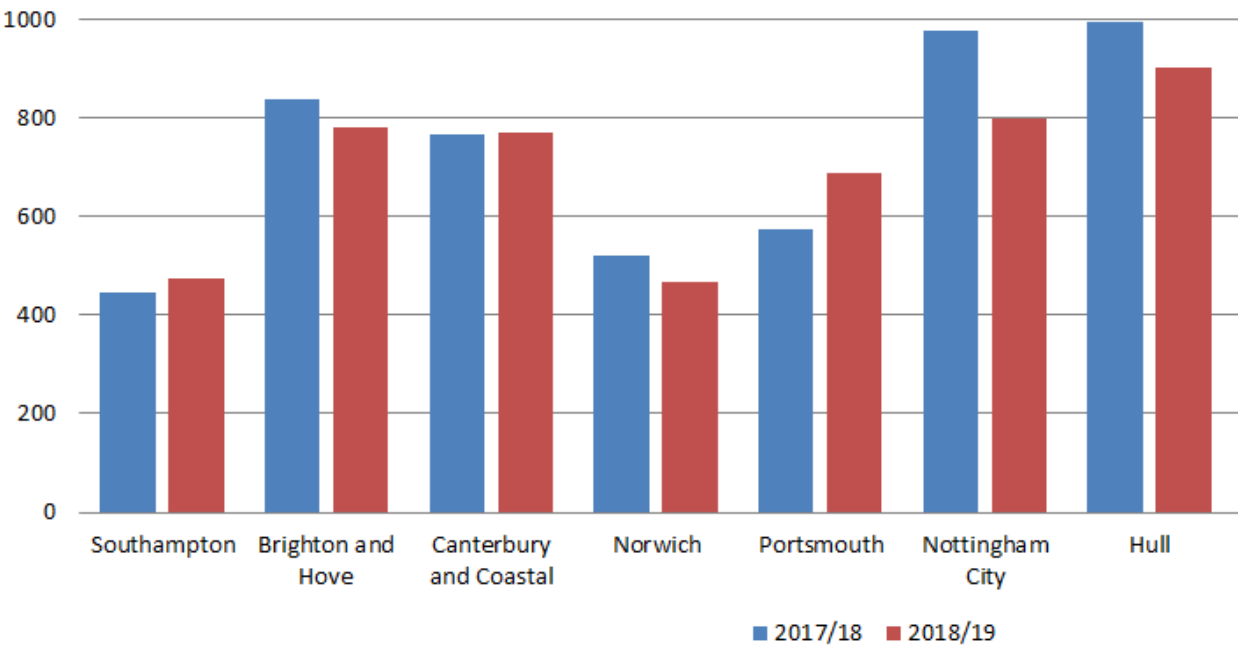
Date	Title	Action proposed	Action Taken	Progress Status
			health budges, Adult Joint Funded Personal Health Budgets, Funded Nursing Care, Section 117 - Learning Disabilities, Section 117 - Mental Health and Specialist Rehab / ECR. The enclosed information only provides data relating to CHC, as requested by the panel. This is one element of the £24m we will spend on these packages in 2019/20.	
		3) That NHS Southampton City CCG investigate the use of mobile conference facilities for care homes to enable health and care professionals to attend multi-disciplinary team assessments remotely.	The CCG has provided to all team members details about setting up teleconferencing for family meetings and Multi-Disciplinary Teams and this will be offered as a matter of course as part of normal business from 1 October 2019. Additionally IT resources to support this are being secured (smart mobile phones / iPad) to support facetime / skype type conferencing as needed.	Completed
		4) That the Panel re-consider the issue of Continuing Healthcare when the proposed Social Care Green paper is discussed by the HOSP.	We await the publication of a social care Green Paper.	
		5) Information on the use of the 'Trusted Assessor Model' for reviewing applications for Continuing Healthcare	The trusted assessor model is not currently used in Continuing Healthcare in Southampton. There are currently no plans to introduce this model in the foreseeable future. The use of Trusted Assessors is not common practice in Continuing Healthcare as it would potentially cause a conflict with the application of the national framework.	Completed
29/08/19	Primary Care in Southampton	1) That, in addition to patient list numbers and practice boundaries, the Panel are provided with the following information from NHS Southampton City CCG: a) The number of GPs, nurses and allied health professionals working within each registered GP practice in Southampton.	Patient list numbers were shared in the August report to HOSP. Practice boundaries can be found on this interactive map: https://drive.google.com/open?id=1umTDpXuj5RpSjNNK3DknhrpajQUaulwh&usp=sharing. Information answering 1 (a) and (b) is attached as Appendix 3. Please note no data is available for a ten year period.	Completed

