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Health Overview and Scrutiny Panel

Thursday, 8th December, 2022
at 6.00 pm

PLEASE NOTE TIME OF MEETING

In light of the current Covid Omicron variant surge this meeting will be held as a hybrid meeting. To be lawfully constituted it will still be held in the Civic Centre and open to the public but only core members of the Cabinet/committee along with key supporting officers will be in the room in order to keep everyone as safe as possible. Other officers, elected members and the public are encouraged to join the meeting via Microsoft Teams and contribute and/or make formal deputations that way.

Members

Councillor Professor Margetts (Chair)
Councillor Guest
Councillor Houghton
Councillor Noon
Councillor W Payne
Councillor White
Councillor Shields

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.

USE OF SOCIAL MEDIA: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

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

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

Southampton: Corporate Plan 2020-2025 sets out the four key outcomes:

- Communities, culture & homes - Celebrating the diversity of cultures within Southampton; enhancing our cultural and historical offer and using these to help transform our communities.
- Green City - Providing a sustainable, clean, healthy and safe environment for everyone. Nurturing green spaces and embracing our waterfront.
- Place shaping - Delivering a city for future generations. Using data, insight and vision to meet the current and future needs of the city.
- Wellbeing - Start well, live well, age well, die well; working with other partners and other services to make sure that customers get the right help at the right time

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 2.

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

2022	2023
30 June	9 February
1 September	6 April
20 October	
8 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 - 6)

To approve and sign as a correct record the minutes of the meeting held on 20 October 2022 and to deal with any matters arising, attached.

7 NHS DENTISTRY (Pages 7 - 16)

Report of the Hampshire and Isle of Wight Integrated Care System updating the Panel on arrangements for NHS dentistry following a change in national legislation.

8 INTEGRATED CARE PARTNERSHIP - INTERIM INTEGRATED CARE STRATEGY (Pages 17 - 50)

Report of the Hampshire and Isle of Wight Integrated Care Board recommending that the Panel note and support the direction of travel outlined in the attached draft Interim Integrated Care Strategy.

9 MONITORING SCRUTINY RECOMMENDATIONS (Pages 51 - 54)

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

Wednesday, 30 November 2022 Director of Legal and Business Services

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 20 OCTOBER 2022

Present: Councillors Professor Margetts (Chair), Houghton, Noon, W Payne Shields, and White

Apologies: Councillors Bunday

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

The apologies of Councillor A Bunday were noted.

It was noted that following receipt of the temporary resignation of Councillor A Bunday from the Panel, the Service Director – Legal and Business Services acting under delegated powers, had appointed Councillor Shields to replace them for the purposes of this meeting.

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

Councillor Margetts declared that he was a governor of Southern Health NHS trust.

Councillor Noon declared that he worked in Adult Social Care.

The Panel noted the declarations of interest and considered that it did not present a conflict of interest in the items on the agenda.

RESOLVED that Councillor Margetts and Councillor Noon would be involved in the discussion of the items on the agenda.

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

RESOLVED: that the minutes for the Panel meeting on 1 September 2022 be approved and signed as a correct record.

17. **SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST - CARE QUALITY COMMISSION REPORT AND UPDATE**

The Panel considered the report of the Chief Executive, South Central Ambulance Service NHS Foundation Trust which provided the Panel with an overview of the Trust's Care Quality Commission inspection findings and the improvement programme to address the issues raised.

Will Hancock, Chief executive, South Central Ambulance NHS Foundation Trust (Virtual); Tom Stevenson, Improvement Programme Communications Lead, South

Central Ambulance Service NHS Foundation Trust (Virtual) Michela Morris, Head of Operations for Southampton and South West, South Central Ambulance Services; and James House, Managing Director, Southampton Place, Integrated Care Board; were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- The poor rating from the Care Quality Commission was a surprise as the service had been rated good in previous inspections.
- Assurance was provided that in recognition of the improvements required robust action plans had been implemented.
- The Panel expressed their thanks for the hard work and commitment of the frontline staff who work hard in often difficult circumstances to deliver compassionate care to the people with whom they had contact.
- The service was partnered with a wide range of organisations across the south and implementing change can be challenging as agreement needed to be reached with many different services.
- The staff training and appraisal programme had been reviewed and found that when pressures escalated, due to a high level of calls requiring emergency response or life support, the focus was on patient care and staff training and development activity diminished.
- Managers had been visiting staff at their workstations to examine what changes could be made by the service in the short term and what changes were required that were the responsibility of the hospitals and other health services.
- The report did not include feedback from the trade unions regarding the implementation of plans to improve support for staff.
- The service had also delivered the Covid booking and passport service for NHS England and Public Health England which had stretched the service over the last couple of years.
- There had been some challenges with the supply of resources such as vehicles that had been ordered 18 months ago and had still not been delivered.
- The shortage of staff to be recruited into services required health services in the area to collaborate on workforce planning in the south.
- A new leadership training programme had been introduced to change the management culture in the organisation and the speak-up-guardian approach, that had been adopted across the whole NHS, had been promoted within the service.
- Improvement was required in the governance of safeguarding referrals that had been made by service staff and additional staff and training had been implemented to clear the backlog.
- Response times was an area that required improvement for the service across the whole area, however, in Southampton response times were good as the University Hospital Southampton were very good at taking on patients as soon as the ambulances arrived.
- The Integrated Care Board had a good relationship with the service and there was a shared understanding of the service strengths and required improvements.

RESOLVED that the Panel would be kept updated on inspection activity and findings with a view to SCAS returning to update HOSP on progress at a future meeting of the Panel.

18. **THE INTEGRATED CARE PARTNERSHIP AND THE DEVELOPMENT OF THE INTERIM INTEGRATED CARE STRATEGY**

The Panel considered the report of the Integrated Care System which provided an update on the development of the Integrated Care Partnership (ICP), the development of the Integrated Care Strategy and local Place-based governance arrangements.

Terry Clark, Director of Commissioning, Integrated Health and Care, Ros Hartley, Director of Partnerships, Integrated Care Board; and Councillor Fielker, Cabinet Member for Health, Adults and Leisure were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- There were two parts to the statutory integrated care system, an Integrated Care Board (ICB), which was an organisation governed with a board and the other was an Integrated Care Partnership (ICP) which was a joint committee with upper tier local authorities and the NHS that would collaborate on service delivery and build on the work and strategies of the local Health and Wellbeing Boards.
- The ICP would develop relationships with a wide range of organisations including the police, health watch and voluntary sector organisations.
- The terms of reference for the governance and operation of the ICP were being developed and arrangements would be in place by April 2023, however the ICP would continue to grow and develop all the time.
- Southampton had a history of strong partnership working over the past ten years.
- The ICP would focus on the local delivery of health and care services and would also be able to focus on the scope for benefits of scale across the whole area, for example collaboration on a workforce recruitment and retention strategy.
- It would be important for residents to have the opportunity to contribute to the ICP and to take part in the decision making about the delivery of health and care services in their local area.
- The arrangements would need to ensure that local areas received value for money from the funding they contributed to the Integrated Care System.
- The report provided information on the integration of health services; however, the Panel were keen for additional focus on the integration of health and social care services.

RESOLVED that the draft Interim Integrated Care Strategy would be considered at the 8 December meeting of the Panel.

19. **ADULT SOCIAL CARE - PERFORMANCE UPDATE**

The Panel considered the report of the Interim Director of Adult Social Services which provided an update on performance against Key Performance Indicators for Adult Social Care.

Vernon Nosal, Interim Director of Adult Social Services and Councillor Fielker, Cabinet Member for Health, Adults and Leisure were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- This was the first comprehensive performance report that had been considered by the Panel.
- New staff had been recruited and work force stability had increased.
- Feedback was collected from staff as part of an annual council staff survey.
- Staff feedback had indicated that processes could be more efficient.
- For a number of indicators statistical neighbour comparisons could only be provided on an annual basis.
- The report highlighted exceptions in performance, such as where there had been a significant change or a consistently very low or very high indicator.
- Direct payments were complex and digital solutions had been explored to help make it simple and easy to access for people. There was a fixed traditional model of care provision that was not as flexible as people demanded. A micro economy of services that are flexible and suitable to meet the needs of direct payment clients would be helpful.
- The review figures reported that 70% of reviews had been completed, however, a number of Panel Members reflected that this did not correspond with feedback from local residents who are in receipt of adult social care services, many of whom reported that they had not had a review.
- The service operated a waiting list for completing reviews, which prioritised the completion of reviews according to risk.
- It was important that reviews were completed in a timely manner to ensure that the service was providing the right care.
- The service was bound by the Mental Capacity Act to make sure that they find out what people want and if it was clear that someone did not have mental capacity, they were required to use the protection courts to approve care plans.
- Councillors had received feedback from service users that when they had made a complaint about a care service it had been difficult to progress and resolve the issues. It was important that the service was managing complaints effectively.
- Care services were provided by organisations that had been commissioned by Adult Social Services, and these organisations were responsible for the management of the staff that provided care.
- A transformation programme had been developed for the adult social care service.

RESOLVED

1) That an overview of the transformation programme would be appended to the next Adult Social Care Performance report, which was scheduled to be considered by the Panel at the 9 February 2023 meeting.
2) That the Adult Social Care workforce indicators would be included within the performance dataset to be considered at future meetings.
3) That, reflecting concerns about the accuracy of the data reported, an audit of the performance relating to reviews undertaken would be conducted.

20. **MONITORING SCRUTINY RECOMMENDATIONS**

The Panel considered the report of the Service Director – Legal and Business Services, which updated the Panel on the responses received to recommendations from previous meetings.

The Panel noted that the requested information had been received apart from a timetable outlining the key milestones for the review of community and mental health services, which had not yet been received.

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	NHS DENTISTRY
DATE OF DECISION:	8 DECEMBER 2022
REPORT OF:	HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE SYSTEM

CONTACT DETAILS		
Executive Director	**Title**	**Managing Director / ICB lead for dentistry, pharmacy, and optometry**
	Name	**Jo York**

STATEMENT OF CONFIDENTIALITY		
N/A		
BRIEF SUMMARY		
Hampshire and the Isle of Wight Integrated Care Board now has delegated responsibility for dentistry, alongside pharmacy and optometry. The local authority retain their statutory responsibilities for surveillance and improvement of oral health of our population. This paper provides an overview of contractual challenges, the opportunities now available with new arrangements coming into place, and the work currently underway to make progress.		
RECOMMENDATIONS:		
	(i)	That the Panel notes the report.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To update the Panel on arrangements for NHS dentistry following change in national legislation.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	N/A	
DETAIL (Including consultation carried out)		
3.	The attached report provides an update on NHS dentistry.	
4.	Integrated Care Boards (ICBs) have an explicit purpose to improve health outcomes for their whole population and the delegation will allow us to integrate services to enable decisions to be taken as close as possible to our residents. We are working to ensure our residents can experience joined up care, an increased focus on prevention and better access to care and advice.	
5.	The COVID-19 pandemic caused NHS dental providers to close for routine care, causing backlogs in routine dental treatment. In time dental practices restarted their routine treatment but with new safety controls in place, limiting the capacity for dental providers to see as many residents as before. We know Southampton's residents continue to struggle to access dental services, and this is partly due to the existing health inequalities which already exist in the city. Across the ICB footprint, we have asked the four Healthwatches to review the feedback they have received from our communities**.**	

RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	N/A
Property/Other	
7.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	N/A
Other Legal Implications:	
9.	N/A
RISK MANAGEMENT IMPLICATIONS	
10.	N/A
POLICY FRAMEWORK IMPLICATIONS	
11.	N/A

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

Southampton dentistry update: December 2022

Context

1. Hampshire and the Isle of Wight Integrated Care Board now has delegated responsibility for dentistry, alongside pharmacy and optometry. The local authority retain their statutory responsibilities for surveillance and improvement of oral health of our population.

2. Integrated Care Boards (ICBs) have an explicit purpose to improve health outcomes for their whole population and the delegation will allow us to integrate services to enable decisions to be taken as close as possible to our residents. We are working to ensure our residents can experience joined up care, an increased focus on prevention and better access to care and advice.

3. The COVID-19 pandemic caused NHS dental providers to close for routine care, causing backlogs in routine dental treatment. In time dental practices restarted their routine treatment but with new safety controls in place, limiting the capacity for dental providers to see as many residents as before.

4. We know Southampton's residents continue to struggle to access dental services, and this is partly due to the existing health inequalities which already exist in the city. We also know that the proportion of our population accessing dentistry services across the city is slightly lower than other parts of Hampshire and Isle of Wight; however the improvements to access following the closedown during the pandemic is on the same trajectory as the rest of Hampshire and Isle of Wight.

5. There are a range of challenges which need to be overcome to make significant improvements; this paper provides an overview of contractual challenges, the opportunities now available with new arrangements coming into place, and the work currently underway to make progress.

Contracting

6. Primary dental care is commissioned as units of dental activity (UDAs) with the number of UDAs awarded to each course of treatment dependent upon the treatment delivered. A UDA is a unit of payment given to providers which is used for different courses of treatments. More complex dental treatments would count for more UDAs than simpler treatments. For

example, an examination is one UDA whereas dentures equates to 12 UDAs clinical activity. The number of UDAs a patient will need in a year will depend upon their oral health.

7. NICE guidelines suggest recalls for treatment range from three to twelve months for children and three to 24 months for adults. There is a direct correlation between deprivation and oral health, with those from more deprived households often needing more UDAs a year as they may have more frequent check-ups with higher treatment need identified which attract more UDAs.

