


# Integrated Commissioning Plan

2018/19 – 2020/21

NHS
Southampton City
Clinical Commissioning Group

SOUTHAMPTON
CITY COUNCIL

# Our Vision & Strategic Priorities

**ICU Vision:** Working together to make best use of our resources to commission sustainable, high quality services which meet the needs of local people now, and in the future

## NHS Southampton City CCG

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|---|---|
| **Better Care Southampton** | Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton |
| **Mental Health** | Improve the quality, capacity and accessibility of mental health services whilst joining up care with other local community services |
| **Primary Care** | Build a model of general practice that will be the strong, effective and sustainable foundation of our integrated health and social care system |
| **Cancer & Pathways Transformation** | Increase earlier detection and treatment of cancer to improve survival, and transform clinical pathways to improve patient outcomes and deliver care closer to home in the community |
| **Urgent & Emergency Care** | Redesign and strengthen the urgent and emergency care system to ensure patients can access the right care, in the right place, first time |

**Integrated Commissioning Unit (ICU)**

## Southampton City Council

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

# Our Priorities & Objectives

## Integration

*Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton*

## Prevention & Earlier Intervention

*Strengthen prevention and early intervention to support people to maintain their independence and wellbeing*

## Safe & High Quality Services

*Ensure that people are provided with a safe, high quality, positive experience of care in all providers*

## Managing & Developing the Market

*Support commissioning activities that facilitate a strong provider market that is able to respond to an increasingly diverse customer group*

# Integration

*Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton*

## Our objectives

- People have told us that they want their **care and support to be joined up** by professionals who talk to each other so that they don't have to keep telling their story again and again.
- With complexity of need increasing and more people requiring a range of support and interventions, it is important that more **services work together** to meet people's needs in a joined up and holistic way.
- This requires **a more joined up approach** between children's and adult services, health, housing and social care, primary/community services and hospital care, physical health and mental health and between the public, private and voluntary sector.
- People have also told us that they want to be **more involved in decisions** about their care and support and want more choice and control.
- We will therefore **challenge existing service delivery models and review alternative and innovative new ways of working** to ensure we are always achieving the best outcomes for local people in the most efficient ways possible.
- We will continue to promote the use of **personal budgets and direct payments**.
- We will build on the **development of clusters** to organise joined up service provision at the most local level.
- We will promote **co-location and integrated teams, facilitate workforce development** across the system and ensure that the opportunities from **digital transformation** are harnessed across the system to support more joined up and personalised approaches to care.
- We will make it easier for services to work in a more joined up way by exploring **procurement, contracting and reward mechanisms** that promote integration.
- We will continue to increase the use of **pooled budgets and integrated commissioning** to ensure that the Council and CCG are working together to achieve shared aims and make best use of our collective resources.

## What will success look like by 2020/21?

- ✓ Person centred, joined-up care and support delivered through an integrated approach which is centred around six clusters in the city.
- ✓ Families experience a seamless journey of support that enables children to have the best start in life.
- ✓ Delivery of care and support centred around integrated care planning through interoperable systems.
- ✓ Individuals and families in control of their care or support with the help of a lead professional (where this is required) or simplified information and advice systems.
- ✓ Effective hospital discharge with seamless arrangements in place to support an individual's recovery.
- ✓ Access to community resources which have been developed by a strong community solutions approach.
- ✓ Effective crisis support when needed regardless of the day or time of the week, that enable families/individuals to recover quickly and get back on track.
- ✓ Continue to pool CCG and Council resources to support joined up provision, with an increased proportion invested in community based services to reflect the shift in the balance of care.

# Prevention & Earlier Intervention

*Strengthen prevention and early intervention to support people to maintain their independence and wellbeing*

## Our objectives

- There is evidence that preventative approaches and early intervention are cost effective in avoiding health and social care need and in reducing deterioration where people are already experiencing difficulties. We will therefore **invest in services which help people to modify the behaviours** that can cause ill health, including helping people to stop smoking, maintain a healthy weight, take more exercise and promote safe alcohol consumption levels.
- With increasing levels of need, we also need have to **find new ways of supporting people at the earliest opportunity**, whilst ensuring that public sector services are available for those who require them. This means using **risk stratification and predictive modelling tools** to identify people's needs as early as possible and respond in a coordinated way.
- We will also commission services which **help people to maintain their independence** and remain in their own homes for as long as possible. This means **services which are community based** and which offer flexibility in order to respond to the unique needs of the individual, that are **strengths based** and focused on what people can achieve rather that what they cannot do and where the use of care technology is maximised.
- There is increasing evidence that loneliness and social isolation effect the outcomes for people with health and social care needs and we will therefore work with others to develop **opportunities for people engage in their local communities and consider social prescribing** approaches.
- Our focus on cluster based work supports an approach where **our workforce gets to know local community networks** and resources, and is able to help people to access these.
- We recognise the important role that **parents and carers** play and we will work with others to ensure they are well supported in their caring roles for dependent children and/or adults, but also in relation to meeting their own needs.
- Access to **reliable and timely information and advice** is critical in supporting prevention and early intervention approaches and we are working with the local authority and voluntary sector to deliver integrated and easily accessible services to the whole population.
- We recognise the role that adequate housing and access to **employment opportunities** plays in keeping people healthy and well. We are working with others to **develop a wider range of accommodation** for people including supported housing and also to help people who are further from the workplace to get back into work or training.
- We know that some people have difficulty accessing primary care and other preventative health services. We are particularly focusing on **improving take up for people with mental health and learning disabilities** as we know these groups are particularly vulnerable. This includes improving the take up of health screening.

## What will success look like by 2020/21?

- ✓ Individuals take more responsibility for their own health and wellbeing.
- ✓ The balance of care has shifted from treating acute illness, towards prevention and earlier intervention.
- ✓ People are supported to change behaviours which lead to long term health and social care need.
- ✓ Earlier intervention prevents people's needs escalating and helps people to stay independent for longer.
- ✓ Fewer individuals are lonely and socially isolated.
- ✓ Access to information and advice which enables people to take more control over their lives.
- ✓ Access to community resources which people can access easily and which supports their independence.
- ✓ Community solutions and assets reduce demand for funded care.
- ✓ Carers are supported in their caring role and have access to services to maintain their own health and wellbeing.
- ✓ Health inequalities are reduced.

# Safe & High Quality Services

*Ensure that people are provided with a safe, high quality, positive experience of care in all providers*

## Our objectives

High quality care for all is at the centre of all we do as commissioners in Southampton for Health and Social Care. During 2018/19 our quality objectives continue this focus:

- Continuing to build on the expectation that **all care whatever the setting meets or exceeds the CQC fundamental standards** of care.
- Closely monitoring the quality of provider services across the system and **taking appropriate action** when standards are not met.
- Through thematic quality improvement events, building on the **quality of key pathways** of care.
- Continuing to strengthen the **safety culture**, ensuring all providers are open, honest and learning continuously from incidents and complaints to support improvements in the quality of care.
- Continuing to **reduce the risks of healthcare associated infections** in the city, in all settings, working with providers towards the city being a national leader in this field.
- Implementation of the revised national framework for **Continuing Healthcare** in conjunction with partners across the city.
- Developing a Local Delivery System approach to **high quality care improvement and assurance** which reduces duplication and supports providers in the provision of high quality health and social care.
- Embedding **best practice in safeguarding adults and children** across the integrated commissioning unit.

## What will success look like by 2020/21?

- ✓ Individuals are safe and protected appropriately as part of high quality care provision.
- ✓ A safety culture which is open, honest and continuously learning.
- ✓ Well managed and quality assured market for nursing, residential and home care.
- ✓ Working with all providers in health and social care settings to further improve quality following CQC inspections.
- ✓ Choice and diversity to enable sustainable informal care arrangements in the community.
- ✓ Evidence based, measuring what matters, commissioning for outcomes and quality.
- ✓ Low levels of healthcare associated infections in all settings.
- ✓ All contracts reflect safeguarding adults and children requirements which providers are complying with.

# Managing & Developing the Market

*Support commissioning activities that facilitate a strong provider market that is able to respond to an increasingly diverse customer group*

## Our objectives

We will continuously review our commissioning arrangements to ensure:

- Service design, procurement, and contracting methodologies are fit for purpose.
- Contracts are **outcome-focussed** and flexible enough to respond to changing needs.
- **Return on investment** in third party-provided services is maximised.
- The City Council and CCG are taking full advantage of the commercial and contractual opportunities that flow from **integrated commissioning**.
- Opportunities to increase impact through **regional collaborative commissioning** are explored wherever possible.
- Opportunities to develop better co-ordinated health services with commissioners and providers in **neighbouring areas** that work better between community and hospital based care.

We will design our commissioning intentions in a manner that:

- Promotes **sufficiency, diversity, and sustainability** within the local market for care and support services.
- Proactively encourages **growth and resilience** in the local care and support workforce.
- Makes best **use of the third sector**, including social enterprises, community groups, and other community assets.
- Aligns with the **principles of personalisation**, reduces reliance on traditional methods of transacting for care and support services, and enables service users to use direct payments to choose from a broad range of options for meeting their eligible needs.