Date	Title	Action proposed	Action Taken	Progress Status
		b) The ratio of GPs per 10,000 population in Southampton over a ten year period.		
		2) That, to improve access to GP appointments, consideration is given to encouraging GP *practices to provide advice on answerphone messages of the alternative options that are available to obtain an appointment with a GP in* Southampton.	We are discussing this with practices in its routine meetings with practice managers and we are analysing how each practice in the city promotes alternatives to its GP appointments. A publicity campaign for evening, weekend and bank holiday appointments will commence in mid-October 2019 and end in March 2020.	Completed
		3) The Panel agreed that at this stage the proposed Estates Review does not constitute a substantial variation or development and therefore does not require separate consultation with the Panel, however, the Panel did request that the review terms of reference were circulated to the HOSP.	This information will be shared once completed.	

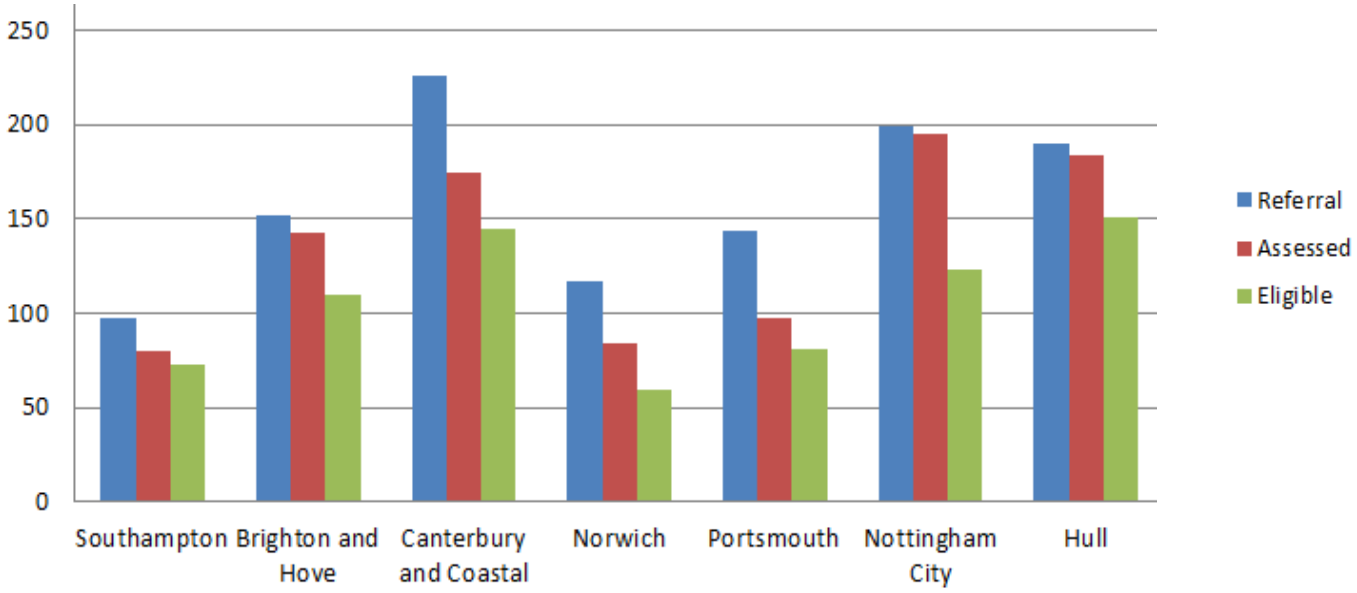
1. **Number of people eligible in year per 50k population by comparator group**