8. The model of existing primary dental care was introduced in 2006 when the General Dental Services (GDS) Contract and Personal Dental Services (PDS) Agreement were introduced. Under that arrangement which remains in place, contracts specify a defined number of UDAs for a defined contract value, with those issued in 2006 based on treatment proved during a 12-month test period in 2004/5. This period, now almost twenty years ago, was during the time when a dental practice could set up where they wished and deliver as much or as little NHS care as they chose. The current dental contract framework and legislation no longer allow practices to set up or provide as much as they wish; for existing practices this is limited to their contracted activity and new NHS practices can only be established after an open procurement process.

9. GDS contracts exist in perpetuity, unless they are voluntarily terminated by the provider or the commissioner as a result of contractual breaches.

10. At the current time a commissioner is not able to reduce contracted activity in one area and move this activity to an area it considers of greater need. There have been annual increases in dental budget allocations as agreed nationally, but this does not take into account increases in population size.

New procurement

11. There have been a number of contracts that have terminated in our area, as a result of providers choosing to hand their contract back.

12. Prior to the pandemic a procurement was undertaken in the areas of Hampshire and Isle of Wight that were impacted by this the greatest. The recommissioning of general dental services in our area was delayed due to the pandemic.

13. This review was completed by NHS England's Dental Public Health team in January 2022, which also took into account further terminations that had occurred during the pandemic. In line with the results of this review, the South East region are commissioning new contracts in the five areas of greatest need, based upon deprivation, to increase recurrent UDAs in these areas.

14. The number of UDAs commissioned will be proportionate to the deprivation of the local authority so that the more deprived areas have a greater number of UDAs commissioned.

15. The budget available to re-commission is derived from what is currently used to commission non-recurrent activity ending on 31 March 2023, the budget released from recently terminated contracts, as well as reserve funding.

16. This will allow 222,000 UDAs to be recurrently commissioned across Hampshire and Isle of Wight and will give greater choice to patients living and working in the more deprived areas and reduce the need for patients to travel to receive dental care. Bids were received as part of this process and two were successful in Southampton, which equates to 42,000 UDAs across two locations; one is located in Shirley and the other in Woolston. The provider will advertise locally when they are in a position to open their patient list.

17. The successful bidders are currently mobilising their services which are to be delivered from a mixture of current premises and newly developed premises. It is anticipated that this will come into effect 1 April 2023, subject to any unforeseen delays.

18. This is subject to recruitment and no unforeseen delays with building works or equipment delivery. We will be monitoring mobilisation and working closely with providers to support this where we can. While this is unfortunately 5 months away, the offer of additional funding for additional sessions for urgent care as well as temporary activity for routine care remain and the new allowance under Dental System Reform (DSR) for practices to be paid for over performance up to 10% is also available to practices. With the challenge of recruitment, we do not anticipate these options will increase access significantly.

Monitoring dental contracts

19. All dental contracts are monitored to ensure they reach their contracted activity and dental practices must be within a -4/+2% tolerance at the end of the financial year. Practices that underperform are required to repay the funding for unachieved activity. Where practices over-perform by up to 2% this is deducted from their following year's activity requirement.

20. A performer (dentist) providing largely full time NHS care delivers approximately 7,000 UDAs per annum, although activity can differ from performer to performer. Providers that hold an NHS contract are required to engage dental performers to undertake the delivery of the contracted activity; commissioners do not have a contractual relationship with a performer. The Provider is also responsible for employing the appropriate support staff to deliver their contracted activity.

21. Since July 2022, when practices have been required to deliver 100% of their contracted activity, there has been an overall increase in activity, but most of this activity is focussed on reducing the backlog of care and not on new patients.

Routine and urgent care priorities

22. For routine care, details of practices providing NHS dental care can be found on: https://www.nhs.uk/service-search/find-a-dentist or by ringing 111 who will provide details of local dental practices providing NHS care.

23. We recognise the anxiety of not having access to an NHS dentist for routine care. NHS England has put in place additional funding to all practices in the region in order to provide sessions outside normal contracted hours for patients who did not have a regular dentist and had an urgent need to receive dental treatment. The offer of funding additional sessions remains open so that should practices subsequently determine they have the staffing levels to safely deliver additional NHS sessions, these will be established.

24. Should any patient need urgent dental care, or they have been able to access temporary urgent care and still require further treatment to stabilise their oral health or need dental treatment before undergoing certain medical or surgical procedures, or be a Looked After Child they will be able to contact one of the practices to obtain treatment available through the link above or calling 111. With the focus remaining on reducing this backlog, practices may not be able to provide routine care for patients that do not have an urgent clinical need.

National and regional actions

25. A recent procurement has resulted in the award of new contracts in multiple locations across Hampshire and these are anticipated to start delivering care from April 2023. In the meantime, temporary activity continues to be delivered by several practices across our locality, until the new contracts are able to begin to see patients.

26. Earlier this year there was an announcement of planned changes to the NHS dental contract with the first phase now implemented. These changes are:

    - Introduction of a minimum indicative UDA value of £23.00
    - Patients with fillings or extractions of three or more teeth in a course of treatment will attract 5 UDAs (previously no limit on number of teeth per course for 3 UDAs)
    - Molar endodontic treatment will attract 7 UDAs to recognise the time this takes to complete (previously 3 UDAs)
    - Agreement for national dental team to provide patient leaflets etc to help dentists and patients implement the NICE guidance relating to patient recall intervals
    - Promotion of guidance to assist with effective skill mix in dental staff
    - Amendments to dental contract to allow contractors to deliver up to 110% of their actual contract value on a non-recurrent basis when agreed with commissioners to ensure this meets local needs.
    - Contractors to ensure their entry on NHS.uk https://www.nhs.uk/service-search/find-a-dentist is up to date as a quarterly requirement or when unexpected changes to opening times occur allowing patients to find a practice who is accepting NHS patients, easier.

27. More widely, Health Education England has published 'Advancing Dental Care (ADC) Review Report', the culmination of a three-year review to identify and develop a future dental education and training infrastructure that produces a skilled multi-professional oral healthcare workforce, which

can best support patient and population needs within the NHS. The Government is currently considering the next steps.

28. In addition, the Government is also considering moving forward with water fluoridation, a public health initiative the Chief Dental Officer strongly supports. As the robust international evidence shows, water fluoridation is another public health tool that can reduce the incidence of tooth decay amongst adults and children – saving potentially thousands of teeth and improving oral health inequality in the process.

Local actions

29. We know there have been and remain significant recruitment and retention challenges. In addition to the new national contract that will be implemented nationally, we are actively looking at ways to bring new dentists to the area.

30. We are also building a new dentistry team within the ICB, to help progress our local focus and transformation agenda, as well as a specific focus on recruitment.

31. In June 2022 a Dental Summit was held in Portsmouth. The summit recommended a steering group be set up, led by Professor Chris Louca, to progress a bid for a Centre for Dental Development at the University of Portsmouth Dental Academy.

32. The ICB is working closely with NHS England as part of the transition of responsibility for dentistry, pharmacy and optometry commissioning. The opportunity to bring these responsibilities into the ICB means we will be able to continue to work at scale – as has been the case with this commissioning for many years – while bringing in a new place-based focus addressing local needs. The place-based Primary Care Operational Groups, which until now have been the local governance route for GP services, have had their remits expanded to take in these new responsibilities.

33. We are aware that access to dental services is a key concern for local people. Across the ICB footprint, we have asked the four Healthwatches to review the feedback they have received from our communities. The review so far has highlighted that access to NHS dentistry is difficult for many people with services often offered only if people are prepared to pay. Local communities find it difficult to find a dentist for themselves and their children despite making numerous phone calls to many dental practices over a long

period of time. Once the review is complete, we will be working with the Healthwatches to determine the next steps and how we work together to identify potential short, medium and long term solutions.

34. The ICB's initial priorities will be to ensure appropriate oral health strategies are in place across the system, and to build relationships with providers, addressing their concerns and supporting them with their services and estates. As this work progresses we will keep the Panel updated.

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	INTEGRATED CARE PARTNERSHIP - INTERIM INTEGRATED CARE STRATEGY
DATE OF DECISION:	8 DECEMBER 2022
REPORT OF:	HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE BOARD

CONTACT DETAILS				
Executive Director	**Title**	**Chief Strategy and Transformation Officer**		
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

This report sets out the key priorities as outlined in the draft Interim Integrated Care Strategy.

Background

- Southampton City Council is part of the Hampshire and Isle of Wight Integrated Care System, which was set up in July 2022 as part of the new Health and Social Care Act 2022. The Integrated Care System sees the formation of two new statutory health and care components; the Integrated Care Board and the Integrated Care Partnership.
- Integrated Care Partnerships are formed of upper tier local authorities and member(s) of the newly formed Integrated Care Board. The partnerships can choose to co-opt other members. Their primary purpose is to develop the Integrated Care Strategy for the Integrated Care System and to oversee and ensure the delivery of this strategy.
- Whilst the Integrated Care Partnership is still in formation, there is a national requirement that Integrated Care Partnerships write an Interim integrated care strategy by December 2022. Work has been ongoing over the last year, alongside partners in Local Authorities and other partners (e.g. Fire and Rescue, Police, Voluntary and Community Sector, Healthwatch, Local residents etc.) to build a case for change based on local evidence and insight in order to develop the strategic priorities for health and care in the Hampshire and Isle of Wight System.
- The purpose of the Integrated Care Strategy is to describe our ambitions and priorities across the Hampshire and Isle of Wight system where we can achieve tangible benefits by working together as a new, wider partnership across the system. It should build on the work of the Local Health and

Wellbeing Boards, but should not duplicate, but set priorities where joint working, beyond place, is most helpful. • The strategy which will be submitted in December 2022 will be Interim and there will be further work to do in 2023 as a partnership to develop this strategy and ensure it delivers the ambitions it sets out. • The Integrated Care Partnership is establishing the governance support required to ensure the partnership is successful and the delivery of the strategy. • The attached paper sets out the proposed strategic priorities for the Hampshire and Isle of Wight System.		
RECOMMENDATIONS:		
	(i)	That the Panel note and support the direction of travel as outlined in the draft strategy.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The daft strategy has been developed in partnership with local authorities; the Joint Strategic Needs Assessment and Health and Wellbeing Strategy for Southampton City alongside those of our other local authorities have been used to inform the case for change and priorities. The strategy has been developed in close partnership working with the Directors of Public Health from the local authorities to ensure that it builds on and supports the work ongoing at a place level. To ensure the effective delivery of the strategy, it is recognised that partnership working with our Health and Wellbeing Boards will be vital.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not Applicable	
DETAIL (Including consultation carried out)		
3.	Attached as Appendix 1 is a presentation that outlines the detail of the draft strategy and how we have engaged across the Southampton system with partners to inform the development of five strategic priorities.	
4.	Representatives from the Hampshire and Isle of Wight Integrated Care Board will be in attendance to present the draft Interim Integrated Care Strategy and answer questions from the Panel.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	There are no resource implications inherent in supporting the Interim Integrated Care Strategy.	
Property/Other		
6.	There are no property or other implications	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
7.	Not Applicable	
Other Legal Implications:		
8.	None	

RISK MANAGEMENT IMPLICATIONS	
9.	None
POLICY FRAMEWORK IMPLICATIONS	
10.	None

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	ALL
SUPPORTING DOCUMENTATION	
Appendices	
1.	Draft Hampshire and Isle of Wight Interim Integrated Care Strategy

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	No
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	No
Other Background Documents **Other Background documents available for inspection at: n/a**	
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.	Report to 20th October 2022 HOSP meeting: Appendix 1 - The development of the Interim Integrated Care Strategy and Place Based arrangements.do.pdf (southampton.gov.uk)

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DRAFT
All sections of this document are draft and under frequent revision and edit

Hampshire and Isle of Wight Interim Integrated Care Strategy DRAFT

As at 24 November 2022 (for publication December 2022)

This interim strategy has been jointly developed by partners and stakeholders of our integrated care partnership

Hampshire and Isle of Wight

Our integrated care partnership brings together a broad range of organisations from the NHS, local authorities, the fire and rescue service, police, Healthwatch and the voluntary sector. These organisations work together to look at where we can work together in even better ways to join up care, reduce health inequalities, and support communities and local people to be healthier, happier and wealthier. The integrated care partnership is responsible for setting the strategy for health and care in Hampshire and Isle of Wight to meet local healthcare, social care and public health needs. This interim strategy has been jointly developed by partners and stakeholders. We will continue to work with new and existing partners to further develop and deliver our strategy.

Intention is to have this or just organisation names if that's preferred) on inside cover of the document

Foreword

Building a better future together

The Hampshire and Isle of Wight Integrated Care Partnership brings together a broad alliance of partners whose key focus is centred on improving the health, happiness, wealth and wellbeing of the population. Building on our strong track record of working together as partners and with local people, we look to the future with great optimism. We are united in our ambition to work with communities to create a society in which every individual can truly thrive throughout the course of their life, from childhood through to old age. Our mission is to deal with the pressures and challenges of today, seize opportunities and together build a better future.

Through working closely with local communities, with regard to health and care, we know that people want:

- More choice and control over their own health and wellbeing
- Clear, timely and accessible information and communication to support them to better manage their own lives, including their health and care, and
- To be able to access a greater range of services and resources from their homes and communities, making the best use of technology where appropriate.

Providing better joined up services in Hampshire and Isle of Wight

We share a vision of being one of the best health and care systems in England, drawing on national and international innovation and research to support our work. Our strategy requires a commitment from all partner organisations across all sectors to work together in new and different ways to address our challenges and transform our health and care system. We aim to address the challenges people experience in accessing services and to ensure that services feel joined up and seamless to the people using them.