## What will success look like by 2020/21?

- ✓ We have a sufficient, diverse, and resilient local supply of the care and support services needed to deliver the best health and social outcomes for the city.
- ✓ Best value principles underpin the ICU's approach to purchasing, contract design/review, and procurement strategy development.
- ✓ Contracting arrangements redesigned to support the delivery of integration.
- ✓ A wider range of options available for individuals whose needs can no longer be met in their own home.
- ✓ A commercial relationship with our suppliers of care and support services.
- ✓ A robust approach to the performance management of services under contract.
- ✓ Involvement of providers and communities in the development of commissioning intentions.

# Our plan on a page for 2018/19

| | Integration | Prevention & Earlier Intervention | Safe & High Quality Services | Managing & Developing the Market |
|---|---|---|---|---|
| **Our priorities** | *Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton* | *Strengthen prevention and early intervention to support people to maintain their independence and wellbeing* | *Ensure that people are provided with a safe, high quality, positive experience of care in all providers* | *Support commissioning activities that facilitate a strong provider market that is able to respond to an increasingly diverse customer group* |
| **Our workstreams** | 1. Supporting appropriate timely discharge & out of hospital model<br>2. Shape & support new models of care<br>3. Enhanced health support in care homes<br>4. Adult mental health<br>5. CAMHS transformation<br>6. Crisis care<br>7. LD integration<br>8. Transforming care for people with learning disabilities<br>9. Developing the older person's offer<br>10. Addressing the needs of high intensity users (HIUs)<br>11. Improving the outcomes for children with SEND<br>12. Implementing the new short breaks offer<br>13. Personal health budgets<br>14. End of life and complex care<br>15. Transforming locality care for children<br>16. Transforming community services/ nursing | 17. Community development/ infrastructure<br>18. Community navigation<br>19. Substance misuse review and redesign<br>20. Sexual health and teenage pregnancy<br>21. Carers<br>22. Care technology<br>23. Housing related support<br>24. Prevention and early help for children and families<br>25. Falls prevention | 26. Learning from deaths<br>27. Safety and learning culture<br>28. Antimicrobial prescribing<br>29. Antidepressant prescribing<br>30. Quality of internal providers<br>31. Embed safeguarding across the ICU<br>32. Continuing Healthcare (CHC) | 33. Home care procurement<br>34. Housing with care<br>35. Nursing home and complex residential care market capacity<br>36. Children's residential care<br>37. Placement service development<br>38. Market sustainability assurance<br>39. High cost placement negotiations<br>40. Provider workforce development |
| **Our key measures of success** | • 3.5% delayed transfers of care (DTOC) rate*<br>• 31,351 non-elective admissions<br>• 732 permanent admissions to residential homes (per 100,000 population)<br>• 75% people with learning disabilities receiving annual physical health checks<br>• 10% reduction in ED attendances and non-elective admissions for the Top 100 HIUs<br>• ≥93% care leavers in contact and in suitable accommodation | • 2,666 injuries due to falls (per 100,000 population)<br>• ≥40% successful completions of people in treatment (alcohol)<br>• 17.5% of people with common mental health conditions accessing IAPT<br>• 50% of people who complete IAPT are moving to recovery*<br>• ≥95% of routine CAMHS referrals receive contact within 16 weeks<br>• ≥95% of urgent CAMHS referrals offered an appointment to be seen within 1 week<br>• ≥35% take up of LARC in Sexual Health services | • 85% of CHC assessments taking place in an out of a hospital setting*<br>• 90% of CHC assessments completed within 28 days<br>• ≤45 cases of C-Difficile<br>• Zero cases of MRSA | • ≥90% contract reviews on schedule<br>• ≥90% placements that are sourced through the Placement Service Team<br>• 10 days average waiting time from referral received to Home Care start date<br>• 10 days average waiting time from referral received to residential/nursing placement start date |

**The targets for these KPIs are set nationally*

# Our Commissioning Principles

## OUTCOMES DRIVEN

Improving outcomes for the local population will be at the heart of the commissioning process with commissioners taking shared responsibility for outcomes on a city wide basis.

## EVIDENCE BASED

Commissioning should seek to meet needs in an evidence based way and contribute to the development of the local evidence base for effective practice.

## INTEGRATION

The commissioning process will integrate services around the needs of individuals and families, recognise local diversity and support greater personalisation and choice so that people are empowered to take responsibility, shape their own lives and the services they use.

## ENGAGEMENT

Residents will be active participants in the commissioning process including planning, design, monitoring and evaluation.

## PREVENTION & TACKLING HEALTH INEQUALITIES

There will be an increasing focus on prevention and earlier intervention and on tackling long-standing inequalities in outcomes.

## QUALITY & VALUE FOR MONEY

Resource allocation and commissioning decisions will be transparent, contestable and locally accountable and driven by the goal to achieve optimum quality, value for money and outcomes. The importance of investment in the local community will be prioritised.

## FAIRNESS

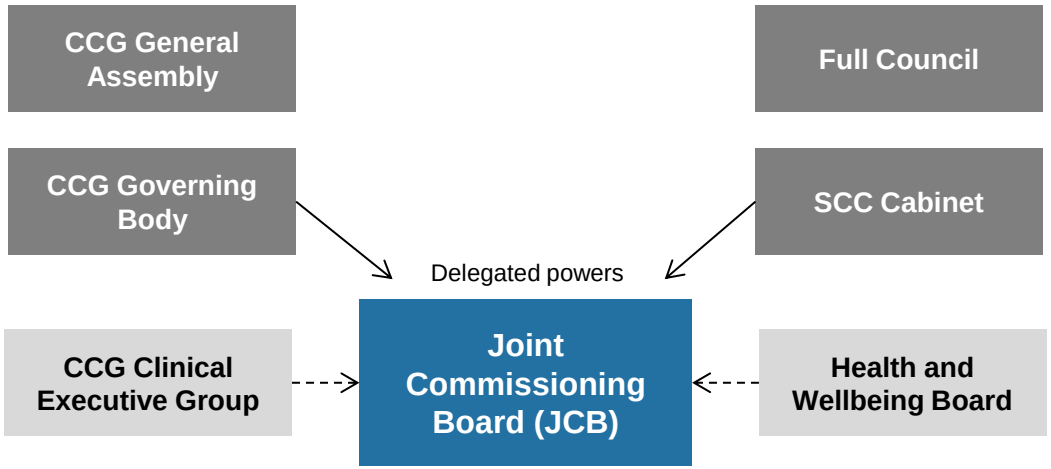
The commissioning process will ensure that the same approach (e.g. service specification and performance monitoring) is applied to all commissioned activity to ensure fairness and that no delivery vehicle is given or gain unfair advantage.

## PARTNERSHIP WORKING

Commissioning arrangements will be sufficiently flexible to support a variety of different partnership approaches, e.g. with education, housing, other Local Authorities, the voluntary sector or other health partners, depending on the best way of delivering the required outcomes.

# Our Governance Structure

The Council and CCG have established a **Joint Commissioning Board (JCB)** to commission health and social care in the City of Southampton. It will encourage collaborative planning, ensure achievement of strategic objectives and provide assurance to the governing bodies of the partners of the integrated commissioning fund on the progress and outcomes of the work of the integrated commissioning function.




The **Joint Commissioning Board (JCB)** will act as the single health and wellbeing commissioning body for the City of Southampton and a single point for decision makers. The Board has been established to ensure effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements between Southampton City Council and Southampton City CCG.

As such, the Board will develop and oversee the programme of work to be delivered by the Integrated Commissioning Unit and review and define the integrated commissioning governance arrangements between the two bodies.

The Board will monitor the performance of the integrated commissioning function and ensure that it delivers the statutory and regulatory obligation of the partners of the Better Care Fund.

The **CCG Governing Body** and **SCC Cabinet** may grant delegated authority to those of its members or officers participating in the Board to make decisions on their behalf, whilst retaining overall responsibility for the decision made by those members or officers.

# Integration

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| Project | Description | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1. Supporting appropriate timely discharge and out of hospital model** | We have been developing 3 hospital discharge pathways designed to simplify and streamline current processes.<br><br>Pathway 1 (Simple) – for the majority of patients where the discharge is managed by the hospital ward.<br><br>Pathway 2 (Rehabilitation and Reablement) – for patients that need care or therapy primarily supported by the integrated Urgent Response Service or commissioned homecare or residential care packages.<br><br>Pathway 3 (Complex) – deals with patients that require a complex assessment process (e.g. Continuing Health Care (CHC)) or have complex difficult to source care needs. | Pathway 3 discharge to assess pilot | | | Evaluation | | Develop and Implement Hospital Discharge Pathway 3 (Complex) following Pilot Phase | | | | | | | | | • Reduction in DTOC (delayed transfers of care), towards achieving national 3.5% rate.<br>• Reduction in length of stay for patients with pneumonia, cellulitis or UTIs (Home IV pilot)<br>• Reduction in the number of people needing long term packages of care.<br>• 85% of CHC assessments being completed in an out of hospital setting.<br>• Simplified, integrated processes.<br>• Improved outcomes for patients. |
| | | | | | Implement Home IV pilot | | | | | | Evaluate and rollout | | | Potentially extend Home IV pathway to community referrals | | | |
| | | | | | | Falls assessment capacity agreed | | | | | | | | | | | |
| | | | | | | | Implementation of additional falls capacity | | | | | | | | | | |
| | | | | | | Low level health needs proposal | | | | | | | | | | | |
| | | | | | | | | Pilot low level health pathways | | | | | | Implementation | | | |
| | | | | | | | Reablement care model agreed | | | | | | | | | | |
| | | | | | | | | Implementation of reablement future care model | | | | | | | | | |
| | | Work with Homecare Project Group to ensure hospital discharge and URS "move on" are incorporated in the new Homecare Framework | | | | | | | | | | | | | | | |
| | | Support the continued implementation of SAFER discharge bundle across both acute and community hospitals. | | | | | | | | | | | | | | | |
| | | Roll out Trusted Assessment to Support Pathway 1 | | | | | | | | | | | | | | | |
| | | Develop a shared vision for a 7 day hospital discharge | | | | | Develop and implement a 7 day hospital discharge model. | | | | | | | | | | |
| | | | Work with Clusters to develop support for Hospital Discharge Pathways (including Welcome Home scheme) | | | | | | | | | | | | | | |
| | | Embed 3 Reablement Beds at Abbey Care Home | | | | | | | | | | | | | | | |
| | | Investigate opportunity to work alongside WHCCG on reducing excess bed days associated with elective Trauma & Orthopaedic (T&O) and NEL Interventional Radiology and if appropriate develop an associated QIPP scheme. | | | | | | | | | | | | | | | |
| | | | | | Implement as appropriate | | | | | | | | | | | | |
| | | | Investigate hospital avoidance opportunities/benefits associated with developing sensory impairment activity to include Stroke, Diabetes, Falls Pathways and if appropriate develop an associated QIPP scheme | | | | | Implement as appropriate | | | | | | | | | |