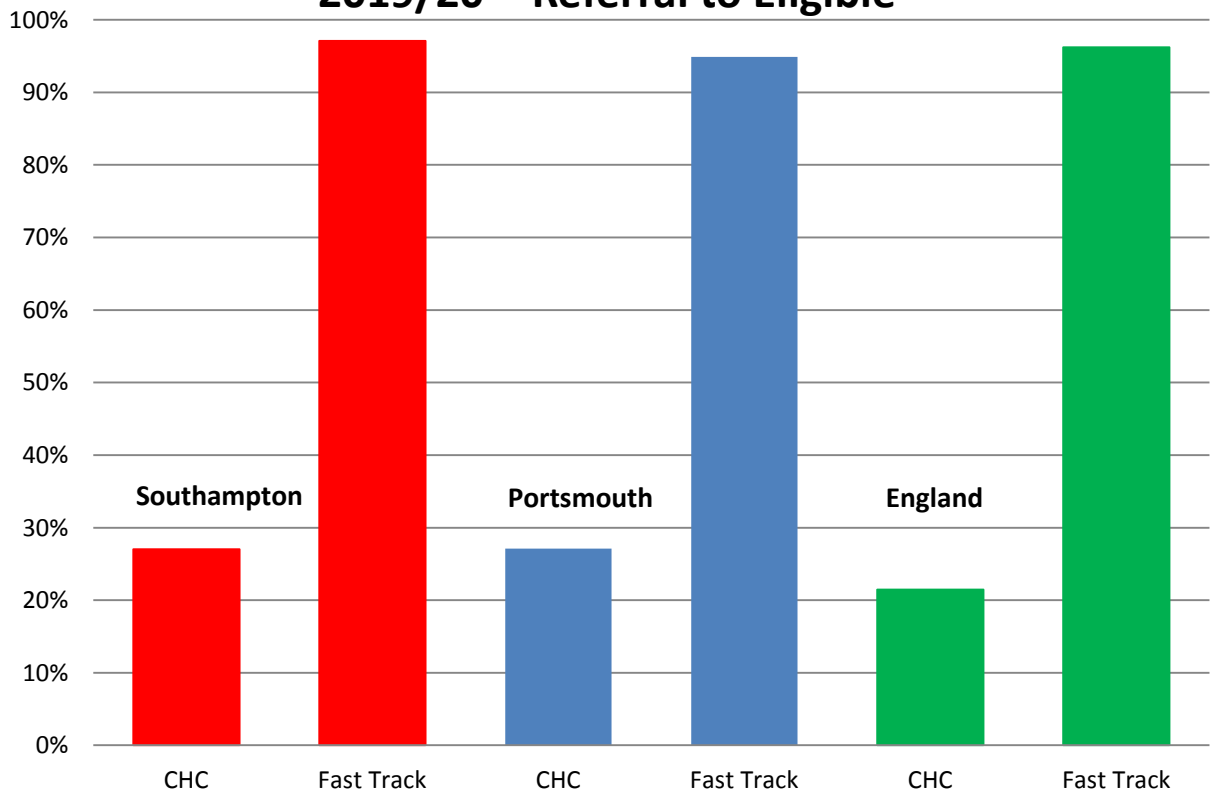
2. **Number of CHC eligible individuals in years**