This interim strategy, our first as a new integrated care partnership, is ambitious. It is set against a challenging backdrop. Local people are experiencing widening inequalities, varied access to services and in some cases, poor experiences of health and care support. The Covid-19 pandemic and significant increases to the cost of living have placed additional pressure on households and individuals, as well as on voluntary, community and public sector resources including education, housing, fire, police, social care and health services. Demand for health services is increasing more quickly than its funding and more quickly than we can recruit and train staff. Funding levels in social care have been repeatedly cut for over a decade, whilst care demands have continued to rise. The November 2022 Autumn Statement is positive for health and care finances but challenges remain. Rising inflation, increasing energy prices and government fiscal policy, impact households and businesses across the country, and place additional pressure on already overstretched public and voluntary services.

We know too, that staff across our various organisations continue to work incredibly hard under continued strain and that the impact of the pandemic is far from over. Recruiting, developing, supporting and retaining outstanding staff across all partner organisations is a core strategic priority for us as a partnership, to enable us to deliver excellent outcomes and services for local people, as well as developing new roles. We want all colleagues in employed and voluntary roles within Hampshire and Isle of Wight to feel they can make a fulfilling contribution and build a rewarding career.

It is vital that we work on our priorities together to provide a health and care service fit for all for the future

Across our system, we have lots of plans, strategies and insight. Through the integrated care partnership, we are embracing the opportunity to better coordinate our efforts and strengthen the golden thread which connects us, our services and our support for local people. We are committed to working together to explore new options to make best use of the collective resources available. This interim strategy is a strong first step and will continue to evolve and build momentum as we develop how we work together. We would like to thank the huge number of colleagues and members of our local communities for their input in shaping this interim strategy and their ongoing commitment, insight and support.

We are ready for the opportunities ahead and we are committed to working together to provide the best possible care and support, and ultimately, to improve the health, happiness, wealth and wellbeing of local people.

Developing our interim strategy

Our interim strategy has been created through our Integrated Care Partnership, rooted in the needs of local people and communities.

Together we have looked at the data and evidence available through joint strategic needs assessments and existing local health and wellbeing strategies. Through these we have identified the key issues facing residents and services across Hampshire and Isle of Wight. Our aim in this strategy is to focus initially on a small number of priority areas in which our partnership can make the most meaningful positive difference by working together. We have identified actions we can take together as a partnership, based on the evidence of what works across Hampshire and Isle of Wight, other parts of the country and elsewhere in the world.

This interim integrated care partnership strategy provides a strategic direction and key commitments at a headline level. It is not a detailed operational plan. Our local authorities and the NHS are required to give full attention to the partnership strategy in considering how we plan, commission and deliver services. The integrated care board and NHS partners take into account this partnership strategy when developing more detailed delivery plans to support the national requirement for a five-year NHS 'joint forward plan' by April 2023.

Information and people involved in shaping this strategy

1. **We reviewed the available data and evidence** (Hampshire and Isle of Wight Joint Strategic Need Assessments, Health and Wellbeing strategies, system diagnostics)

2. **We worked with our local communities and across partner organisations to understand their perspectives and priorities** – we had multiple conversations with the integrated care partnership and in other focus groups and meetings with colleagues to inform and our themes for initial focus as a partnership.

3. **We identified five priority areas for initial focus:** children and young people; mental wellbeing; prevention of ill health and promotion of healthy lifestyles; workforce; digital and data. We continued working with all partners to identify data, insights and evidence around each of these themes.

4. We held a workshop on 28 September 2022 in which members of the public and colleagues **reviewed the evidence** under each theme and **created a longlist** of ideas for our joint work as a partnership on our five priority areas. Following the workshop we continued to work with all partners to flesh out these ideas.

5. We agreed the **priority areas** for our interim strategy. These are the areas around which we will focus our early work together as a new partnership. We have each committed to working together to seize opportunities to enhance our existing work in these areas. It is important to note that this strategy does not set out all the work happening across Hampshire and Isle of Wight. Furthermore, we will review our strategy regularly as a partnership to ensure our priority areas of focus are relevant and that we make continuous progress against them. This will include working with health and wellbeing boards to further develop, implement and refresh our partnership strategy.

This strategy:

- ✓ builds on **work already completed** (including the joint strategic needs assessments and health and wellbeing strategies)
- ✓ focuses on **better integration of health, social care, wider public sector and voluntary sector services**
- ✓ sets priorities for joint working where **collective working (beyond place) is most helpful**
- ✓ Is **co-developed** with a wide range of partners
- ✓ will **be updated regularly** to reflect the changing needs of local people and opportunities to work even more effectively together

Our strategy on a page

Stand by to update with final version

Our shared aims	Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development.
Our challenges	Our population is growing and ageing. Improvement in life expectancy has stalled and begun to fall. Vulnerable people are dying younger and suffering poorer health than the general population. Inequalities are getting worse and drive worse outcomes. Challenges in workforce supply, funding, demand for services outstripping supply, impact of Covid-19 and cost of living. Without check inequalities will grow, years lived in poor health will increase and services will not cope.			
A radically different approach	Working together across all partners to take a community-centred approach to wellbeing. Seizing the opportunities offered by working together as a system and partnership with a mandate to use collective resources in new and different ways to build a better future - health, happiness, wealth and wellbeing.			
Priority areas: Themes that emerged from evidence and conversations in Hampshire and Isle of Wight	**Children and young people** We want all children to get the best possible start in life, regardless of where in Hampshire and Isle of Wight they are born.	**Mental wellbeing** We want mental wellbeing to be at the forefront of all that we do and to ensure as much importance is given to mental wellbeing as physical health.	**Promoting good health and providing proactive care** We want to enable every individual to live more of their life in a state of good health and be able to access resources and services in their communities.	
Initial areas of focus for the partnership	**Work to ensure the "best start in life" for every child** by focussing on the care and support that families receive in the first 1000 days of a child's life			
	Providing proactive, integrated care for people with complex needs to provide care closer to home and shift focus from cure to prevention			
	Improving social connectedness (reducing social isolation) to enhance people's physical and mental health and wellbeing			
	Supporting people with the cost of living to reduce the impact of financial pressures on people's lives			
	Better supporting people affected by childhood trauma by adopting a trauma informed approach			
	Providing healthy lifestyles and mental wellbeing support in community settings for examples schools and youth groups, community centres			
We will focus on these areas to enable delivery of our priorities	**Our workforce:** We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight. .	**Build workforce capacity to meet demand**	**Ensure the availability of the right skills and capabilities**	**Ensure people who provide services are well supported and feel valued**
	Digital solutions, data and insights: We want to harness the benefits that digital solutions can offer and ensure they are available to everybody, regardless of age and household income	**Empower people to use digital solutions**	**Support our workforce**	**Improve information sharing between IT systems** / **Improve our digital solutions**
Developing the "Hampshire and Isle of Wight way"	**As we work together to deliver our priorities, we will continue to learn together, and build our culture, capabilities and collaboration as a new integrated care partnership:** working with communities; adopting a continuous learning approach; developing a shared understanding of our opportunities and challenges, and shared vision; focusing on outcomes; building a high trust and high support culture; drawing on insights from all partners; listening to each other; focussing on priorities that resonate with all partners; making the best use of collective resource and capacity, strengthening our population health approach and developing our approach to collective assurance and accountability.			

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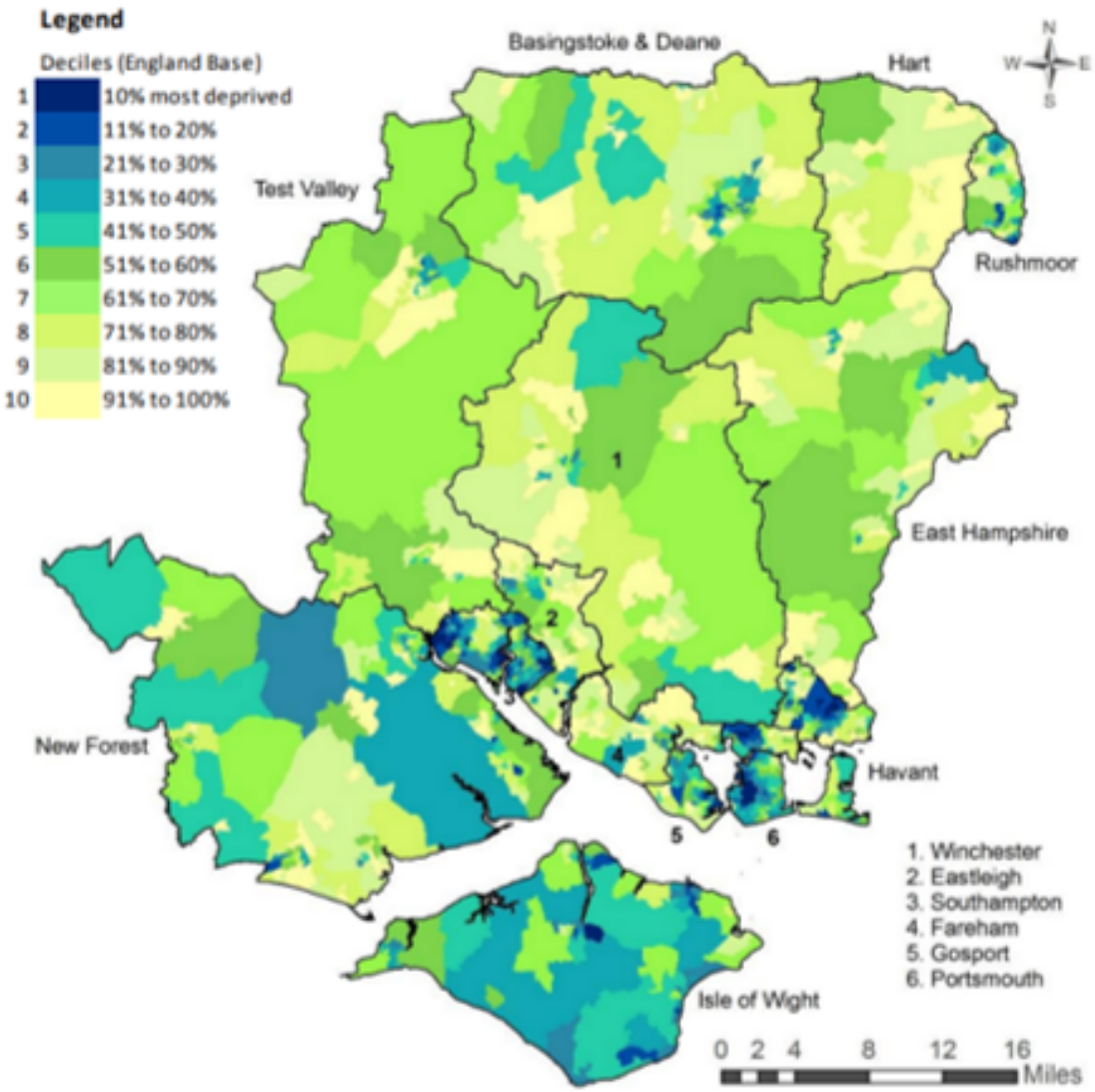
Introduction and context

SECTION IN DRAFT



The population we serve

The Hampshire and Isle of Wight integrated care system serves a population of 1.9 million people and is the 10th largest of the 42 systems across England. Our four places – Hampshire, Portsmouth, Southampton and Isle of Wight - are the foundation of our system.

Overall, our population is ageing and living with increasing frailty and multiple health needs, especially in rural areas, particularly west Hampshire and the Isle of Wight. In urban areas such as Southampton and Portsmouth, the population is younger (particularly owing to university students) and more ethnically diverse here and in north-east Hampshire compared to the rest of the area (overall 93.8% white). There are also higher levels of deprivation and mental health vulnerability in these areas. The age of people living on the Isle of Wight is similar to other places popular with retirees, but more people live alone. We also have coastal communities; 92.7% of the Island's population are resident in areas defined as coastal. These areas have lower life expectancy and higher rates of many diseases in comparison to non-coastal areas.

Steeped in iconic history, areas of outstanding natural beauty, and hundreds of miles of coastline, this is a beautiful part of one of the most prosperous countries in the world – but we know that not all members of our community are in a position to experience it as such. In Hampshire and Isle of Wight, healthy life expectancy has decreased in most areas, meaning people are living more of their lives in poor health.

This is particularly the case for people living in the most deprived areas. Smoking, poor diet, physical inactivity, obesity and harmful alcohol use remain leading health risks, resulting in preventable ill health.

We know that baseline levels of health, as well as people's experience of public services, are not the same for everybody and can vary depending on where somebody was born and lives as an adult, their level of income and education and factors such as ethnicity, gender, age and sexuality. This is known as experiencing **health inequalities**; addressing these inequalities in Hampshire and Isle of Wight is a priority that runs throughout this strategy.