# Integration

*Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton*

| Project | Description | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **2. Shape & support new models of care** (including cluster development) | Working with providers to shape and support new models of care, including further strengthening cluster leadership and workforce development. | Support development of cluster operating model → Support implementation of cluster operating model | | | | | | | | | | | | | | | • Effective implementation of primary and community integrated care in clusters.<br>• Improved patient experience of person centred coordinated care.<br>• Improved management of need and risk in the community.<br>• Fewer hand-offs and less duplication.<br>• Reduction in avoidable hospital admissions.<br>• Reduction in delayed discharge and hospital length of stay.<br>• Reduction in care home admissions.<br>• Reduction in falls. |
| | | Support cluster leadership development | | | | | | | | | | | | | | | |
| | | Support development of estates plan | | | | | | | | | | | | | | | |
| | | Support system to maximise digital transformation | | | | | | | | | | | | | | | |
| | | ◆ Whole system workforce event | | | | | | | | | | | | | | | |
| | | Develop whole system workforce transformation plan → Support implementation of workforce transformation plan | | | | | | | | | | | | | | | |
| | | Building on the restructure of Adult Social Care in 17/18, ensure that opportunities are fully embraced to embed the new strengths-based model of adult social care and housing into clusters (e.g. co-location) | | | | | | | | | | | | | | | |
| | | Explore delegation of key areas of operational commissioning. | | | | | | | | | | | | | | | |
| | | Support establishment of Local Solutions Groups | | | | | | | | | | | | | | | |
| **3. Enhanced health support in care homes (EHCH)** | We are developing 3 workstreams as part of a pilot that focuses on:<br>• Offering primary care support to 15 care homes (delivered by SPCL),<br>• Developing case and risk management (delivered by Solent)<br>• City wide leadership, training and support to staff within the homes (delivered by the ICU) | Continue EHCH Pilots → Evaluation → Develop and implement mainstream ongoing EHCH model | | | | | | | | | | | | Further refinement of the model | | | • 100% of residents in the 15 pilot homes will have had a comprehensive assessment.<br>• Contribute to an overall reduction in non-elective admissions and conveyances from residential and nursing homes.<br>• Improved professional relationships. |
| | | Continue to promote improved relationships between the care home and acute hospital sectors. | | | | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **4. Adult mental health (AMH)** | Implement Mental Health Matters (MHM) and Five Year Forward View (FYFV) for Mental Health to improve local services and meet national targets. | *Long term conditions* | Increase access to Improving Access to Psychological Therapies (IAPT) service including a focus on long term conditions | | | | | | | | | | | | | | | • 17.5% of people with common mental health conditions accessing IAPT.<br>• 60% of people with SMI receiving physical health checks.<br>• 53% of people experiencing a first episode of psychosis will be treated within 2 weeks of referral.<br>• Maintain 50% recovery rates for IAPT.<br>• 25% increase in number of people accessing IPS services. |
| | | | Agree long term condition pilot areas | | | | | | | | | | | | | | | |
| | | | | | | Begin recruitment and finalise expansion model and costings | | | | | | | | | | | | |
| | | | | | | Deliver increased access to services including long term conditions | | | | | | | | | | | | |
| | | *Navigation service* | Pilot Adult Mental Health navigation service | | | | | | | | Implement city wide navigation services to include MH and Dementia navigation | | | | | | | |
| | | *Peer support* | Coproduce peer support strategy | | | | Produce options papers and formal sign off | | | Procurement of Peer Support service | | | | | Implementation | | | |
| | | *Autism support* | Finalise procurement documents for Autism Support Service | | | | | | | | | | | | | | | |
| | | | | Procurement | | | Procurement ratification | | | | | | | | | | | |
| | | | | | | | Provider mobilisation | | | Contract commence | | | | | | | | |
| | | *Developmental disorders* | Work with current ADHD and autism diagnosis providers to develop future service | | | | Sign off new pathways and mobilisation | | | Implement revised pathways | | | | | | | | |
| | | | Continue to develop coherent developmental disorders pathway for children and young people and adults with ADHD, autism and Asperger's. | | | | | | | | | | | | | | | |
| | | *Primary care* | Design primary care Mental Health services | | | Implementation of enhanced MH primary care models | | | | | | | | | | | | |
| | | *Personality disorders* | Personality Disorder pathways development | | | | Mobilisation of new model | | | Implementation of enhanced Personality Disorder pathway | | | | | | | | |
| | | *0-25 transition service* | | | | | | Develop 0-25 years transition service for mental health. | | | | | | | | | | |
| | | *Suicide strategy* | Continue implementation of a suicide prevention strategy. | | | | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **5. Child and Adolescent Mental Health Services (CAMHS) transform-ation** | Implement CAMHS Transformation plan to improve local services and meet national targets. | *Continue to develop an early intervention mental health team with increased investment* | Review of impact of current CAMHS team | | | New posts in place | | | | | | | | | | | | • ≥95% routine CAMHS referrals receive contact within 16 weeks.<br>• ≥95% urgent CAMHS referrals offered an appointment to be seen within 1 week.<br>• 95% of children and young people with an eating disorder receiving treatment within 4 weeks (routine)<br>• Co-production network in place.<br>• Improved service user experience.<br>• Improve recording of the mental health services dataset (MHSDS) to ensure National CAMHS Access target is met. |
| | | | | | | | | Sign off CAMHS service specification, including performance and monitoring | | | | | | | | | | |
| | | *Young people's counselling service* | Mobilise new Young People's Counselling Service | | | | | | New service in place | | | | | | | | | |
| | | *Community CAMHS grants* | Review community CAMHS Grants | | | Agree 18/19 spending plan | | | | | | | | | | | | |
| | | *Eating disorders* | | | | Community Eating disorder service: review current service provision against agreed staffing establishment and national standards | | | | | | | | | | | | |
| | | *Improve recording of the mental health services dataset (MHSDS)* | Set up Task & Finish Group | | | | | | | | | | | | | | | |
| | | | Solent to report a proxy indicator monthly to provide assurance of access rates | | | | | | | | | | | | | | | |
| | | | Report activity from other Solent services (non CAMHS) that provide evidence based mental health interventions | | | | | Work with non-NHS Providers to develop systems to report to MHSDS | | | | | | | | | | |
| | | *Crisis pathway* | | Review crisis pathway, linking with HIOW STP | | | | | | | | | | | | | | |
| | | *CAMHS liaison nurse in ED* | Review impact of CAMHS Liaison Nurse in ED with West Hampshire | | | Implement recommendations from CAMHS Liaison Nurse in ED review | | | | | | | | | | | | |
| | | *Building strength & resilience* | Review Building Strength & Resilience Service (BRS) | | | | Recommendations agreed from BRS review | | Implementation of BRS review recommendations | | | | | | | | | |
| | | *Personal health budgets* | Explore PHBs in CAMHS | | | | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **6. Crisis care** | Implement crisis care concordat to ensure an end to end pathway is in place across the Hampshire & Isle of Wight footprint, which addresses current issues, such as use of Police cells for those in crisis, pressure on ED, delays in accessing crisis care and poor service user experience | *Crisis resolution* | Continue to develop crisis resolution and home treatment teams to be effective and properly resourced delivering best practice standards as described in the CORE fidelity criteria | | | | | | | | | | | | | | | • Meet CORE fidelity for crisis resolution home treatment team.<br>• Crisis lounge open 24/7.<br>• 24/7 telephone support available.<br>• Meet CORE 24 psychiatric liaison standard. |
| | | | Develop community mental health teams to be able to respond flexibly to first signs of crisis following evidence of best practice | | | | | | | | | | | | | | | |
| | | *Crisis Lounge* | Continue to recruit to Crisis Lounge to achieve 24/7 access | | | Evaluate Crisis Lounge outcomes | | | | | | | | | | | | |
| | | *NHS 111 24/7 Mental Health support* | | ◆ 24/7 111 mental health telephone support paper to STP/CCGs for sign off | | | | | | | | | | | | | | |
| | | | | | Recruitments to 24/7 MH 111 pilot | | | ◆ Implementation of pilot | | | | | | | | | | |
| | | *Core Mental Health liaison services 24 hours a day, 7 days a week* | Final recruitment to CORE 24 psychiatric liaison in UHS | | | ◆ 24/7 CORE 24 implementation | | | | | | | | | | | | |
| | | | Review CORE 24 model and review all mental health and substance misuse support in UHS | | | Develop and agree options appraisal for integration of MH and SM support within UHS | | | | | | | | | | | | |
| **7. LD Integration** | Creation of an integrated health and social care team to support people with learning disabilities in Southampton, putting the individual at the centre | *Comms & engagement* | Ongoing engagement, consultation and communications with stakeholders | | | | | | | | | | | | | | | • Integrated health and social care team for LD across SCC, CCG and SHFT.<br>• Improved service user outcomes including increases in placement stability and meaningful daytime occupation.<br>• Simplified and more responsive services for clients, carers and wider stakeholders .<br>• Improved cost efficiencies by developing shared assessment, business process and infrastructure.<br>• Reduction in cost of packages of care. |
| | | | ◆ Comms plan developed | | | | | | | | | | | | | | | |
| | | *Review of clients* | | ◆ Client mapping exercise complete | | | | | | | | | | | | | | |
| | | | | | ◆ Work plan to review clients agreed | | | | | | | | | | | | | |
| | | | | | | | | | Embedding new working practices to ensure clients are reviewed meeting local and national standards | | | | | | | | | |
| | | *IT* | | ◆ IT options paper | | | | | | | | | | | | | | |
| | | | | | ◆ Decision made on IT and admin support | | | | | | | | | | | | | |
| | | *Recruitment* | | | | | ◆ Integrated Service Manager appointed | | | | | | | | | | | |