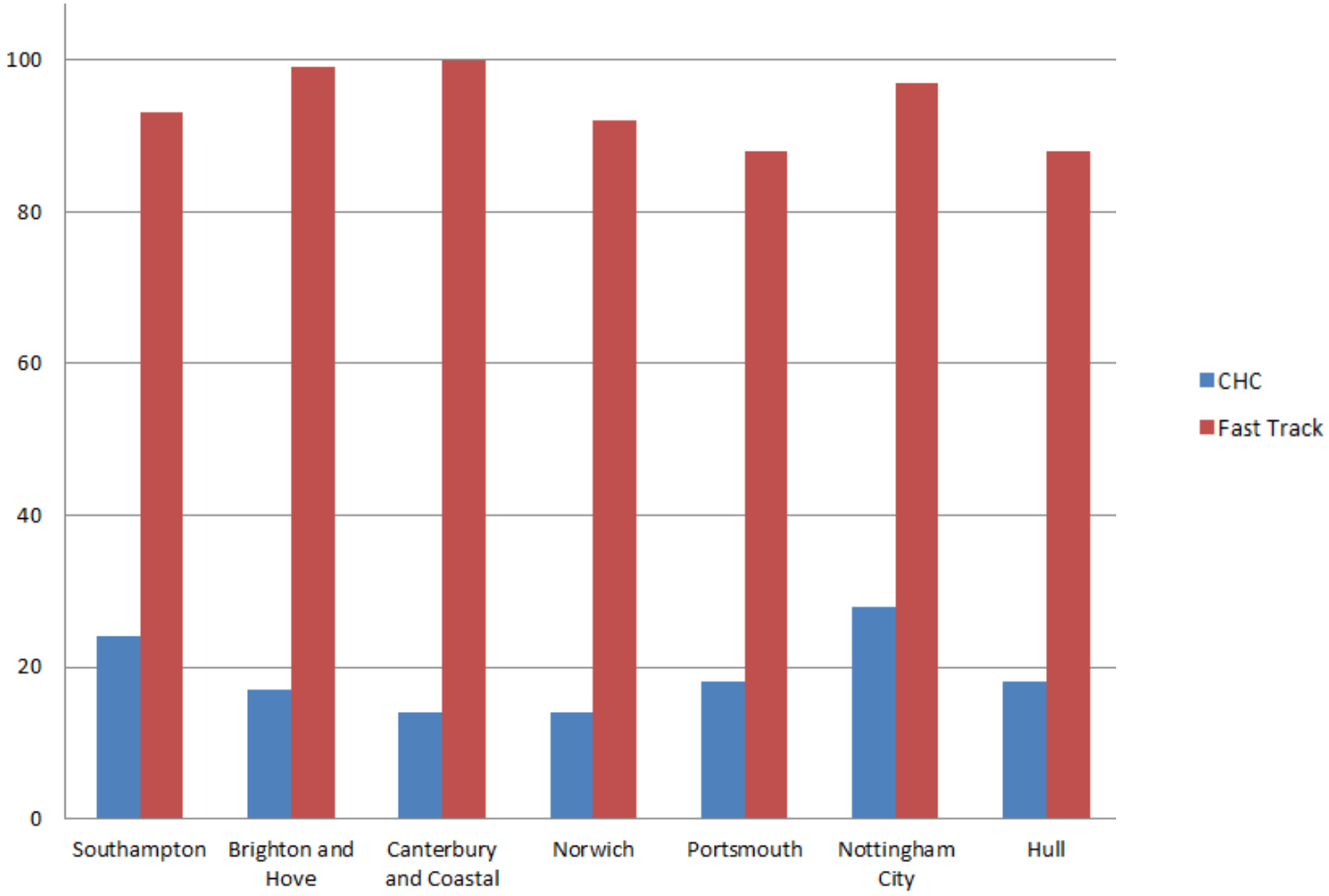
3. Number of Clients referred, assessed and eligible for CHC Quarter 1 2019/20 by comparator group