Demographics	In the next 5 years, the 75+ age group is expected to grow by 18% with likely increases in complex multimorbidity, a big driver of health service need, particularly in west Hampshire and Isle of Wight. But younger populations in Southampton and Portsmouth drive different needs. Cancer and circulatory disease accounted for just over half of the deaths (51%) across Hampshire and Isle of Wight in 2020. Ethnic diversity varies across the patch and is increasing overall.
Deprivation	Life expectancy and healthy life expectancy at birth are lowest for people living in more deprived areas of the patch. On average, people in the more deprived areas live a shorter life than those in the least deprived areas (3 years less for men and 2.8 years for women). They are also more likely to spend more of their life in poor health.
Maternity, children and young people	There were 18,945 births in 2020, continuing the decrease in birth rate observed in recent years. Smoking rates among pregnant women (9.1%) are above the national ambition of 6% by end of 2022. Many babies and mothers would have missed out on the best start in life during the Covid-19 pandemic, which also led to increasing childhood obesity, mental health disorders and missed vaccinations.
Behaviours	Smoking (at 92.7% recording is lower than England), poor diet, physical inactivity, obesity and harmful alcohol use are leading health risks, driving preventable ill health. Tobacco, high body mass index and high blood sugars drive the most death and disability across the system.
Inequalities	Several population groups across Hampshire and the Isle of Wight experience more health risks and outcomes compared to England. People in disadvantaged areas are at greater risk of having multiple conditions and that too, 10 to 15 years earlier than people in affluent areas. Trends for both Southampton and Isle of Wight show increases in male life expectancy inequality. Additionally, Covid-19 has exposed, exacerbated, and created new health and social care inequalities.
Ill health and multimorbidity	Southampton and Portsmouth have higher preventable, premature death rates due to cancer, cardiovascular, liver and respiratory disease compared to England, again highlighting the focus on prevention. Deaths from these key causes are also major contributors to the gap in life expectancy between the most and least deprived quintiles across the system. Cardiovascular disease is the single biggest condition where lives can be saved. These issues need to be tackled through effective public health measures and primary prevention.

Produced by the Hampshire & Isle of Wight, Southampton and Portsmouth Public Health Intelligence Teams

The issues that affect our health and wellbeing

As is the case elsewhere in the United Kingdom, people are dying earlier than they should due to preventable and avoidable ill health and there are wide inequalities in life expectancy. Almost every aspect of our lives – our jobs, homes, access to education, public transport and whether we experience poverty, racism or wider discrimination – impacts our health and, ultimately, how long we will live. These factors are often referred to as **the wider determinants of health**.

SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

Long term conditions: Around 30 per cent of all people with a long-term physical health condition also have a mental health problem with a higher proportion reporting high levels of anxiety

Housing: Those in rented accommodation are more likely to feel lonely often, especially in 16–24-year-old population groups

Health behaviours: Adults with depression are twice as likely to smoke as adults without depression. People with schizophrenia are three times more likely to smoke than other people and tend to smoke more heavily.

Social connectiveness: Those with an underlying health condition more likely to feel lonely often – especially in the younger 16–24-year-old population groups

The impact of deprivation

Life expectancy and healthy life expectancy at birth are lowest for people living in more deprived areas. On average, people in the more deprived areas of Hampshire and Isle of Wight live a shorter life than those in the least deprived areas (**3 years less for men and 2.8 years for women**). They are also more likely to spend more of their life in poor health. Portsmouth and Southampton see greater levels of deprivation, ranking 57 and 55 out of 317 local authorities in England (where a ranking of 1 = the local authority with the highest level of deprivation).

Hampshire is among the least deprived authorities although there are areas that fall within the most deprived areas in the country.
10% of children in Hampshire aged 0 to 15 years are living in income deprived families, and9% of residents aged 60 or over experience income deprivation

Isle of Wight is the 80th most deprived authority in England. 92.7% of the Island's population are resident in areas defined as coastal and these coastal areas have lower life expectancy and higher rates of many diseases in comparison to non-coastal areas.Just over half the population of the Island lives in area which are in the three deciles of highest deprivation.

Portsmouth is ranked 57th most deprived authority in England. 13% of Portsmouth's population live in the 10% most deprived areas nationally, and over 60% are in the most deprived two quintiles.
25% of households in Portsmouth are in relative poverty. In 2019/20 17% of children were in absolute low-income families (before housing costs). This varies from 29% of children in the most deprived ward to 7% of children in the least deprived ward.

Southampton is ranked 55th most deprived authority in England. 28% of Southampton's population live in neighbourhoods within the 20% most deprived areas nationally.

Health Inequalities

Some communities experience significantly poorer **access, outcomes and life expectancy** than the rest of our population. In Hampshire and Isle of Wight we see:

- Higher levels of emergency care compared to the rest of England, especially in more deprived areas, where access to primary care, outpatient care and planned care are lower.
- Deaths from cancer, circulatory and respiratory diseases are the greatest causes of the differences in life expectancy between the most and least deprived. More deprived areas see higher levels of heart disease, diabetes, chronic obstructive pulmonary disease and mental health issues. People living in these areas are also more likely to experience not just one, but multiple ongoing health conditions.
- A boy born in our most deprived areas will live on average between 6.1 years to 9.1 years less compared to a boy born in our least deprived area, and for a girl, between 2.3 years to 5.5 years less.
- Covid-19 has created additional health and social care needs and disproportionately impacted people living in more deprived areas, people with learning disabilities, older people, men, some ethnic minority groups, people living in densely populated areas, people working in certain occupations and people with existing conditions.
- Premature mortality in people with severe mental illness is higher than the national average on the Isle of Wight, Southampton and Portsmouth.

Across Hampshire and Isle of Wight, these are some of the differences between the most deprived 20% of residents and the least deprived 20%:

Revisions needed to this graphic: acronyms and using the correct measure for educational attainment (DPHs)

The challenging environment in which services are operating

Our strategy is set in the context of an increasingly difficult environment for all partner organisations.

Although NHS funding has not decreased in real terms, demand for services increases faster than the funding. The NHS is responding to ever more complex and long-lasting care needs without an accompanying increase in resource. In local authorities, budgets for the full range of services, including housing, education, public health and social care, have drastically reduced for over a decade, whilst demand and complexity of need has continued to grow, as have challenges sustaining the independent sector care market.

Recruiting and retaining health and care staff remains a challenge. Local employment levels are relatively high but low skilled. National staff shortages have been further exacerbated by the Covid-19 pandemic and the current cost of living. Meeting these challenges requires looking in new ways at the workforce we have, including new staffing models and the ability for staff to create meaningful career paths across health and social care. For our staff to provide excellent care to local people, they need to feel well looked after and supported and have access to opportunities to grow their skills and talents.

Cost of living pressures affect residents and services alike. Rising inflation and increased costs of energy and food have a negative impact on people's health, which drives up demand for healthcare services. Modelling carried out by Bristol University recently found that the impact of cost of living pressures over the winter could cause between 5 and 13% additional demand for urgent care and mental health services[1].

Demand for all health and care services is continually increasing. The number of people waiting for an operation has increased, but fundamental problems with flow through hospitals and workforce availability limit the rate with which services can treat people. Urgent care is currently experiencing unprecedented pressure. For both physical and mental healthcare, many people are being admitted to hospital who would be better looked after in the community. People are staying in hospital longer than is beneficial - waiting to be discharged, and then sometimes being readmitted. If emergency activity continues to rise at historic rates, there will be 15-20% more non-elective admissions by 2025. This will put increased pressure on our ability to treat people waiting for planned care procedures.

There are several drivers for these pressures including people's underlying health, difficulties recruiting staff, higher levels of absence due to Covid-19 and the amount of funding available. In winter 2021 there were around 55,000 people in Hampshire and Isle of Wight at particularly high risk of needing emergency care, of whom just over half had at least one of the following, largely preventable conditions: heart disease, chronic obstructive pulmonary disease, and diabetes.

Addressing the issues that affect people's health and wellbeing in such a challenging environment requires us to think differently. This strategy is not about simply doing more, it is about taking a radically different approach.

1 Revealed: how cost of living pressures will exacerbate emergency care demand | Comment | Health Service Journal (hsj.co.uk)

We are working with local communities to understand what is most important to them

In developing this strategy, we have reflected on insight from our local communities, which partners across the partnership have sought in a number of ways.

What we did

- Surveys on a range of topics, online and face to face, in clinical and community settings, with many directly targeted to different local communities
- Co-design groups, workshops and events on topics such as our community involvement approach, digital transformation and the development of the new integrated care partnership
- Attended local community events, both in person and virtually
- Discussed issues at regular Integrated Care Board and other groups with representatives from across communities
- Focus groups on a range of topics
- Funding partners such as Healthwatch and community groups to undertake targeted research
- Engagement programmes to support procurement and transformation plans

What we heard

- People want more join up between different services, from GPs to hospitals to social care; education and housing too
- People want to be more involved in how their care is delivered, to have better communication with health and care services, and be clearer about what is available to them
- Access is an issue, with people identifying the need for more specialist access and shorter waiting times, and more consistent support services across our geography
- Whilst people say digital technology has its benefits, it is important to ensure that no-one is left behind. Face to face appointments are still highly valued
- Cost of living is a concern across the system. Also people see opportunities to improve and expand the health and care workforce including use of volunteers
- Other issues weigh on people too. In rural areas, equipment and plant theft are big concerns. In urban areas people are concerned with protecting their homes and property
- Carers and young carers support, and greater collaboration with schools, primary care and other health services is vital

Our response to the needs of our population is primarily through our work in local places

This strategy has been developed in collaboration with local authorities to ensure this strategy builds on the work of our four health and wellbeing boards and their strategies and plans in our four local places - Hampshire Southampton, Portsmouth and the Isle of Wight.

Our strategy identifies a small number of priority areas where there is an opportunity to add value across our four places, recognising that most of the work undertaken to tackle health inequalities, improve health outcomes and service delivery, and contribute to social and economic development is delivered in local places.

These are the themes that are common to all four local health and wellbeing strategies:

Children and Young people	Reduce Inequalities Work with parents, families, schools and early years settings Improve physical wellbeing and improve lifestyles Improve emotional wellbeing and mental health
Living Well and Improving Lifestyles	Encourage healthier lifestyle choices and healthy approaches in schools and organisations Promote mental wellbeing and reduce mental ill health Promote active travel, create a greener, cleaner environment
Connected Communities	Joined up approaches across providers Building community networks Building on social capital
Housing	Ensure residents are able to live in healthy and safe homes Ensure home environments enable people to stay well Recognise and ensure that communities and families are not adversely impacted through poverty

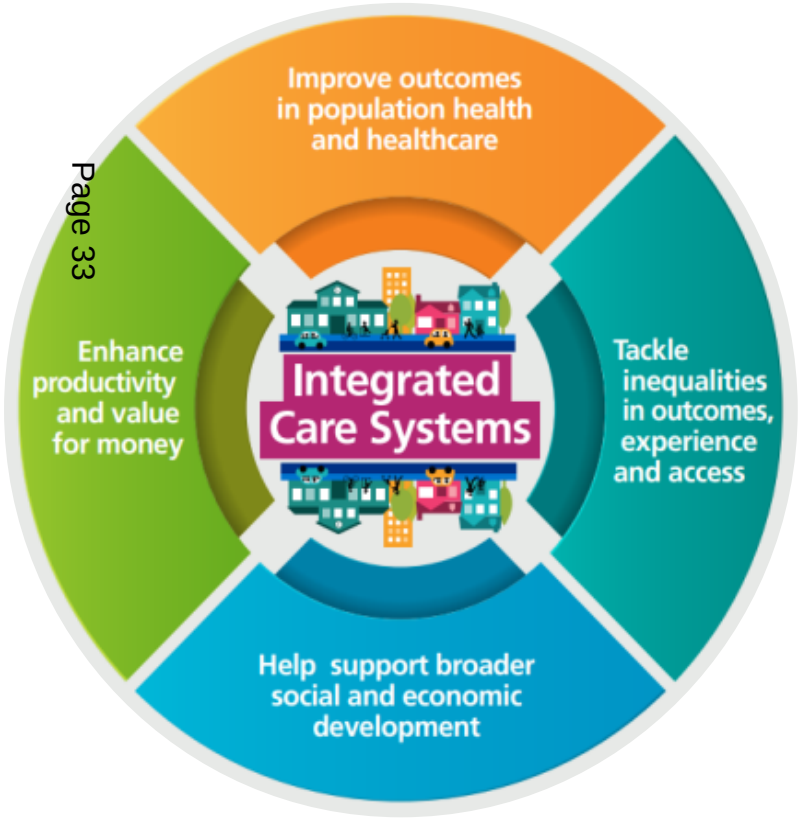
Hampshire	Enable planning for older age living Ensure Palliative Care Collaboration is in place Support those at end of life to be in preferred setting Encourage improvement in skills and capacity to have early conversations on end of life Improve bereavement support and service locally
Isle of Wight	Invest in prevention and early intervention to help health and wellbeing Improve housing standards and reduce fuel poverty, social isolation and loneliness Include health inequalities in policy development and commissioning Reduce health inequalities gap in the city
Portsmouth	Provide immediate support to people in financial hardship Helping people access the right support at the right time Repair relationships to support our most vulnerable Develop stronger models of support for landlords and tenants for longer, successful tenancies Develop models of housing that suit individual needs Implement Homelessness and Rough Sleeping Strategy to provide support for the most vulnerable
Southampton	Support people to live active, safe and independent lives and management their own wellbeing Reduce inequalities in health outcomes, make Southampton a healthy place to live and work with strong and active communities Ensure people in Southampton have improved health experiences as a result of high-quality integrated service

The work we do together as a whole integrated care system complements and supports the work that we do together in our four places

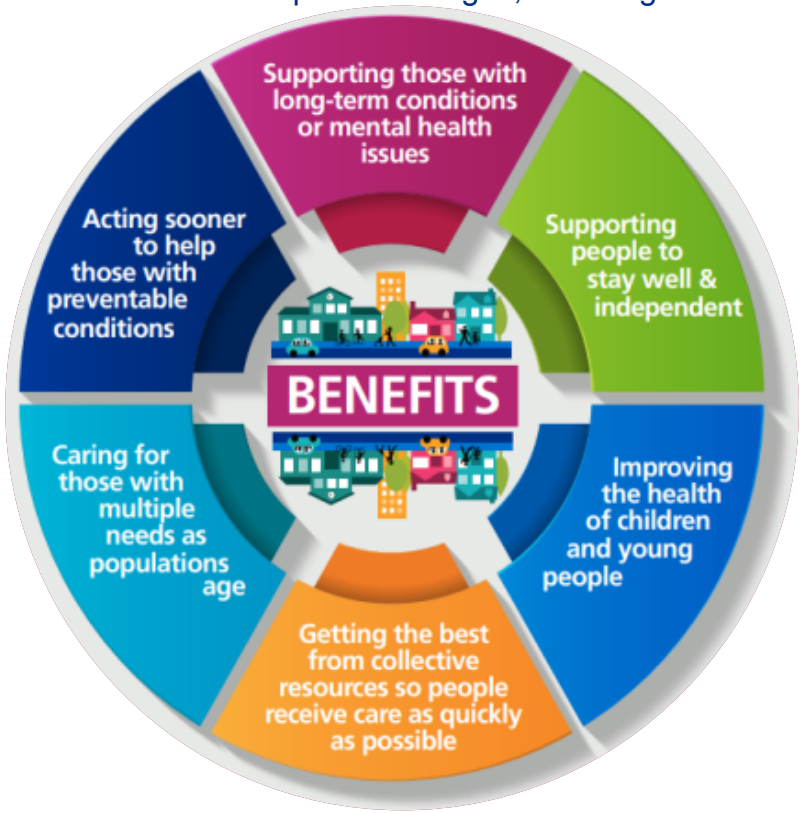
What is an integrated care system?