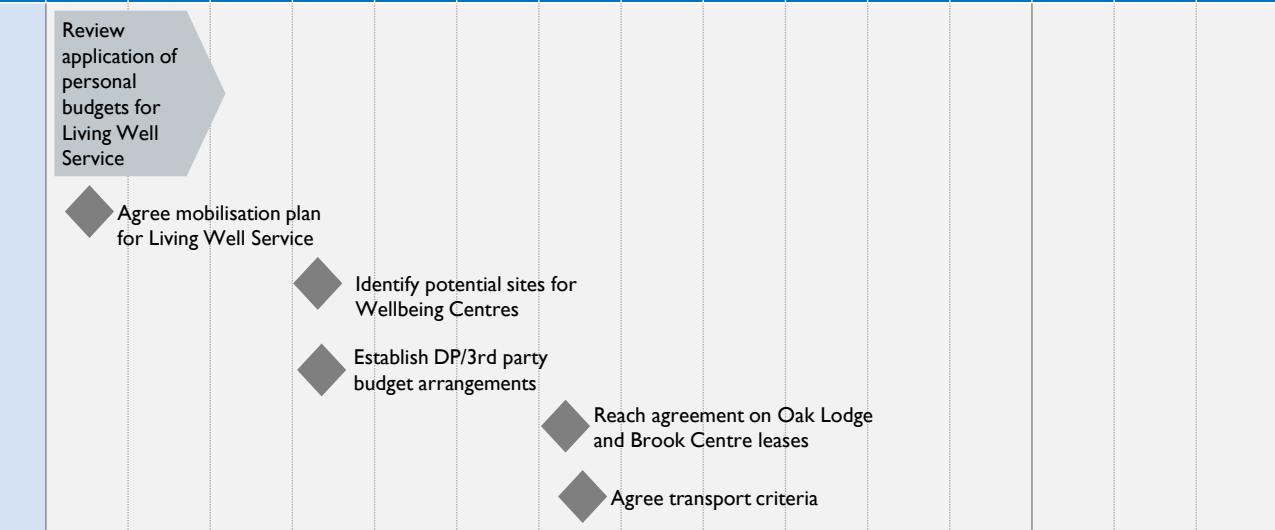
# Integration

*Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton*

| Project | Description | | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **8. Transforming care for people with learning disabilities** | Implementation of the Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Plan for people with learning disabilities, including those with autism. The plan includes all CCGs and local authorities in the SHIP area as well as NHS England specialist commissioning for the region. | *Annual health checks* | Continue to improve access to annual health checks for people with a learning disability through health facilitation nurse and working with support providers | | | | | | | | | | | | | | | • 75% of people with learning disabilities receiving physical health checks.<br>• Four new supported living schemes developed by end of 2018/19.<br>• 155 individuals are supported through the life skills project. |
| | | | | | | Inclusion of annual health check awareness within life skills team offer | | | | | | | | | | | | |
| | | | | | | | | | | | Inclusion of annual health check awareness within life skills team offer | | | | | | | | |
| | | | | | | Quarterly monitoring of provider health check uptake | | | | | | | | | | | | |
| | | *Prevention services* | Working with commissioners and providers of mainstream prevention services such as weight management, cancer screening, sexual health and others to ensure that reasonable adjustments are made so individuals with learning disabilities can access them | | | | | | | | | | | | | | | |
| | | *Primary care* | Continue to support GP practices to become Learning Disability friendly | | | | | | | | | | | | | | | |
| | | *LD Training* | Develop and distribute LD Training Needs Assessment survey to providers | | | Develop training action plan | | | | | | | | | | | | |
| | | | | | | | Implement new training action plan | | | | | | | | | | | |
| | | *Market engagement* | Publish final version of LD Market Position Statement and engage with the market to work towards the future vision for LD services | | | | | | | | | | | | | | | |
| | | *Supported housing* | Development of proposed supported housing options (potential tender and/or use of SCC investment opportunities) which will enable expansion of the portfolio of high quality housing options for individuals with learning disabilities | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | 34 new supported living tenancies created | | | | |
| | | *Life skills* | Life Skills Offer begins supporting individuals. | | | | | | | | | | | | | | | |

# Integration

*Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton*




| Project | Description | | Outcomes |
|---|---|---|---|
| **9. Developing the older person's offer** | Implementation of the older person's offer, promoting independence, health and wellbeing. | *Living well service*<br>*Meals on wheels*<br>*Nutrition and hydration strategy* | • Improved sense of wellbeing, physical and mental stimulation and reduced feelings of loneliness.<br>• Improved access to advice services and support.<br>• Increased early identification and prevention.<br>• Reduction in residential home permanent admissions, by promoting independence.<br>• Fewer unnecessary hospital admission/ readmission and reduction in XBDs. |

# Integration

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| Project | Description | | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **10. Addressing the needs of high intensity users (HIUs)** | Develop systems and interventions to better meet the needs of people who frequently present in crisis to ED, primary care and hospital. | *Wrap-around intensive support service* | Develop and pilot a personalised wrap around support service for a small case load of individuals identified by the Top 100 list | | | | | | | | | | Evaluation | | | | | • 10% reduction in ED attendances and NEL admissions of the Top 100 HIUs.<br>• Better care planning in place.<br>• Better access to support for mental health/psychological needs. |
| | | *Psychological & therapeutic support* | Develop model of psychological and therapeutic support for HIUs, including those within medically unexplained symptoms (MUS) | | | | | | | | | | | | Evaluation of psychological and therapeutic support for HIUs | | | |
| | | | | | | Agree pilot in relation to MUS, as appropriate | | | | | | | | | | | | |
| | | | | | | Link HIUs into extension of IAPT services, ensuring appropriate referral routes | | | | | | | | | | | | |
| | | | | | | | | | | | | Link HIUs into development of IAPT services for MUS or pain management | | | | | | |
| | | | | | | | | Pilot dedicated support for MUS, as appropriate | | | | | | | | | | |
| | | *SCAS Demand Practitioner* | Continue 12 month pilot of the SCAS demand practitioner role | | | | | | | | | | | | | | | |
| | | | | | | | Evaluate SCAS demand practitioner | | | | | | | | | | | |
| | | | | | | | | Decision on SCAS demand practitioner full rollout | | | | | | | | | | |
| | | *Other interventions* | Enhancement of existing Community Navigation service to target HIUs | | | | | | | | | | | | | | | |
| | | | Further work on care plans and MDT approaches to establish better links across the system | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | Evaluation of community navigation work with HIUs to help inform future commissioning arrangements | | | | | | |