4. CHC Average conversion rate Q1 2017/18 to Q1 2019/20 - Referral to Eligible



5. Conversion Rate - Percentage of people referred who were eligible by standard CHC pathway and fast track pathway



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				GPs		Nurses		Other Healthcare		Admin	
PRAC_CODE	PRAC_NAME	CCG_CODE	TOTAL_ PATIENTS	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE
J82040	WEST END ROAD SURGERY	10X	14429	6.00	5.92	4.00	1.91	4.00	2.77	14.00	10.12
J82207	HILL LANE SURGERY	10X	9285	5.00	4.27	2.00	1.51	2.00	0.97	12.00	8.59
J82115	ATHERLEY HOUSE SURGERY	10X	5312	3.00	2.40	1.00	0.76	1.00	0.36	9.00	5.25
J82213	BROOK HOUSE SURGERY	10X	5611	2.00	1.92	2.00	0.96	1.00	0.43	7.00	4.84
J82122	ALMA ROAD SURGERY	10X	9744	7.00	5.01	3.00	2.05	1.00	0.64	20.00	13.61
J82605	WALNUT TREE SURGERY	10X	4282	3.00	1.49	2.00	1.01	0.00	0.00	5.00	3.41
J82622	LIVING WELL PARTNERSHIP	10X	27931	15.00	9.12	11.00	7.91	7.00	4.41	54.00	38.12
J82663	HIGHFIELD HEALTH	10X	6528	4.00	1.60	1.00	0.61	1.00	0.53	9.00	6.02
J82126	RAYMOND ROAD SURGERY	10X	4620	2.00	2.13	2.00	1.09	1.00	0.53	8.00	4.90
J82128	OLD FIRE STATION SURGERY	10X	8857	7.00	6.00	4.00	2.51	2.00	0.77	16.00	11.27
J82062	CHEVIOT ROAD SURGERY	10X	15484	13.00	10.63	5.00	2.39	3.00	2.25	21.00	14.15
J82001	BURGESS ROAD SURGERY	10X	9450	7.00	4.99	5.00	3.81	1.00	0.80	11.00	7.73
J82002	LORDSHILL HEALTH CENTRE	10X	11763	12.00	13.32	4.00	2.64	2.00	1.01	21.00	13.85
J82141	BATH LODGE PRACTICE	10X	9996	1.00	0.92	7.00	5.55	2.00	1.41	24.00	14.44
J82081	ST. MARY'S SURGERY	10X	23889	19.00	13.43	12.00	8.40	3.00	2.32	36.00	24.55
J82208	ST. PETERS SURGERY	10X	5862	5.00	6.13	2.00	1.27	1.00	0.69	10.00	6.79
J82180	TOWNHILL SURGERY	10X	5516	4.00	2.27	3.00	2.12	1.00	0.61	18.00	9.26
J82183	MULBERRY HOUSE SURGERY	10X	6217	4.00	2.99	5.00	3.27	1.00	0.40	16.00	7.68
J82101	CHESSEL PRACTICE	10X	10400	5.00	3.87	5.00	4.57	4.00	3.59	15.00	11.67
J82022	VICTOR STREET SURGERY	10X	12276	7.00	5.37	6.00	4.76	2.00	1.53	22.00	18.17
J82024	SOLENT GP SURGERY	10X	18578	10.00	5.39	10.00	8.51	6.00	3.39	20.00	15.33
J82076	WOOLSTON LODGE SURGERY	10X	14800	13.00	10.08	7.00	4.84	3.00	1.64	24.00	16.27
J82080	UNIVERSITY HEALTH SERVICE	10X	18109	6.00	3.43	3.00	1.59	1.00	0.67	13.00	9.28
J82087	STONEHAM LANE SURGERY	10X	7143	9.00	6.76	3.00	2.09	2.00	1.13	10.00	6.67
J82088	THE SHIRLEY HEALTH PARTNERSHIP	10X	14291	9.00	7.29	4.00	3.20	3.00	1.67	25.00	17.27
J82092	ALDERMOOR SURGERY	10X	8206	6.00	3.83	4.00	2.60	2.00	1.97	12.00	11.35

			GPs		Nurses		Other Healthcare		Admin	
	Total patients	Headcount	FTE	Ratio of FTE per 10,000 patients	Headcount	FTE	Headcount	FTE	Headcount	FTE
Jun-19	288579	184.0	140.6	4.87	117.0	81.9	57.0	36.5	452.0	310.5
Jun-18	285827	163.0	124.9	4.37	111.0	74.4	53.0	34.1	410.0	260.4
Jun-17	284957	167.0	135.0	4.74	no data	no data	no data	no data	no data	no data
Sep-16	280061	162.0	131.7	4.70	no data	no data	no data	no data	no data	no data

- Information is taken from NHSDigital pages relating to GP Workforce and resources and raw data is available here: https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services

- Care should be taken in interpreting the data since all issues of this dataset prior to June 2019 are deemed as Experimental statistics

- Data quality for this dataset is deemed more reliable from Jun 2019 onwards

- A note (see right) from NHS Digital explains the nature of experimental statistics

This is an Experimental Statistics publication

Government Statistical Service

This document is published by NHS Digital, part of the Government Statistical Service

Experimental statistics are official statistics which are published in order to involve users and stakeholders in their development and as a means to build in quality at an early stage. It is important that users understand that limitations may apply to the interpretation of this data. More details are given in the report.

All official statistics should comply with the UK Statistics Authority's Code of Practice for Official Statistics which promotes the production and dissemination of official statistics that inform decision making.

Find out more about the Code of Practice for Official Statistics at; www.statisticsauthority.gov.uk/assessment/code-of-practice

Find out more about Experimental Statistics at; https://gss.civilservice.gov.uk/wp-content/uploads/2016/02/Guidance-on-Experimental-Statistics_1.0.pdf

Experimental
Due to the changes in the collection tool and the need to produce estimates for all staff groups for practices that did not provide fully valid data, the General Practice Workforce, England September 2018 workforce report has been badged 'Experimental statistics'.

Care needs to be taken when interpreting these figures as they are labelled as Experimental.

Given the classification of 'Experimental statistics' NHS Digital invites comments and feedback on the methodology applied. Feedback is welcomed via email at gp-data@nhs.net