NHS England defines an integrated care system as “partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.” (NHS England » What are integrated care systems?)

The purpose of integrated care systems is to bring partner organisations together to:



Collaborating as an integrated care system is expected to help health and care organisations to tackle complex challenges, including:



Every part of our integrated care system has a role to play in delivering the priorities set out in this strategy.

Our **four local places** analyse the health and care needs of their residents and set local strategies for meeting these needs in their area. Their work feeds into and informs this partnership interim strategy document. The four places take local action to deliver for the needs of their local communities alongside the priorities agreed in this document.

The Integrated Care Partnership develops the strategy to address root causes of health and wellness, tackle health inequalities and bring partners together to work together in new ways. The Integrated Care Partnership sets strategic priorities based on sound evidence and that are within our gift to tackle as a partnership.

Our **Integrated Care Board** is responsible for planning NHS services across Hampshire and Isle of Wight and allocating resources across all health services. The integrated care board will ensure that the planning, quality monitoring, improvement and transformation of health services aligns and contributes to the priorities described in this partnership strategy.

Each organisation in our integrated care system sets strategies that address the challenges and opportunities facing their specific organisation. As partners that have worked together to agree partnership strategic priorities, these organisations will ensure that their organisational strategies contribute to the delivery of the priorities set out in this document.

Our strategic priorities

SECTION IN DRAFT

Core to our strategy: a new way of working together in partnership

To enable the best possible outcomes for the people of Hampshire and Isle of Wight, we are thinking and acting beyond the core services we deliver (and the way we currently deliver these services) to focus on improving the overall wellbeing of our population. We know that health and care is impacted by multiple factors including education, housing, employment and environment. We also know that the links between our services and the way people access them, and 'flow' through them – can make a big difference to experiences, outcomes and the efficiency of these services. We can only address these factors through partnership working between all public services, the voluntary, community, faith and social enterprise sector, our local businesses and employers and, most importantly, communities themselves. To do this we need to move towards:

- a radically different and more ambitious partnership approach to supporting people to build health, happiness, wealth and wellbeing, recognising the importance of the wider determinants of health and focus on reducing health inequalities.
- high-quality **care and support for our population** built on collaboration between all partners removing any artificial divides and using our collective resources to best affect, making decisions based on data, intelligence and insight
- A model **of community empowerment** which listens to and works alongside communities and enables and supports people to live healthy, independent lives, reducing the need for services and ensuring that, when people do need services, we deliver consistently **high quality, efficient, effective services** wherever people go in Hampshire and the Isle of Wight.

On 28th September 2022 we held an event with a wide range of stakeholders, who will be involved in the integrated care partnership moving forward, to help us to determine our strategic priorities. Together, we developed a set of principles based on feedback for how we should work as a partnership:

1. use the voice of the public, communities, patients and our staff to shape our work
2. use evidence on which to base our decisions, looking critically at the wider determinants of health inequalities, innovative and evaluative in our approach
3. focus on where we can make improvements and the experience people have of all our services, making changes centred around local people and populations
4. keep engaging across the system so that:
   - our priorities are co-produced and all partners have an opportunity to shape them;
   - we understand the priorities driving each of our partner organisations;
   - all partners can recognise the importance and relevance of whole system strategic priorities.
5. not seek to detract from organisations' existing strategies or health and wellbeing board plans. Our work should supplement and support existing plans and strategies.
6. use clear language to describe our work.

Hampshire and Isle of Wight partners have worked together over the last year to design the integrated care partnership; including what our priorities should be and how we will deliver them as a system. Whilst the partnership is still in its formation there are a number of features which will support in the development of the integrated care partnership:

- ✓ Our partnership will develop and change over time as we work together and learn more
- ✓ We will build from what is already working well in the system
- ✓ Our places are the foundation of the partnership
- ✓ We have opportunities through coming together at scale and will focus on what we can add to support people across our system

Five priority areas emerged from our initial assessment of data and understanding insights from communities and colleagues. Working together in our new partnership, we will initially focus on these five priority areas:

Selecting our priorities as a partnership

Our priorities seek to address the challenges, described on page xxx within the context of the current environment, described on page xxx, focusing on an initial, small number of priority areas for us to work together on as a new partnership over the next few years.

When deciding on our priorities, we considered the extent to which each priority was a significant problem or opportunity in Hampshire and Isle of Wight, and the potential the partnership has to make progress in terms of better meeting the needs of local people, and supporting them to lead healthier, happier, wealthier lives with an increased sense of wellbeing.

This is an interim strategy, produced during the formative months of the partnership, at the end of 2022. The partnership is committed to working together to further explore the proposed areas of focus under each of our strategic priorities, develop detailed delivery plans, and continually improve and refine the strategy to ensure our priorities remain relevant and that we make continuous progress against them.

We codeveloped the following strategy design principles to support us as a partnership, in decided which priorities we should include in our strategy. These principles are as follows:

- ✓ People and communities have told us are important to them
- ✓ Address the root causes of what affects people's health and quality of life
- ✓ Address health inequalities
- ✓ Address at least one of the following points:
    - Making care and services more joined up for people
    - Making it easier for people to access the services they need
    - Giving people more choice and control over the way their care is planned and delivered
- ✓ Affects more than one geographical area (i.e. place) and warrants a system-wide focus. (If the priority area only affects one place then it is better sitting in a local health and wellbeing strategy)
- ✓ Are supported by a strong, evidence-based case for change – for example there are currently poor outcomes in this area
- ✓ Need all system partners to work together to tackle them and make best use of our combined capacity and capabilities
- ✓ Are recognisable and relevant to all system partners and support existing strategies
- ✓ Are within our gift as a partnership to impact.

The intended impact of our strategy

Ultimately, we intend for our work together as a partnership to improve the health, happiness, wealth and wellbeing of the local population.

In doing so, over the medium to longer term, this will:

- Reduce the demand for health and care services
- Enable us to further improve the quality of service we provide
- Relieve pressure on the people who work in our organisations
- Enable us to live within our financial means

In the meantime, partners in local places; partnerships working with people with very specific needs, for example around housing; and organisations with common features, such as our primary care colleagues, acute hospital trusts and the voluntary and community sector, will continue to work together to do all they can to meet the health and care needs of local people in increasingly effective ways.

In combination, through our immediate and longer-term work together, across the whole system and more locally, we deliver on the intended benefits of integrated care, as previously described:

Our strategic priorities

Stand by to update with final version

Our shared aims	Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development.
Our challenges	Our population is growing and ageing. Improvement in life expectancy has stalled and begun to fall. Vulnerable people are dying younger and suffering poorer health than the general population. Inequalities are getting worse and drive worse outcomes. Challenges in workforce supply, funding, demand for services outstripping supply, impact of Covid-19 and cost of living. Without check inequalities will grow, years lived in poor health will increase and services will not cope.			
A radically different approach	Working together across all partners to take a community-centred approach to wellbeing. Seizing the opportunities offered by working together as a system and partnership with a mandate to use collective resources in new and different ways to build a better future - health, happiness, wealth and wellbeing.			
Priority areas: Themes that emerged from evidence and conversations in Hampshire and Isle of Wight	**Children and young people** We want all children to get the best possible start in life, regardless of where in Hampshire and Isle of Wight they are born.	**Mental wellbeing** We want mental wellbeing to be at the forefront of all that we do and to ensure as much importance is given to mental wellbeing as physical health.	**Promoting good health and providing proactive care** We want to enable every individual to live more of their life in a state of good health and be able to access resources and services in their communities.	
Initial areas of focus for the partnership	**Work to ensure the "best start in life" for every child** by focussing on the care and support that families receive in the first 1000 days of a child's life			
	Providing proactive, integrated care for people with complex needs to provide care closer to home and shift focus from cure to prevention			
	Improving social connectedness (reducing social isolation) to enhance people's physical and mental health and wellbeing			
	Supporting people with the cost of living to reduce the impact of financial pressures on people's lives			
	Better supporting people affected by childhood trauma by adopting a trauma informed approach			
	Providing healthy lifestyles and mental wellbeing support in community settings for examples schools and youth groups, community centres			
We will focus on these areas to enable delivery of our priorities	**Our workforce:** We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight. .	**Build workforce capacity to meet demand**	**Ensure the availability of the right skills and capabilities**	**Ensure people who provide services are well supported and feel valued**
	Digital solutions, data and insights: We want to harness the benefits that digital solutions can offer and ensure they are available to everybody, regardless of age and household income	**Empower people to use digital solutions**	**Support our workforce**	**Improve information sharing between IT systems** / **Improve our digital solutions**
Developing the "Hampshire and Isle of Wight way"	**As we work together to deliver our priorities, we will continue to learn together, and build our culture, capabilities and collaboration as a new integrated care partnership:** working with communities; adopting a continuous learning approach; developing a shared understanding of our opportunities and challenges, and shared vision; focusing on outcomes; building a high trust and high support culture; drawing on insights from all partners; listening to each other; focussing on priorities that resonate with all partners; making the best use of collective resource and capacity, strengthening our population health approach and developing our approach to collective assurance and accountability.			

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Children and Young People

What have we heard from our communities and partners?

"Children and young people should be our first priority; they are the future of Hampshire and the Isle of Wight"

- "We know if you get it right in the first 1,000 days, then the chances of positive outcomes are massively increased, even if they then experience adversity after first three years"
- "If a child enters school with a health inequality, this gap is likely to never close"
- "Adverse childhood experiences and trauma can lead to cardio-vascular disease, poor mental health, obesity, not educated, repeat victim and perpetrator – if we can work together on it will really benefit us"
- Young carers are cut off and potentially suffering from social isolation

The outcome we want to achieve: We want all children to have the best possible start in life, regardless of where in Hampshire and Isle of Wight they are born, and have positive physical, emotional and mental wellbeing.

Where we are today?

- **Best start in life:** Many babies and mothers have missed out on the best start in life during the Covid-19 pandemic, which exacerbated existing health inequalities and led to increasing childhood obesity, mental health disorders and missed vaccinations.
- **Obesity**: the England average is 9.9% in reception year - children on the Island and Portsmouth are above this, and Southampton is 9.9%. The British Medical Journal reports hospitalisation, illness and avoidable long term conditions could be reduced by 18% if all children were as healthy as the most socially advantaged.
- **Mental health:** Children whose parents have a mental health disorder, those in a family with unhealthy family functioning, and/or in lower income households are more at risk of developing a mental health disorder. 16,485 children and young people accessed NHS funded mental health services in 2021/22 (37% more children than in 2019/20). When compared to their peers, children under the care of mental health services are almost 20 times more likely to enter the judicial system. There has been a 295% increase in referrals to children and young people inpatient services since the start of the pandemic (over 50% of this for specialised eating disorder services)
- Increases in **Education Health and Care Plans** for children with Special Educational Needs and Disabilities.

What do we know works?

- If children and families **get the best start in a child's first 1,000 days** of life, then the likelihood of that child going on to achieve more through education, maximise their potential and lead healthy independent lives increases.
- **Intervening early**, redirecting resources towards prevention and working restoratively with families and individuals supports them to build on their own strengths and resilience to improve their lives. Family hubs provide additional resource in three geographies to extend and deepen family support programmes and support parents early on in their parenting journey
- **Strong integrated pathways of support** eg: there is strong evidence in Portsmouth that children want school based support on healthy lifestyles and mental health support. Early support for child emotional wellbeing including schools based programme - e.g. My Happy Mind.
- **Peer support** groups for pregnant women and their families
- Focused, family-based multi-professional support for **neurodiverse children**.

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- Focusing on the **"best start in life" for every child** by ensuring families receive good care and support (including for their mental wellbeing) in the first 1,000 days of a child's life
- **Improving access and mental health outcomes** for children and adolescent mental health services
- **Working with schools on prevention and early intervention** to reduce the risk and increase protective buffers at an individual, relationship, community and societal level. Meeting the health needs of vulnerable groups including 'looked after children' and care experience young people
- Continuing our **trauma-informed approach** led by Public Health, Police and Crime Commissioner and Hampshire Constabulary
- **Co-locating services** to enable a family-based approach to accessing services, co-designed with parents and carers to ensure a common language and understanding across services
- Further developing a **joint children's digital strategy**

What are the benefits for:

Local people: reduced health inequalities, improved mental health and wellbeing (reduced anxiety, reduced suicides, reduced eating disorders) and physical health, improved educational attainment, better inclusion and engagement in schools, societal benefits e.g. reduction in crime
Our staff: increased fulfilment knowing they can deliver the above, plus reduced pressure, increased satisfaction
Partners: positive impact on society and the economy, reduced demand for services in the future.