# Integration

*Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton*

| Project | Description | | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **11. Improving the outcomes for children with Special Education Needs and Disability (SEND)** | Continue to develop services to improve outcomes for children/young people with SEND. | *Transition processes* | ◆ Transition workshop | | | | | Develop improved transition processes to help young people better prepare for adulthood | | Roll out new transition processes | | | | | | | | More children and young people with SEND will:<br>• Have control over the support and services they receive (increased uptake of personal budgets and personal health budgets)<br>• Receive the support they need to promote their health and wellbeing (reduced waiting times for services, increased coverage of LD health checks)<br><br>Children and young people with SEND will:<br>• Have greater achievement, attainment and equal opportunities in life (increased school attendance, reduction in exclusions)<br>• Be safe and secure.<br>• Feel supported to develop greater autonomy, independence and resilience to prepare for adulthood (reductions in NEET) |
| | | | | | | | | Establish sustainable medium term arrangements for Post 19 Learning and Skills Hub | | | | | | | | | | |
| | | *Jigsaw Service* | Finalise Jigsaw Service Review & agree development plan | | | Support implementation of Jigsaw development plan | | | | | | | | | | | | |
| | | *Personal health budgets* | | | | | | | | | | Scope potential SEND PHB offer | | | Extend offer of PHBs to children with SEND | | | |
| | | *Autism support service* | Procurement of new Autism support service (all ages) | | | | | | | | ◆ New Autism support service commences | | | | | | | |
| | | *Early years* | ◆ Early Years SEND workshop | | | | | | | | | | | | | | | |
| | | | | | Development of a more integrated health/education/social care model of Early Years provision and support | | | | | | | | | | | | | |
| | | *0-19 prevention and early help* | Develop clear offer of support for children with SEND in the integrated 0-19 prevention and early help service | | | | | | | | | | | | | | | |
| | | *SEN Strategic Review* | Scope health contribution towards achieving SEN Strategic Review recommendations – in particular, better support for children with Social, Emotional and MH needs, including ASD and challenging behaviour, within the city, linking to review of therapy services | | | | | | Review therapies and orthotics specification | | | | | | | | | |
| | | *School CAMHS forum* | ◆ Establishment of Special School CAMHS Forum | | | | | | | | | | | | | | | |
| | | *Continence service* | Review children's continence service | | | | | | | | | | | | | | | |
| | | | | | | ◆ Agree spec | | | | | | | | | | | | |

# Integration

*Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton*

| Project | Description | | 2018/19 | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **12. Implementing the new short breaks offer** | Implement new model of short breaks post Cabinet approval | *Request for proof of DLA implemented from April 2018* | New eligibility criteria implemented for Low & Complex needs | | | | | | | | | | | | | | | • New eligibility criteria implemented for Low, Medium, Substantial and Complex levels to improve consistency and equity.<br>• Increased range of services through procurement and grants. |
| | | | Substantial level; Staff training and development | | | | | | | | | | | | | | | |
| | | | Medium level; interim personal budget available | | | | | | | | | | | | New eligibility criteria implemented for Medium level | | | |
| | | | Low level; improved information through websites and Parent carer forum | | | | | | | | | | | | | | | |
| | | *Develop procurement and grant funding approach for short break services* | Design and development | | | | | | Procurement | | | | | | | | | |
| | | | | | | | | | Grant applications requested | | | | | | | | | |
| **13. Personal health budgets** | Extending the offer of personal health budgets | | Expand personal health budgets beyond CHC (e.g. long term rehab needs, such as acquired brain injury) and work with local providers and community representatives to support wider take-up of PHB's | | | | | | | | | | | | | | | • 26 personal health budgets in place by Q4.<br>• Concept of PHB's adopted by provider(s)<br>• PHB's available wider than CHC.<br>• Opportunities for individuals to have joint health and social care budget. |
| | | | Investigate development of the PHB offer for use within nursing and residential homes | | | | | | | | | | | | | | | |
| | | | Work with Solent to establish reference costs | | | | | Reference costs established | | | | | | | | | | |
| | | | Work with SCC to secure/commission services to support the roll-out and expansion of PHB and DP, as identified through task and finish work. | | | | | | | | | | | | | | | |

# Integration

*Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton*

| Project | Description | | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **14. End of life and complex care** | Work with partners to implement the EOL strategy including the development of an independent hospice model. | *Fully integrated hospice service* | ◆ Support UHS to identify additional/ new charitable partner | | | | | | | | | | | | | | | • More people dying in their preferred place of death.<br>• Reduction in NEL admissions and length of stay.<br>• Reduction in nursing home admissions.<br>• Improved patient, family and carer experience.<br>• Skilled workforce to support sustainable model of service delivery. |
| | | | Deliver a fully integrated hospice service, including: hospice at home (building on the existing NHS Solent PSW service), nurse-led beds, and bereavement services with the aim to become an independent hospice by 2020/21 | | | | | | | | | | | | | | | |
| | | *End of life education* | End of life education – expanding provision of six steps training to home care providers | | | | | | | | | | | | | | | |
| | | | Deliver education, training and support to increase the numbers of people achieving their preferred place of death | | | | | | | | | | | | | | | |
| | | *Personal health budgets* | Develop and support the roll out of personal health budgets and promoting personalisation | | | | | | | | | | | | | | | |
| **15. Transforming locality care for children** | Work with providers to improve local health services' ability to support children and families in managing common childhood illnesses in communities rather than hospital, through trialling ways to help professionals share their understanding of individual patient's needs through cluster based MDTs, locality clinics and redesign of COAST to support this care. | *Revised model* | | ◆ Agree revised model for children's acute community nursing service following overhaul of Southampton COAST offer | | | | | | | | | | | | | | • Increased confidence amongst parents, primary care and community staff in managing common childhood illness in the community leading to reduction in NEL admissions and ED attendances.<br>• ≥95% routine CAMHS referrals receive contact within 16 weeks.<br>• ≥95% urgent CAMHS referrals offered an appointment to be seen within 1 week.<br>• Increase in GP capacity as a result of parents feeling more confident to manage their child's condition.<br>• Improved patient/ relatives experience of care and other professionals. |
| | | *Connecting care* | | | | | | | Evaluate effectiveness of Southampton Connecting Care hubs | | | | | | | | | |
| | | | | | | | | | | | Ensure continued appropriate attendance of public health nursing services from the 0-19 prevention and early help service and CAMHS in Connecting Care MDTs | | | | | | | | |
| | | *Mental health* | Achieve better connectivity of primary and community care pathways for young people with behavioural, emotional and mental health issues to improve numbers of young people accessing CAMHS early help support and reduce waiting times. | | | | | | | | | | | | | | | |

# Integration

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| Project | Description | | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **16. Transforming community services/ nursing** | Developing community services, particularly community nursing, to support the management of higher levels of acuity in the community. | *Operating Model* | Support Solent to strengthen operating model within clusters (case management, MDT, risk stratification) | | | | | | | | | | | | | | | A strengthened community nursing offer which is better integrated with primary care services, creating a seamless person centred care, to support:<br>• Reduction in delayed discharge/XBDs (e.g. Supporting CHC assessment)<br>• Reduction in avoidable hospital admission and LOS (through managing greater acuity in the community, supporting care homes, extended reach of case management) |
| | | *Review of pathways and services* | Support Solent to review referral processes to support integrated working | | | | | | Review of the HENS service and pathway to simplify | | | | | | | | | |
| | | | Review of the virtual ward process to facilitate greater involvement of primary care (linking to cluster operating model) | | | | | | | | | | | | | | | |
| | | | | | | Review the process and use of step up care to maximise resource effectiveness and improve patient outcomes | | | Support Solent to explore most appropriate pathway for management of plurex drains in the community | | | | | | | | | |
| | | | | | | Review tissue viability service | | | Review phlebotomy service | | | | | | | | | |
| | | *Development of pathways and services* | Support Solent to develop wound care across services/settings to introduce an integrated approach | | | | | | | | | | | | | | | |
| | | | | | | Develop standard operating procedure across providers for CHC screening, assessment and full application | | | | | | | | | | | | |
| | | | | | | Support Solent to develop improved support to Nursing Homes and include staff within cluster MDTs | | | | | | | | | | | | |
| | | | | | | | | Support Solent to develop a Nursing in the Community workforce development plan | | | | | | | | | | |
| | | | | | | | | | Support Solent to develop self management pathways for patients with specific long term conditions | | | | | | | | | |
| | | | | | | | | | Support Solent to develop the pathway and dispensing of dressings used within community settings | | | | | | | | | |

# Prevention & Earlier Intervention

# Prevention & Earlier Intervention

*Strengthen prevention and early intervention to support people to maintain their independence and wellbeing*

| Project | Description | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **17. Community Development/ infrastructure** | Develop and procure a community solutions service which builds on community assets to increase local services which people can access easily. | Further development of local solutions groups in all six clusters in the city | | | | | | | | | | | | | | | • Increase in community voluntary sector activity.<br>• Increase in volunteering as a core part of resilient communities offer. |
| | | Review options for community development infrastructure and reach agreement of final model | | | | | | | | | | | | | | | |
| | | | Implementation of agreed approach for community development infrastructure | | | | | | | | | | | | | | |
| | | | | Mapping of community resources by local solutions groups | | | | | | | | | | | | | |
| | | | | Promote formal and informal social prescribing | | | | | | | | | | | | | |
| | | | | | | | | | | Promote resilience in community development organisations | | | | | | | |
| **18. Community navigation** | Develop future city wide integrated model of community navigation. | Development of community navigation, with clear KPIs, through network of organisations, through process of co-production with service providers, referrers and service users and with reference to national models of best practice | | | | | | | | | | | | | | | • Increased uptake of social prescribing options.<br>• More people supported to develop their own person centred plan.<br>• Reduction in NEL admissions.<br>• Reduction in HIU activity.<br>• Reduction in ED attendances. |
| | | AMH navigation pilot commences | | | | | | | | | | | | | | | |
| | | | | Support providers to come together to develop more integrated models of provision | | | | | Future model and commissioning intentions agreed | | | | | | | | |
| | | | | | | | | | | Implementation of city wide integrated model | | | | | | | |
| | | | | Implement use of GENIE tool, through volunteers, establish link between SID and GENIE, commence research into implementation and impact with the CLARHC | | | | | | | | | | | | | |
| **19. Substance misuse** | Review the substance misuse services in Southampton and develop commissioning intentions for 2019/20 onwards. | Continue to implement alcohol QIPP and begin implementation of alcohol CQUIN in UHS | | | Evaluate impact of alcohol liaison and in-reach QIPP | | | Develop options appraisals for 18/19 contract and continue to implement QIPP and CQUIN schemes | | | | | | | | | • A newly commissioned service commencing July 2019.<br>• ≥40% successful completions of people in treatment (alcohol)<br>• Increased % of successful completions of people in treatment for opiates and non-opiates. |
| | | Substance Misuse Services Review | | | | | | | | | | | | | | | |
| | | Review and engagement | | Cabinet approval to consult (if required) | | | | | | | | | | | | | |
| | | | | | Formal consultation | | | Final service model | | | | | | | | | |
| | | | | | | | | | Cabinet & Council | | | | | | | | |
| | | | | | | | | | | Procurement | | | 4 month set up | | | | |