Mental wellbeing

Working through comments from mental health team – awaiting wording and data updates

What have we heard from our communities and partners?

"The non-clinical route into mental health and wellbeing support is just as important as the clinical route"

- Prioritising and promoting mental health and wellbeing is a priority across all partners, for all population age groups
- "Focus on illness is too strong and should be more of a focus on wellness"
- "Secondary care in mental health is just the tip of the iceberg - there needs to be many rafts of supporting scaffolds in place"
- "We need to challenge ourselves that access is the same and equitable", and continue to improve parity of physical and mental health
- We need to state tangible solutions with ambitious targets and do a few things well

The outcome we want to achieve: improve the population's mental health, emotional wellbeing and physical health, by focussing on prevention and working more closely with communities in the provision of excellent, equitable, joined-up services, care and support.

Where we are today?

- **Prevalence of mental health conditions varies across our geography**, e.g. the Island has the highest prevalence of severe mental illness, followed by Southampton and Portsmouth
- **Mental health problems have greater and wider impact in some groups than others**, e.g. the largest proportion of the population claiming Employment Support Allowance due to mental health problems is those aged 18-24yrs; impacts are inequitable in deprived and ethnic minority communities
- **We are below the national average and peer top quartile for some services**, e.g waiting times for children and young people, people living with a serious mental illness who have not had their regular 'physical health check' in primary care, and below national targets for improving access to psychological therapies and dementia diagnosis
- **There is a mismatch between the needs of population and the capacity of services**, and this varies across our system, so some people more impacted than others
- **Far reaching mental health impact of Covid19 still to be fully realised**; but has exacerbated inequalities for marginalised people/groups, especially those struggling with their mental health and wellbeing before the pandemic.

What do we know works?

- **Collaboration and determined focus on prevention and early intervention** e.g. Isle of Wight's Mental Health Alliance, partnering between Shout mental health text service & 111 Mental Health Triage Team, social prescribing.
- **Single points of access and 'no wrong door' approaches** - through join up between local authorities, primary care and voluntary care / social enterprises, improve the quality and availability of urgent care
- **Lessening the stigma around mental health and wellbeing** – coordinated communication campaigns between services / organisations e.g. 'Its OK not to be OK'
- **Digitally enabled support and care**, e.g.: psychological therapies and advice and information
- **Adopting 'outreach' approaches** through other healthcare interactions e.g. dentists, opticians to identify individuals who may be at risk
- **Expanding access to support in local communities** via innovation between partners e.g. co-location of services, mobile/pop up support in 'trusted' places where people live or gather e.g. Hampshire Homeless Health Teams, Joint work with Faith Leaders (Covid 19 Vaccination)

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- **Emotional wellbeing** and prevention of psychological harm - including excess morbidity and excess mortality associated with severe mental illness.
- **Improving mental health and emotional resilience** for children and young people, especially as they move into adulthood, and for families, parents and carers of children
- **Better connecting people** to avoid loneliness and social isolation
- Focused work to **prevent suicide**
- **Improving access to bereavement support** and services locally, for all age groups
- **Addressing inequalities in access and outcomes and enabling people to navigate through services**
- **Supporting the mental health and wellbeing of our staff** through policy and workforce development eg: Mental Health First Aiders

What are the benefits for:

Local people: reduced health inequalities, improved mental health and wellbeing (reduced anxiety, reduced suicides, reduced eating disorders) and physical health, greater independence, and for children and young people - improved educational attainment
Our staff: increased fulfilment knowing they can deliver the above, plus reduced pressure, increased satisfaction
Partners: increased effectiveness, improved productivity and workforce supply (resulting from improved mental health and physical health and/or reduced caring responsibilities for others with mental health support needs), positive impact on the economy, unmet need recognised and addressed.

Promoting good health and providing proactive care

What have we heard from our communities and partners?

"We need to be tackling the 'causes of the causes' of people's ill health"

- If trends continue, preventable ill-health and deaths will grow, as will health inequalities and our services will become increasingly unsustainable. There is a great deal we can and are doing, but there is more we could do together
- Deprivation is often hidden in rural communities – we need to prioritise areas of greatest need/ inequality – recognising we can't do all of this at once
- There is a role for all partners in improving health of our population, not just in terms of managing the conditions that people have already been diagnosed with, but addressing some of the wider determinants of health

The outcome we want to achieve: We want to enable every individual to live more of their life in a state of good health and be able to access resources and services in their communities and to narrow the gap between the richest and poorest.

Where we are today?

- **Outcomes vary widely**, eg: some of the lowest avoidable and preventable mortality rates in some areas, other areas significantly above national median
- **Some people suffer poorer health and die younger**, eg: people with learning disabilities (life expectancy 14 years less for males, 18 years less for females), people who are homeless, gamblers, refugees carers, people with mental health needs (eg: a person with schizophrenia dies up to 20 years earlier, the last 7 years in poor health)
- **The greatest contribution in life expectancy gap** between the most and least deprived is linked to circulatory diseases, cancer and respiratory diseases
- **Stagnating lfe expectancy improvements** particularly in the more deprived areas, (especially females). Time spent in good health has decreased
- **These outcomes can be changed,** eg: smoking remains the biggest preventable killer and major contributor to health inequalities; alcohol admissions are increasing, particularly in Southampton and west Hampshire; top issues noted in patient records: 1. hypertension, 2. depression, 3. obesity
- **Feeling isolated** is linked to early death, poor health and wellbeing - social isolation is associated with a greater risk of inactivity, smoking, risk-taking behaviour, coronary heart disease, stroke, depression and low self-esteem.

What do we know works?

- **Taking a life course approach** recognising there are a wide range of protective and risk factors that influence health and wellbeing over the life span and that people's outcomes can be improved throughout life
- **Reducing health inequalities** through the life course requires a whole-of-society approach dealing comprehensively with all health determinants. We know that clinical care only contributes to 20% of an individual's health outcomes and therefore to improve our populatic health and wellbeing we need to focus on the other contributing factors, eg: health behaviou (smoking, diet, alcohol), socioeconomic factors (family/social support), the environment people live in (housing)
- **Promoting healthy behaviours** eg: healthy diet, healthy weight, smoking cessation - helps with major conditions i.e. cancer, depression, dementia, diabetes and cardiovascular diseas
- **Better connecting people** (tackling social isolation) improves health outcomes and reduces the need for health services and residential care, supports employment and increases workplace productivity. Services which build on the community model of empowerment, like social prescribing in healthcare settings, voluntary and community befriender services and local government community connector services all have positive impacts. These services can deliver up to a 68% reduction in using services; up to 88% of people who acces these services have a better understanding of their community support and a 10% increase wellbeing measures eg: connectedness to others.
- **Providing proactive, integrated care for people**, especially those with complex needs, providing care closer to home, shifting focus to prevention, and reducing reliance on suppor services including urgent or emergency care.
- **Core 20+5 approach** to health inequalities: focusing on the most deprived 20% of the population plus other local population groups experiencing inequalities in five clinical areas: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- **Improving social connectedness and support in communities -** leveraging existing community assets and empowering citizens
- **Providing support for healthy behaviours and mental wellbeing in community settings;** targeted approaches on evidence-based issues eg: lung health checks, vaping prevention in children, visual impairment for those with learning disabilities
- **Ensuring equal importance is given to mental wellbeing and physical health** and tackling the stigma of mental health
- Supporting people to minimise the potential health and wellbeing impacts of **cost of living pressures**
- **Providing proactive, integrated care** for people with complex needs
- A **healthy ageing** approach, supporting people to benefit from smoking cessation, alcohol dependency and weight management services; building prevention into pathways regards modifiable risk factors (smoking, obesity, 5-a day, physical activity, alcohol/drugs)
- **Combining resources** on housing, mental health, refugees, homeless, rough sleepers and 'Core20+5'

What are the benefits for:

For local people: no matter what a person's circumstances are, they can be assured of dignity and security as they age; improvedhealth, happiness, wealth and wellbeing; longer lives and increased overall years of good health

For staff: more able to meet needs of local people, fulfilling work, less pressure, with a focus on prevention and early intervention

For partners: people living longer, healthier, happier, wealthier lives which reduces demand and unmet need, delivers efficiencies, improved effectiveness

Our people, digital technology and data are key to enabling us to deliver our priorities

Our people: the people that work across all our services are vital to the delivery of this strategy. We have a highly skilled, dedicated and committed workforce across Hampshire and Isle of Wight, including a huge contribution from volunteers and informal carers.

External factors lead to increased demands on services and the people that deliver them. People are living and working longer, necessitating radical changes in how we structure work, eg: flexibility, mid-career shifts, re-skilling, and delayed retirement. The health and wealth of the workforce affects the health and wealth of local people. In the NHS, 1 in 4 staff members are 'lower paid' (defined as earning up to £12.73 per hour in 2021/22, just below average UK hourly earnings). By comparison, around 4 in 5 social care employees are 'lower paid' by the same measure. Our workforce has faced unprecedented challenges over the Covid-19 pandemic and demonstrated exceptional resilience, including adopting new practices to sustain services for the benefit of local people.

Our workforce is stretched, both in Hampshire and Isle of Wight and across the country. Workforce wellbeing remains a key priority across all sectors. In June 2022 alone the NHS lost 476,900 days (nationally) to sickness and absence due to anxiety, stress and depression. As of September 2021, nearly 100,000 NHS vacant posts, and 105,000 in social care were being advertised nationally. An estimated extra 475,000 jobs are needed in health and 490,000 in social care across the country by the next decade. We recognise the imperative to re-examine the way we work and innovative delivery pathways supported by digital technology.

Workforce challenges in Hampshire and Isle of Wight

- Domiciliary care workforce shortages, particularly in Isle of Wight, south-west and south-east Hampshire
- NHS workforce supply pipelines unable to keep pace with current demand, particularly for nursing, midwifery, medical and allied health roles
- Our workforce is not representative of the communities we serve, which might then impact on the inclusivity of services we provide
- Staff morale and engagement scores are generally declining across the NHS.

Digital solutions, data and insights: harnessing the power and innovation of technology and information technology will help us to deliver better quality, more efficient care, closer to people's homes and communities, in a way that fits people's individual needs and lifestyles. Joining up data, technology and information systems will also support us to join up our care and improve services and support our workforce to be more efficient. Data held by the NHS, and generated by smart devices worn by individuals, presents opportunities to support everyone with access to their health information and personalise many more health interventions.

However, the complexity, cost and time it takes to introduce some new digital solutions, join up data and create insight we can act on continues to present a challenge. Additionally, most local people understand the benefit of digital solutions and shared data, but we must continue to be respectful of the views and preferences of those who still have reservations or are unclear. For example:

- **Sharing patient information** – a Wessex Care Records survey highlighted:
  - 86% understood their information was shared for their care and treatment, but less were aware it was shared for planning services (46%)
  - Respondents were positive about potential future uses such as sharing for planning and improving services (77%)
  - There was less support for sharing with other organisations, ie: the charities/universities carrying out research (58%), other organisations, such as councils, providing care and support (53%) and companies developing new treatments (38%)
- **Face-to-face still highly valued** – Hampshire Fire Service asked what people thought the challenges were to accessing services. Respondents said access to technology was the main barrier (46% said face to face communication was best)
- **Remote monitoring needs to be effective** – Healthwatch England asked people about their experience of remote monitoring. People said there are many benefits to blood pressure monitoring at home, including peace of mind, feeling in control and convenience, but there are serious questions about whether the benefits of better health are being realised and gaps in GP processes need to be addressed to avoid demotivating people and missing opportunities to address blood pressure problems.

Our people (workforce)

What have we heard from our communities and partners?

"Without the workforce, none of our ambitions will be achieved"

- "We can't do anything without our people. They need to be supported, inspired and have good access to continuous development.
- "[We need] a workforce that is engaged, empowered and always learning and striving to improve."
- "There is the opportunity join up our training and retention offer, including creating employment opportunities for our local population to improve their health outcomes"
- Reductions in workforce puts pressure on loyal staff and shortages are getting worse across all roles
- The rising cost of living is creating downward pressure on the real wages of our workforce and making it even harder to recruit
- Our workforce doesn't match need with some areas very well served and others (often more deprived) areas underserved
- There is some duplication in roles, especially between "first contact" staff

The outcome we want to achieve: We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight.

Where we are today?

- Untapped resources in voluntary and community sector
- Increasing sickness absence rates, eg: NHS increased to 5.2% in June 2022; 23.2% of sickness due to anxiety, stress, depression and other mental health
- Annualised growth for the health workforce is 4% per year over the past five years, but there is still shortfall, NHS vacancies at 10% in south east region April –June 2022. 2021/22 NHS staff retention rate at 14%
- At the time of the 2011 census, there were 39,437 unpaid carers across our system providing for family members or friends. The total number is now likely to be much higher. However, during Covid-19, we have seen a breakdown in unpaid carer arrangements and voluntary and community sector care support is also compromised. Many of the people being supported in this way are living with long term, often life long, care and support needs. Without the amazing commitment and dedication of unpaid carers the health and care system would quickly come to a standstill.

What do we know works?

- Concerted focus to improve diversity, inclusivity and belonging and the development of a universal workforce
- Collaboration in recruitment and retention, including international recruitment
- Making every contact count
- Health and wellbeing at work, including support for menopause and staff fast track referrals into support services
- Joining up pathways into education around healthy lifestyles into care, health and voluntary sector roles
- Levelling up through employment - securing good work is a key indicator to improve individual, and collective, health and economic wellbeing outcomes
- Organisational development networks across partner organisations to work together on development and share best practice
- 'Education to employment' projects working with schools and colleges
- Joint leadership and transformation programmes eg: Hampshire 2020 programme

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- Building workforce capacity to meet demand: Grow the workforce for the future by extending recruitment and working closely with education providers, building our ability to share system resources and move between organisations, harness the untapped support of volunteers and implement effective, collaborative workforce planning which accounts for labour market flows across health and care sectors and their interaction with the wider economy, designing innovative new roles with career pathways to suit tailored needs.
- Ensuring the availability of the right skills and capabilities to deliver, safe high-quality care.
- Ensuring people who provide services are well supported and feel valued, taking a system-wide approach to organisational development and support offers for our staff, including access to mental health first aid support and trauma counselling, and supporting people with unpaid caring roles, as well as improving diversity and inclusivity.

What are the benefits for:

Local people: better availability of staff with the right capabilities means better access to high quality services. There is a direct link between staff feeling supported and valued and being able to deliver high quality, compassionate care.
Our staff: increased fulfilment, increased job and career satisfaction, lower levels of stress, avoid duplication of recruitment and training requirements, feel able to deliver care of the quality to which they aspire, improved personal health and wellbeing.
Partners: improved workforce supply and pipeline; creation of new roles to support delivery of key priorities at place (e.g. case management). Ifstaff shortages in one part of the system are addressed, this has a positive impact on workforce capacity across all sectors. Positive impact on the economy and wider determinants of health for local people employed locally.

Digital solutions, data and insights

What have we heard from our communities and partners?

"There is a known need for digital systems to be integrated and compatible: without this there is a decline in efficiency and collaboration"

- "A shared single picture of vulnerability is essential so that we can target activity to the sections of the population that need it most"
- "It's about the enablers. That's where we can get traction as a system"
- Systems are not connecting with each other: too many systems creates duplication. We are wasting time by not have the right access to the right equipment or networks to do work in real time.
- Increased awareness and concern about digital exclusion. This is not just about access to computers and the internet, but includes issues such as privacy, disability and access for carers.

The outcome we want to achieve: We want to harness the benefits that digital solutions can offer to our local people, carers and staff, ensuring they are available to everybody, regardless of age, disability or household income.

Where we are today?

- People are now using **digital tools for online consultations**, accessing their GP record, and to seek advice and guidance.
- **Digital exclusion** is having an increasing impact on the most vulnerable in our society. People that are digitally excluded often pay more for household bills, earn less, have lower levels of educational attainment and can suffer more from social isolation, which impacts on both mental and physical health.
- We have a **range of different IT systems** that do not all "talk" to each other.
- Our **data sets** are not yet as sophisticated or joined up as they need to be to enable excellent decision making including individual care and service planning.
- Health and care can be **slower to adopt** digital innovation.

What do we know works?

- **Giving local people more control of their care** for example by sharing your Covid-19 status or ordering repeat prescriptions through the NHS App or viewing your latest test results and communicating with your healthcare professional via MyMedicalRecord
- **Providing users with simple secure access to the information they need**, for example by providing care homes with access to the system-wide shared care record to see any new patients history such as medications and allergies.
- **Bringing information from multiple sources together in one place** and reducing the number clicks and logins, for example with single sign on to the shared care record or through electronic patient record portals.
- **Reducing unnecessary travel time** for patients and local people by providing robust secure mobile access to systems and giving patients the choice of virtual consultations.

Our areas of focus as a new integrated care partnership:

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in the following areas:

- We will **empower local people** to use digital solutions through promoting and engagement in digital services. We will provide resources and support for local people to engage in digital to ensure equity of access to all health and care services
- We will **support our workforce** to be confident and competent in using digital solutions to provide high quality care
- We will **improve how we share information** between different IT systems and remove the organisational, digital, data and technology boundaries created by legacy systems to better support care provision and the creation of integrated datasets to support planning
- We will **continue to improve our digital solutions**, focusing initially on investment in shared electronic health and care records. We will explore digital innovations in improving health and modernising care and experience, including the use of apps and wearable devices

What are the benefits for:

Local people: can receive care at home, where appropriate and only need to say things once. People feel they are always involved and have control of their own care, can access care and information in a way that meets their individual needs and helps them to make choices about their own health and wellbeing. Our local people do not feel digitally excluded and can access to a range of services.

Our staff: can access equipment that is modern, reliable and fast, and helps productivity, releasing more time for providing care. Staff can review and update patient records when and where they need to, using joined up systems that talk to each other. Staff can easily communicate with colleagues across different organisations involved in the care of local people.

Partners: Reduced efficiencies by saving staff time and avoiding duplication; facilitates joined up care and services; enables real-time, consistent capturing of information which improves our understanding of people's needs and helps decision making; enables joined up data sets to support better planning, including our population health approach.

How we will deliver our partnership strategy

SECTION IN DRAFT

Our ‘strengths based’ approach

Our strategy focuses on a small number of initial priority areas to make the best use of our combined resources, including the strengths of our local communities and our ***strategic assets*** across Hampshire and the Isle of Wight. As we work together to deliver our priorities, we will also develop the way that we work together as a partnership, continuing to learn together and draw on our collective insights and talented people.

The strength of our communities

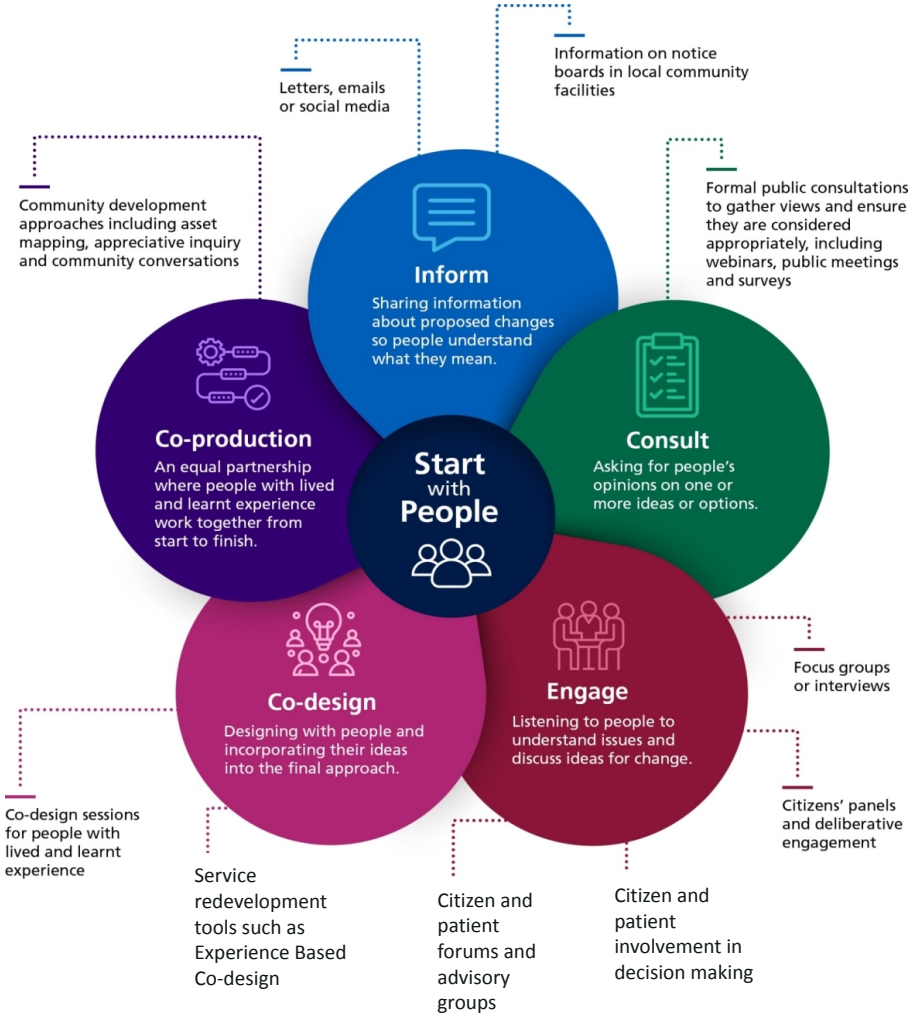
Our ambition is it to harness the resources, skills, knowledge and experience of the communities we serve. We have strong communities, within which many people give their time and skills as volunteers, and thousands of people providing unpaid care to their loved ones. Our voluntary, community and social enterprise sector is a significant asset and makes a huge contribution to our communities.

Thousands of students attend higher education here and we are home to outstanding centres of research and innovation in our local universities and academic health science network. We have a thriving cultural scene and industries providing employment and infrastructure.

Using community assets we will address health inequalities, improve and innovate the way we deliver services and support local communities to improve their health, happiness, wealth and wellbeing.

As described earlier in this document, we have drawn upon insights from local people to inform this interim strategy. Our community involvement approach, incorporates many ways of working with local people (see right), and builds on existing best practice carried out by partners and communities here and in other places, strengthening the valuable relationships we have, and meeting the needs of our diverse communities.

As part of this, we are launching a project aimed at supporting under-served communities to participate in research to improve access, resources and support for these communities. The project brings together voluntary; community; social enterprise; local government; health and adult social care partners, the University of Winchester and people with lived experiences. This will be instrumental in the delivery of this strategy and our ongoing work as a partnership with our local communities.



Developing our learning system

Together we will design a learning and improvement system, building on excellent practice across Hampshire and Isle of Wight, and drawing on evidence and best practice from the highest performing health and care systems nationally and internationally. We will develop a unified approach to change and transformation, and how we will deliver the best outcomes for local people, making the best use of our resources. This will have implications for how we plan, design, deliver and sustain change and improvement. Key to this are our collective insight and innovation capabilities.

Our population health approach: building capability across the "four Is"
Building these capabilities will enable us to deliver a population health management approach to support us in delivering our strategic priorities.

Infrastructure

Organisational and human factors such as dedicated systems leadership and decision making on population health and PHM

Digitised health & care providers and **common integrated health and care record**

Linked health and care data architecture and a single version of the truth

Information Governance – whole system data sharing and processing arrangements that ensure data is shared safely securely and legally

Intelligence

Advanced analytical tools and software and system wide multi-disciplinary analytical teams, supplemented by specialist skills

Analyses and actionable insight – to understand health and wellbeing needs of the population, opportunities to improve care, manage risks and reduce inequalities

Alignment of multi-disciplinary analytical and improvement teams to work with and advise providers and clinical teams

Development of a cross system ICS intelligence function providing support to all levels of system

Interventions

Care model design and delivery through' proactive and anticipatory care models with a focus on prevention and early intervention and reducing health inequalities

Community well-being – asset based approach, social prescribing and social value projects

Citizen co-production in designing and implementing new proactive integrated care models

Monitoring and evaluation of patient outcomes and impact of intervention to feed into continuous improvement cycle

Incentives

Incentives alignment – value and population health based contracting and blended payment models

Workforce development and modelling – upskilling teams, realigning and creating new roles

Enabling governance to empower more agile decision making within integrated teams

Research and innovation
There are vast opportunities for research and innovation to help address challenges around:

- workforce
- mental health and wellbeing, particularly for children and young people
- new approaches to care for people living with long term conditions and for older people
- making the best use of digital solutions
- accessing routine care following the Covid-19 pandemic.

Some of these innovations help us to deliver the right things at the right times in the right place, making the most efficient use of workforce and empowering people in their own care. Other innovations drive technical efficiencies in established pathways of care. As in other global health systems, the adoption of innovations in health and care is patchy, driven by the way innovation is prioritised and funded. In the United Kingdom, we invest heavily in invention, but our ability to make use of inventions does not always keep pace.

Working as an integrated care partnership allows us to better align all the organisations in our system to make better use of innovations. Other factors that support this include the merging and therefore better alignment of central bodies, and our collective experiences of working through the Covid-19 pandemic, which changed our understanding of what is possible and how to enable rapid invention, adaptation and use of innovations. In Hampshire and Isle of Wight we will seek out research and innovation that directly supports our five strategic priorities, work out how these can be adopted across our partners and services, and develop our capacity and capability to sustain and spread innovations as part of our learning system approach. In doing so we will make best use of:

- Relationships with academic networks and institutions
- Commercial support and relationships with industry
- Design support and implementation science
- Real world evidence about what works well
- National networking, sharing, learning and supporting.