# Prevention & Earlier Intervention

*Strengthen prevention and early intervention to support people to maintain their independence and wellbeing*

| Project | Description | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **20. Sexual health and teenage pregnancy** | Continue to review and implement the Teenage Pregnancy Strategy to reduce teenage pregnancy rates.<br><br>Refresh the City's Sexual Health Improvement Plan to identify how the main challenges facing sexual health outcomes and services are to be addressed.<br><br>Identify efficiencies in reproductive and sexual health services to maintain open access sexual health services within available resources. | ◆ Level 3 service activity and demand management plan agreed | | | | | | | | | | | | | | | • ≥35% take up of LARC in Sexual Health services.<br>• Reduction in Teenage Conceptions and birth rates.<br>• Reduction in repeat terminations of pregnancy.<br>• Reduction in HIV Late diagnosis rates.<br>• Financially sustainable and clinically effective integrated sexual health system.<br>• Higher levels of LARC take-up among high risk populations.<br>• Increase in remote testing and self management for asymptomatic STIs.<br>• Shift from specialist service delivery to primary care for routine contraception.<br>• Improved levels of partner notification for STIs. |
| | | Close monitoring of activity levels in the Integrated Sexual health services to manage the impacts of demographic changes, changes in services and changes in reproductive and sexual health behaviours upon service related costs, performance and quality | | | | | | | | | | | | | | | |
| | | Investigate cause of increases in Termination of Pregnancies during last three years, and deterioration (2017-18) in LARC rates among women supported through a termination of pregnancy | | | | | | | | | | | | | | | |
| | | Refresh Southampton City Sexual Health Improvement plan and Teenage Pregnancy Action Plan | | | | | | | | | | | | | | | |
| | | | | ◆ LARC/EHC commissioning incentives/route to market agreed | | | | | | | | | | | | | |
| | | | | | Recommission LARC | | | | | | | | | | | | |
| **21. Carers** | Agree and implement commissioning intentions for carers support services following completion of pilot. | Roll out of carer online assessment tool | | | | | | | | | | | | | | | • Increase in the number of carers identified.<br>• Increase in the number of carers assessments carried out in a community setting.<br>• Increased uptake in direct payments. |
| | | MoU in place between SCC adults and children services | | | | | | | | | | | | | | | |
| | | Social care worker located in community services to support links between carers and cared for services | | | | | | | | | | | | | | | |
| | | Replacement care process for carers developed and agreed | | | | | | | | | | | | | | | |

# Prevention & Earlier Intervention

*Strengthen prevention and early intervention to support people to maintain their independence and wellbeing*

| Project | Description | | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **22. Care technology (telehealth care)** | Continue roll out of Care Technology and implement agreed commissioning intentions for next phase. | *Procurement* | Complete procurement of new service model (CCG) | | | | | | | | | | | | | | | • One nursing home and one residential setting using vital sign monitoring.<br>• 50% (550) of COPD licences actively in use.<br>• 65% conversion rate from referral to installation.<br>• Increase in the use of care technology to support people in their own home.<br>• Reduced demand for care homes.<br>• Reduced use of home care and public sector services.<br>• Reduction in 15 minute calls. |
| | | *Vital signs monitoring and video consultations* | Implement telehealth vital sign monitoring in one residential home and one nursing home | | | | | | | | | | | | | | | |
| | | | Nursing/care homes identified | | | | | | | | Implement video consultations in one nursing home | | | | | | | |
| | | | | | | Kit installed and training | | | | | | | | | | | | |
| | | | | | | | Trial period | | | Operational | | | | | | | | |
| | | *Other interventions* | Use of Just Checking within High cost placement service | | | | | | | | | | | | | | | |
| | | | Increase uptake of MyMHealth COPD app (50% of licences) | | | | | | | | | | | | | | | |
| | | | Trial and implement Care Team application | | | | | | | | | | | | | | | |
| **23. Housing related support (HRS)** | Implementation of new Housing Related Support service for adults and children including integrated access arrangements. | *Housing related support services* | Use local intelligence and data to inform future outcomes and service design for homeless and housing related support service | | | | | | | | | | | | | | | • 2 year work programme in place to support future provision of HRS.<br>• Joint working between HRS and specialist services agreed and implemented.<br>• In liaison with other SCC depts., prepared for the Govt reforms in 2019/20.<br>• Improved pathways to a wider network of housing stock.<br>• Detailed needs assessment completed to inform future commissioning intentions.<br>• Work programme and approaches established.<br>• Implement actions that see positive benefits for both health and housing settings.<br>• More people identified early.<br>• Reduced need for specialist intervention.<br>• Savings identified. |
| | | | Review of housing related support services to support hospital discharge and A&E attendances | | | | | | | | | | | | | | | |
| | | | | | Develop housing related support commissioning intentions relating to substance misuse and street based vulnerable adults | | | | | | | | | | | | | |
| | | | Implement improved quality and safeguarding process for housing related support services | | | | | | | | | | | | | | | |
| | | | Procure semi independent Housing Related Support for vulnerable young people 16+ | | | | | | | | | | | | | | | |
| | | *Hoarders pilot* | | | Engagement and implementation discussions with key agencies and teams (e.g. IAPT, SCC older person HRS team, ASC). | | | | | | | | | | | | | |
| | | | | | | Service development, staff recruitment and pathways designed | | | | | | | | | | | | |
| | | | | | | | | Pilot | | | | | | | | | | |
| | | | | | | | | | | | | Review of progress and learning | | Report on findings | | | | |
| | | | | | | | | | | | | | | Agencies and service areas informed of decision and future options | | | | |

# Prevention & Earlier Intervention

*Strengthen prevention and early intervention to support people to maintain their independence and wellbeing*

| Project | Description | | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **24. Prevention and early help for children and families** | Continue to work with Children's Services and Solent NHS Trust to develop an integrated prevention and early help service for children 0-19 and their families.<br><br>Develop the wider offer of prevention and early help for children 0-19 and their families in partnership with the voluntary and community sector. | *Maternity* | Work with local breastfeeding support services to develop a Southampton breastfeeding improvement plan | | | | | | | | | | | | | | | • Reduction in the numbers of children becoming "in need".<br>• Performance on mandated health visiting checks.<br>• Performance on delivery of National Child Measurement Programme.<br>• Healthy weight of children in Year R and Year 6.<br>• Numbers of settings achieving Healthy Early Years Award or enrolled in healthy schools programmes.<br>• Reduced smoking in pregnancy.<br>• Increase breast feeding at 6-8 weeks.<br>• Reduced avoidable ED attendances/ hospital admissions.<br>• Reduced substance misuse.<br>• Improved attainment and attendance and reduction of fixed term exclusions and NEET.<br>• % of families turned around through Families Matter Phase 2 programme<br>• % pupils achieving good level of development at age 5.<br>• Rate of first time entrants to the youth justice system (per 100,000)<br>• Number of Family Friendly events each year in Southampton. |
| | | | | | Ensure effective transition of breastfeeding support services into the integrated 0-19 prevention and early help local offer | | | | | | | | | | | | | |
| | | | Ensure that the SHIP-wide developments in maternity services reflect and meet the challenges of Southampton women, and performance dashboards show outcomes and service performance and improve self referral into services | | | | | | | | | | | | | | |
| | | | Improve access for pregnant women (and partners) into behaviour change and other health and wellbeing improvement services | | | | | | | | | | | | | | |
| | | *Education* | Develop and roll-out Southampton Personal, Social, Health and Economic (PSHE) Education and Sex and Relationships Education (SRE) Primary School programme | | | | | | | | | | | | | | |
| | | *City-wide play and youth service offer* | Needs assessment, market engagement and service specification development | | | Secure permissions to procure new services and finalise procurement paperwork | | | Procure new services | | | | Mobilise new services | | ◆ Commence new services | | |
| | | *SEND* | Review and commission improved arrangements for meeting the support needs of pre-school age children with Special Educational Needs and Disability (SEND), including support for parents and other services | | | | | | | | | | | | | | |
| | | *Parenting and family support services* | | | Review, procure and mobilise parenting and family support services for struggling families with pre-school age children | | | | | | | | | | | | |
| | | *Digital information, support and advice* | Ensure that the Healthier Together digital platform (0-18.nhs.uk) complements information, support and advice from 0-19 prevention and early help, family support services and maternity services | | | | | | | | | | | | | | |
| | | *Healthy settings* | | | Evaluate impact of Healthy Settings programmes in early years, school, college and community settings | | | | | | | | | | | | |
| | | *Service user engagement* | Pilot improved engagement and involvement of children, young people and parents/carers in the co-production and evaluation of services | | | | | | | | | | | | | | |
| | | *Alternative commissioning approaches* | Work with commissioners, local authority and health services and community and voluntary sector partners to increase understanding of alternative outcome based commissioning approaches, such as social impact bonds | | | | | | | | | | | | | | |

# Prevention & Earlier Intervention

*Strengthen prevention and early intervention to support people to maintain their independence and wellbeing*

| Project | Description | | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **25. Falls Prevention** | Implementation of the falls prevention strategy, with a focus on extending Falls Champions to Extra Care schemes and Home Care providers, expanding the fragility fracture clinics and falls liaison and working with voluntary sector and exercise providers to increase the exercise offer for older people in the City. | *Exercise classes* | Ensure training of 8-10 exercise professionals to postural stability trainer level 4 | | | | | | | | | | | | | | | • Increased identification of people at risk of falling and referral into support services (as evidenced by increased numbers of referrals through fracture liaison, increased number of comprehensive falls assessments, increased uptake of exercise and medication)<br>• Improved prevention e.g. As evidenced by numbers of older people actively exercising.<br>• Reduce falls with injury for patients +65 in line with BCF targets.<br>• Reduction in ambulance conveyances to hospital. |
| | | | Increase numbers of people (pre-fallers) referred to exercise providers from primary care and roll out exercise and falls prevention awareness at whole population level | | | | | | | | | | | | | | | |
| | | | Embed additional falls revolution classes in clusters 3 and 4, for patients following comprehensive falls assessment | | | | | | | | | | | | | | | |
| | | | | | | | | ◆ Finalise falls exercise review and establishment of dashboard | | | | | | | | | | |
| | | | | | | | | | ◆ Future commissioning intentions for falls exercise agreed | | | | | | | | | |
| | | *Fracture liaison service* | Ensure fracture liaison service pathways embedded effectively into the system | | | | | | | | | | | | | | | |
| | | *Service audit and clinical audit* | | Undertake a system wide audit of service compliance against Falls prevention NICE guidance | | | | | | | | | | | | | | |
| | | | | | Clinical Coding Audit to review of falls injury rates in Southampton | | | | | | | | | | | | | | |
| | | *Falls assessments* | | | | Work with community independence team to manage increasing demand for comprehensive falls assessments | | | | | | | | | | | | |
| | | *Falls Champions* | | | | | | | Review the Falls Champions role within residential and home care, as part of the Residential Care Homes support project and Home Care procurement | | | | | | | | | |
| | | *Other interventions* | | | | Evaluate the effectiveness of Razier chairs in extra care, residential care and other settings, developing protocols with the ambulance service to avoid inappropriate ambulance dispatch/conveyance | | | | | | | | | | | | |
| | | | | | | | | | Develop with partners a locally hosted clinical system to coordinate patient level information to improve the management of patients with a falls and bone health risk | | | | | | | | | |

# Safe & high quality services

# Safe & high quality services

*Ensure that people are provided with a safe, high quality, positive experience of care in all providers*

| Project | Description | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **26. Learning from deaths** | Reducing the numbers of avoidable deaths (where health or social care could have impacted on the outcome) across the city. | Support providers and commissioners in further embedding a continuous learning culture, where learning from deaths is part of day to day practice. | | | | | | | | | | | | | | | • Ongoing monitoring of deaths via CQRMs in all main providers.<br>• CCG participation in STP mortality Group.<br>• LeDeR reviews completed as required.<br>• HSMR at UHSFT below 100. |
| | | Embed serious incident (SI) assurance process with health providers in relation to patient death investigations. | | | | | | Test improved partnership working across providers through review of investigations (particularly those which cross more than one provider. | | | | | | | | | |
| | | | | | | | | Ensure primary care (GPs) are supported to have am appropriate system for review of deaths. | | | | | | | | | |
| **27. Safety & learning culture** | Actively promoting an open learning and safety culture. | Embed Serious Incident assurance panels across the main NHS providers and continuous evidence of learning to drive quality improvement where needed. | | | | | | | | | | | | | | | • ≤45 cases of Cdiff.<br>• Zero cases of MRSA.<br>• Providers delivering safe care.<br>• Reduction in Never Events and SIRIs.<br>• Number of assurance panels held/attended.<br>• Safer staffing submissions.<br>• Number of practices in special measures.<br>• Number of practices exiting special measures.<br>• Number of provider led quality events attended. |
| | | Evidence outcomes from new health staffing models to ensure that they are effective and to support Provider to further review new ways of working. | | | | | | | | | | | | | | | |
| | | Review quality elements of the new 2 year NHS contracts to ensure required outcomes are being delivered. | | | | | | | | | | | | | | | |
| | | Embed any changes made to the Primary Care Quality Framework, to ensure potentially vulnerable practices are highlighted. | | | | | | | | | | | | | | | |
| | | Further work with Nursing Homes to ensure they are able to provide support to enable patient/client flow across the system. | | | | | | | | | | | | | | | |
| | | Further enhance and where required, change format of quality visits to providers. | | | | | | | | | | | | | | | |
| | | Embed, as required the process for the monitoring and management of practices in special measures. | | | | | | | | | | | | | | | |
| | | Develop more robust systems and processes to inform and support quality assurance visits. | | | | | | | | | | | | | | | |
| | | Continue to be engaged with provider led quality and organisational learning events | | | | | | | | | | | | | | | |

# Safe & high quality services

*Ensure that people are provided with a safe, high quality, positive experience of care in all providers*

| Project | Description | 2018/19 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2019/20 Apr | May | Jun | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **28. Antimicrobial prescribing** | The Antibiotic Quality Premium consists of three parts relating to a reduction in the number of gram negative bloodstream infections (GNBSI's) and inappropriate antibiotic prescribing in at-risk groups. | Continue work to reduce antimicrobial prescribing, including providing guidelines both for In-Hours and Out of Hours services, GP training at TARGET and give support and feedback to GPs at GP surgery specific meetings to challenge inappropriate prescribing | | | | | | | | | | | | | | | • Awaiting refreshed quality premium targets for 2018/19 from NHS England. |
| | | Maintain NHSE targets for the quality premiums | | | | | | | | | | | | | | | |
| **29. Anti-depressant prescribing** | Reducing antidepressant prescribing whilst supporting clinically effective mental healthcare. | Engage prescribers to use the GP Tutorial on the treatment of Depression and use of the Steps to Well Being service | | | | | | | | | | | | | | | • Reduction in antidepressant prescribing. |
| | | Examine the use of older Antidepressants | | | | | | | | | | | | | | | |
| | | Prepare a MIQUEST (or similar) tool to pull data on the length of prescribing of Antidepressants from GP clinical systems | | | | | | | | | | | | | | | |
| | | | | Investigate lengths of treatment and support appropriate weaning of antidepressants | | | | | | | | | | | | | |
| **30. Quality of internal providers** | Develop a model of monitoring and assurance of children's social care providers. | Monthly quality assurance meetings being led by ICU AD Quality | | | | | | | | | | | | | | | • Mechanism in place to monitor the quality of providers.<br>• All internal provider services rated good. |
| | | KPIs and audit plan finalised | | | | | | | | | | | | | | | |
| | | Regular monitoring visits alongside internal provider quality assurance lead established | | | | | | | | | | | | | | | |
| | | Reports to Inspection Board and JCB on a quarterly basis | | | | | | | | | | | | | | | |
| **31. Embed safeguarding across the ICU** | Reinforce the safeguarding framework to provide assurance across the ICU. | Refine and develop the safeguarding quality tools for children and adults | | | | | | | | | | | | | | | • Mechanism in place to provide assurance of safeguarding within contracts and commissioning. |
| | | | Promote the tools, alongside the self-assessment policy document, to create a robust safeguarding framework | | | | | | | | | | | | | | |
| | | | Support commissioning colleagues and systems partners in reviews of service specifications / tenders / contracts across the ICU | | | | | | | | | | | | | | |

# Safe & high quality services

*Ensure that people are provided with a safe, high quality, positive experience of care in all providers*

| Project | Description | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **32. CHC** | Delivery of 'good to great' continuing healthcare in Southampton. | Embed and help shape national best practice in NHS Continuing Healthcare and Continuing care for children. This will include but not be limited to - NHS England operating model for Continuing Healthcare, Continuing Healthcare Assessment tool, emerging best practice in local and national CHC networks. | | | | | | | | | | | | | | | • 85% of CHC assessments taking place in an out of a hospital setting.<br>• 90% of CHC assessments completed within 28 days.<br>• Improved local CHC processes in line with national requirements.<br>• Transfer assessments from acute hospital to community settings (85% in community) – linked to Discharge project.<br>• Continue to deliver cost-effective, high quality care packages whilst releasing financial savings.<br>• Improved monitoring, reporting and recording of the quality of providers across nursing, residential homes and home care (via an electronic system). |
| | | | | | | | | ◆ New national framework in place | | | | | | | | | |
| | | Refine and develop use of information and other technology to improve efficiency, transition between services and patient/family experience. | | | | | | | | | | | | | | | |
| | | Continue to refine and develop links with community groups and third sector colleagues in supporting policy and process development (for example – expanding scope of independent panel chairs, increased involvement in policy development and stakeholder groups). | | | | | | | | | | | | | | | |
| | | Continue to support work across the STP area to maximise best practice and cost efficiency in CHC. | | | | | | | | | | | | | | | |
| | | Continue to refine and develop educational and other support for system partners and stakeholders, supporting delivery of increased number, quality and timeliness of assessments for patients. | | | | | | | | | | | | | | | |
| | | Support commissioning colleagues and systems partners in reviewing service specifications/contracts across a range of areas (particularly primary care and community nursing) to embed appropriate levers/incentives that support increased engagement and involvement in CHC. | | | | | | | | | | | | | | | |
| | | Collaborate with system partners to develop, agree and implement new system wide approaches to reducing the number of CHC assessments completed in acute settings. | | | | | | | | | | | | | | | |
| | | Support commissioning colleagues in refining, further developing and improving existing community end of life services and care pathways in Southampton. | | | | | | | | | | | | | | | |
| | | Further strengthen the processes to support the transition of children to adult CHC | | | | | | | | | | | | | | | |