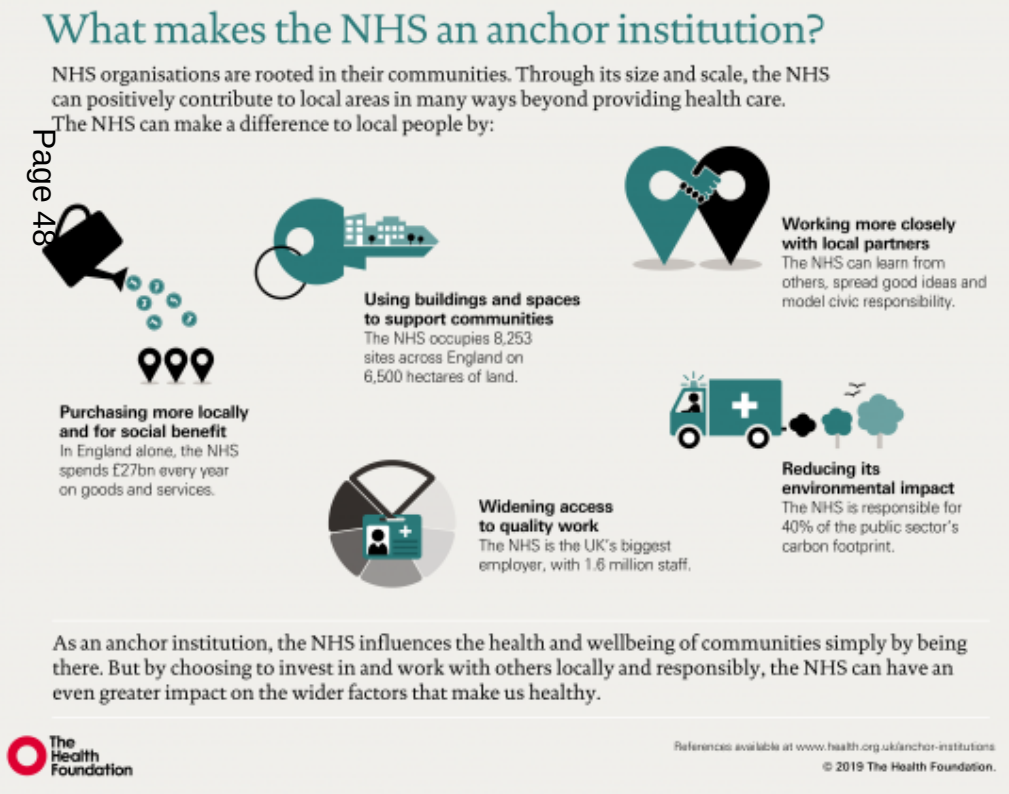
Ensuring our organisations benefit broader society and support environmental sustainability

Our organisations as "anchor institutions"

Large businesses, local authorities, NHS and other public sector organisations, are rooted in their local communities and can make a big contribution to local areas in many ways, far beyond our core purpose as organisations. The term ***anchor institutions*** refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on local health and wellbeing.

The Health Foundation developed the graphic (bottom left) to show how NHS organisations act as anchor institutions in their local communities. Although the graphic refers to the NHS, the same principles apply to partners, including local authorities, universities and large employers.

We are increasingly conscious of our potential to make an even greater contribution to broader society and the environment and are working to better understand and realise this potential. In our workforce priority, we describe our ambition to work together to improve the health, happiness, wealth and wellbeing of local people working in our organisations, and our future workforce, drawing more and more local people into employment and volunteering.



Opportunities to work together for a cleaner, greener environment for us all

Another area of focus for us as anchor institutions, is our work to address the climate crisis, as described below.

- **Reducing carbon emissions** through energy and water efficiencies and clean technology installations will contribute to cleaner air across Hampshire and Isle of Wight, and offer the potential to reduce the pressure on our system by lowering rates of chronic disease such as cardiovascular disease in our local population
- **Supporting local biodiversity** through creating or enhancing green spaces on our estate (land) to promote residents, staff and wider community health and wellbeing now and in the future
- **Empowering and supporting our workforce** to make greener decisions through creating an innovative environment, where our people feel able to embrace sustainability practices in their day-today actions and has a positive effect on their wellbeing at work
- **Reducing indirect environmental impacts** and maximising social value by choosing local and conscientious suppliers where possible e.g. maximising efficiencies in transporting of goods
- **Reducing operational waste** including choosing low carbon alternatives such as reusable equipment and reutilising where possible

Our partnership is committed to maximising our positive contribution to our local area wherever possible.

System funding and finance

All system partners are operating within an increasingly difficult national economic environment. Local authorities continue to work creatively with partners and populations to deliver statutory services within revenue and capital resources. At the time of writing, the impact of the recent 2022 Autumn Statement is still being worked through by councils. However, it is assumed that the overarching position remains relatively unchanged. Challenges coping within normal inflationary pressures, over a decade of reductions in core budgets, in addition to the significant unfunded growth in demand and costs, particularly in adults' and children's social care, and the crisis in special education needs, means that some local authorities are now pressing for fundamental change either in the way these services are funded, or in our statutory obligations.

This further demonstrates the need to focus on the priority areas set out in this interim strategy to improve the health and wellbeing of local people. Partners are also keen to better understand the totality of our funding envelope and explore opportunities to work together to make best use of the funding available.

Money the NHS in Hampshire and Isle of Wight receives

The NHS in Hampshire and Isle of Wight receives £3.7bn for the health and care of its population, equating to approximately £1,756 per head of population. This is a high level of funding per head of population but it is over funded using a national formula and we expect to receive the lower levels of funding growth than other parts of the country in future years, with potentially reduced additional central support for individual NHS organisations' inherent financial challenges.

Of Hampshire and Isle of Wight's £3.7 billion NHS funding:

- £2.1 billion is spent on NHS providers within Hampshire and Isle of Wight, of which £0.3bn is spent on mental health services (a small proportion of which is with providers outside of Hampshire and Isle of Wight).
- £0.3 billion is spent on GP services with a further £0.3bn on wider primary care
- £0.2 billion is spent on continuing care services for people with very complex health and care needs
- £0.1 billion is spent with local councils, including through joint funding arrangements.

Broadly speaking, we receive the same level of income from activities such as training and research and development as other systems of a similar size and scale. However, some systems do receive much more funding for research and development - this is an area we will look to grow in Hampshire and Isle of Wight.

Nationally and in our system, local authorities are facing financial pressures in adult and children's social care, public health and the broader services that impact health and wellbeing outcomes. At the same time the health and care system faces further activity, workforce and financial challenges going forward across the NHS, local authorities and the voluntary sector.

Hampshire and Isle of Wight

Making best use of our resources

As a partnership, we are working together to explore what we can do to make better use of our resources, including:

- How to deliver efficiencies so that more funding can be made available to deliver our five strategic priorities
- Developing an equity model to ensure investment decisions are driven by population need and support reductions in the health inequalities described in this interim strategy
- Collectively driving funding to the right places to ensure best value, care and support for local people
- Making more use of pooled funds through the use of Section 75 agreements between local authority and NHS partners, and similar, where appropriate
- Exploring how we could operate an 'open book' financial culture
- Developing our shared approach to taking difficult financial decisions
- Exploring how all partner organisations can support local economic development.

Section 75 agreements

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

Established section 75 arrangements are already in place between our integrated care board and our four upper tier local authority areas. This mechanism has resulted in a major increase in pooled budgets over the years in some parts of our system, where partners have agreed to share risks and rewards and accountability for outcomes.

Further integration of care, while complex to deliver, is recognised as a much needed response to the challenges of rising demand and budgetary constraints. Our ambition is to utilise the section 75 agreements as the vehicle to further drive integration of services at a local level and also deliver on the strategic objectives of this strategy.

Implementation and delivery plans, measuring progress and learning as we go

During the early part of 2023, we will:

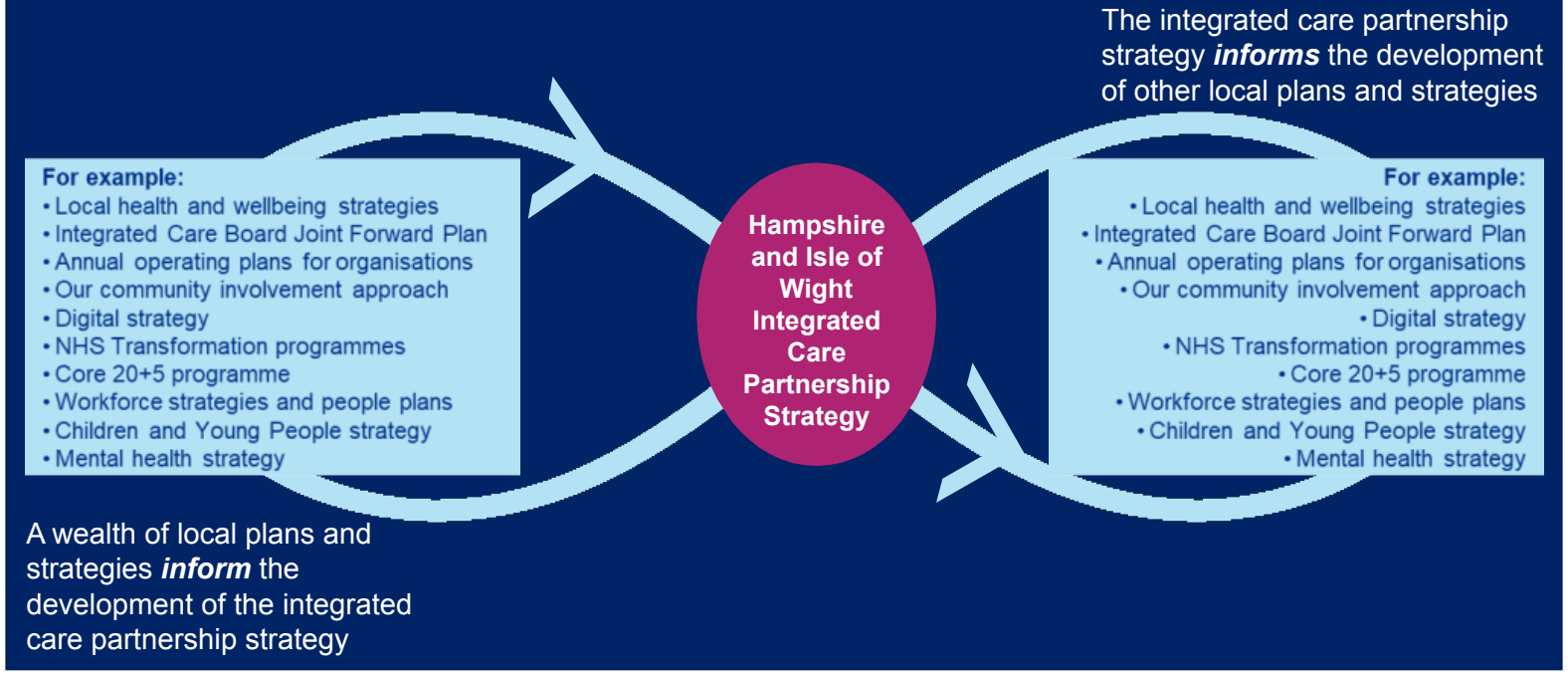
- publish easy read and summary versions of our interim strategy, and invite further reflections and feedback from local people and partners to further inform our next work together to translate this strategy into delivery, as well as future refreshes of this strategy
- work together and with local people, especially those with lived experience, to
  - develop our delivery framework for each of our priority areas
  - create a clear dashboard to measure and report progress in our delivery of our strategy on a quarterly and annual basis. This will be publicly available to ensure transparency and promote accountability
  - establish effective ways of reflecting on, and learning from our work together as a 'learning system'
- use this interim strategy to inform the development of the NHS five-year joint forward plan, and inform future versions of individual health and wellbeing strategies, NHS organisations' plans and other strategies and plans

If you would like to be involved in these activites, please contact [insert contact email address, refer to ICS website?]

An ongoing, iterative process of strategy development across our partnership

Our interim strategy sets out the initial priorities we will address together as a partnership. We will regularly review our five priorities to ensure that they remain relevant to our context and environment and that we are delivering improvements in these areas for our local community.

The integrated care partnership strategy is informed by other local strategies and plan, and in turn informs the refresh of those strategies and plans over time. This is an iterative process, and joining up the priority areas across our various strategies and plans forms part of our new ways of working together.



DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MONITORING SCRUTINY RECOMMENDATIONS		
DATE OF DECISION:		8 DECEMBER 2022		
REPORT OF:		SCRUTINY MANAGER		
CONTACT DETAILS				
Executive Director	**Title**	**Chief Executive**		
	Name:	**Mike Harris**	**Tel:**	**023 8083 2882**
	E-mail	**Mike.harris@southampton.gov.uk**		
Author:	**Title**	**Scrutiny Manager**		
	Name:	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail	**Mark.pirnie@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 (HOSP). It also contains a summary of action taken in response to the recommendations.	
4.	The progress status for each recommendation is indicated and if the HOSP. 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 HOSP.	
RESOURCE IMPLICATIONS		
Capital/Revenue		

5.	None.	
Property/Other		
6.	None.	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
7.	The duty to undertake overview and scrutiny is set out in 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 – 1 December 2022	
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 – 8 December 2022

Date	Title	Action proposed	Action Taken	Progress Status
01/09/22	Review of Community & Mental Health Services	1) That the timetable outlining the key milestones for the review of community and mental health services is circulated to the Panel to enable the identification of appropriate meetings at which the HOSP can be updated on developments.		
20/10/22	South Central Ambulance Service (SCAS) – CQC Report & Update	1) That the Panel are kept updated on inspection activity and findings with a view to SCAS returning to update HOSP on progress at a future meeting of the Panel.	Agreed	
20/10/22	The ICP and the development of the interim Integrated Care Strategy	1) That the draft Interim Integrated Care Strategy is considered at the 8 December meeting of the Panel.	Interim Integrated Care Strategy included on 8 December 2022 HOSP agenda.	
20/10/22	Adult Social Care – Performance Update	1) That, when the Panel are next considering Adult Social Care performance (currently scheduled for 9 February 2023), an overview of the transformation programme is appended to the performance report.	Transformation Programme lead informed and will update as requested.	In progress
		2) That Adult Social Care workforce indicators are included within the performance dataset to be considered at future meetings.	HR will provide a range of metrics for consideration by the panel.	Completed
		3) That, reflecting concerns about the accuracy of the data reported, an audit of the performance relating to reviews undertaken is conducted.	Performance have been asked to comment on accuracy of information presented and any caveats.	In progress

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