# Managing & developing the market

# Managing & developing the market

*Support commissioning activities that facilitate a strong provider market that is able to respond to an increasingly diverse customer group*

| Project | Description | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **33. Home Care procurement** | Planning to meet the requirement for between 400-500 new housing with care places in the next nine years. Developing and commencing delivery of this growth plan, including the establishment of commercial mechanisms, where required. | Engagement programme and development of specification | Issue tender | Close tender | Evaluation | | Contract development | | Mobilisation | | | | | Home Care in place | | | • Increase in Homecare capacity in the city.<br>• 75% of care delivered by Framework providers.<br>• Reduction in DTOC attributable to waits for Homecare package.<br>• Seek alternative way in delivering care to reduce the reliance upon short calls (15mins) particularly outside of housing with care environments.<br>• Reduction in time taken from referral being received by CPS to start of care package.<br>• All framework providers working towards meeting ethical care charter standards. |
| | | | | | | | | Management of Identified risks (including TUPE transfers for staff and Client transfers to new providers) | | | | | | Implementation of refreshed contact monitoring in collaboration with quality monitoring | | | |
| **34. Housing with care** | Develop and commence delivery of growth plan for local extra care housing, including establishment of commercial mechanisms for attracting investment and/ or land and reducing risk where required. | Identification of land options in the city suitable for extra care developments | | | | | | | | | | | | | | | • Increased extra care capacity.<br>• Reduced admissions to nursing homes.<br>• Delayed onset of care and support needs.<br>• Lower incidence of falls.<br>• Less health service utilisation.<br>• Reduced social isolation. |
| | | | | Initial draft options available | | | | | | | | | | | | | |
| | | | | | Filtering of options | | | | | Filtering agreed | | | | | | | |
| | | | | | | | | | | | Further design and investment options | | | | | | |
| | | | | Develop admissions process and cost benefit analysis for Potters Court in advance of opening in 2020 to maximise savings when open and to inform processes within current schemes | | | | | | | | | | | | | |
| | | Facilitating work with partners to progress developments across the city, including cost and access benefits within schemes including Royal South Hants site and Bitterne Regeneration project | | | | | | | | | | | | | | | |
| | | | | Identification of the broader benefits of extra care, specifically relating to Southampton, including the focus on the impacts on the health care economy | | | | | | | | | | | | | |
| | | | | Develop a communications plan to promote accommodation based support (housing with care and supported living) to staff and clients | | | | | Communications plan developed | | | | | | | | |
| | | | | | | | | | Implementation of communications plan | | | | | | | | |

# Managing & developing the market

*Support commissioning activities that facilitate a strong provider market that is able to respond to an increasingly diverse customer group*

| Project | Description | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **35. Nursing home and complex residential care market capacity** | Increasing guaranteed access to homes for people with complex needs through negotiation with homes, including discussions on the appropriate levels of need able to be met. Identifying opportunities for new developments and new agreements for access, ensuring all meet affordability requirements at the point of placement. Managing opportunities to stimulate growth of nursing care in the city. | Contracts agreed to guarantee access for complex care needs (either block or cost and volume basis), where providers wish to engage<br>Appropriate specifications developed to ensure needs are met at the prices agreed<br>Identification of potential land options in the city for new nursing home developments<br>Initial draft options available<br>Filtering of options<br>Filtering agreed<br>Further design and investment options<br>Identification of new developments, and access arrangements agreed<br>Engagement with providers locally and nationally to gauge appetite for increasing capacity of nursing care in the city – including developing current schemes or acquiring other homes | | | | | | | | | | | | | | • Reduced dependency on high cost/ out of area placements.<br>• Reduction in DTOC.<br>• Achievement of savings and cost avoidance. |
| **36. Children's residential care** | Lead a regional consortium of Local Authorities in the recommissioning of residential care for looked after children. | Procurement<br>Evaluation<br>Cabinet approval<br>Contract commences<br>Develop block contract proposal/ business case<br>Framework co-ordination function implemented | | | | | | | | | | | | | | | • Best value and timely access to a sufficient supply of residential placements for looked after children.<br>• Reduction in out of area placements and costs. |

# Managing & developing the market

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| Project | Description | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **37. Placement service development** | Ensure the service offer of the Placement Service remains continuously fit for purpose relative to customer/stakeholder requirements. | ◆ Confirmation of recurrent funding or agree plan for termination of Looked After Children (LAC)/SEN sourcing pilot | | | ◆ Increase scope to sourcing of residential/nursing placements for patients at UHS (HDT/CHC) | | | | | | | | | | | | • Maximisation of SCC/ SCCG's collective purchasing power within the local market for care and support services.<br>• Better access to up-to-date market intelligence.<br>• Social work professionals allocating more time to social work functions.<br>• Reduction in DTOC. |
| | | Run sourcing pilot to support discharge to assess workstream | | | | | | | | | | | | | | | |
| | | | | | | | ◆ Decision to mainstream discharge to assess sourcing via recurrent funding or terminate pilot | | | | | | | | | | |
| | | Run direct payment administration pilot | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | ◆ Decision to mainstream direct payment administration via recurrent funding or terminate pilot | | | | |
| | | | | | | | | | | | | | | ◆ Confirmation of recurrent funding or agree plan for termination of ASC invoice/billing query pilot | | | |
| **38. Market sustainability assurance** | Understand financial pressures on the care sector and develop approaches to support their management. Develop new approaches to the published rate levels, recognising complexity of care provided, and costs associated. Manage all approaches together with High Cost Placement work and the skills and knowledge of the Placement Service. | Negotiations with care agencies undertaken and concluded, resulting in agreed prices that ensure sustainability and consistent delivery of care services | | | Developed new model of published rates/expected rates to pay, across a range of needs in the residential and nursing home sectors, which will help to increase access to capacity, including sign-off by JCB | | | | | | | | | | | | • A nuanced and systematic understanding of inflationary cost pressures within the local market for care and support services.<br>• A sustainable supply of the care and support services required to meet the needs of the local population.<br>• A commercial response to suppliers seeking price increases. |
| | | Cost implications of agreements identified and managed, together with separation between National Minimum Wage and inflation impacts, enabling transfer of resources to the Adult Social Care budget to cover costs | | | | | | | | | | ◆ JCB decision | | | | | |
| | | | | | | | | | | | | Implementation of new rates | | | | | |

# Managing & developing the market

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| Project | Description | 2018/19 | | | | | | | | | | | | 2019/20 | | | Outcomes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| **39. High cost placement negotiations** | Continue to engage commercially and proactively with providers to ensure best price in the cost of purchased/ commissioned services. | | | ◆ 17 Care Funding Calculators (CFCs) across 9 residential care providers completed and 6 supported living schemes reviewed | | | ◆ 34 Care funding Calculators (CFCs) across 18 residential care providers completed and 12 supported living schemes reviewed | | | ◆ 51 Care Funding Calculators (CFCs) across 27 residential care providers completed and 18 supported living schemes reviewed | | | ◆ 68 Care Funding Calculators (CFCs) across 35 residential care providers completed and 24 supported living schemes reviewed | | | | • Assurance of best value in cost of packages of care for people with complex/ high levels of need.<br>• A more joined up approach for split funded patients.<br>• Ensure best use of telecare. |
| **40. Provider workforce development** | Identify workforce development issues and plan for supporting the workforce in the future. Link with current initiatives and programmes to promote care work as an area of opportunity. Ensure workforce capacity issues are identified within all commissioning strategies with key initiatives supported. | Develop and publish Workforce plan including current developments and identifying options | | | | | | | | | | | | | | | • Better recognition of future demands on the workforce.<br>• Plans in place across the care system to develop programmes for supporting the workforce, including within commissioning plans.<br>• Links with telecare and other initiatives to reduce the pressure on care staff while providing appropriate care.<br>• Ensure sufficient supply and skill in the local provider workforce to meet the changing and growing demand for care and support.<br>• Make best use of local regeneration/ economic development initiatives and programmes to promote care work as an area of opportunity.<br>• Ensure workforce capacity requirements and risks are identified within commissioning strategies. |
| | | | Develop LD workforce strategy with the Hampshire-wide STP, identifying key workforce requirements to support further community transitions, and develop plan, including implementation requirements | | | | | | | | | | | | | | |
| | | | | Update service review templates to ensure workforce issues are captured in full within service redesigns | | | | | | | | | | | | | |
| | | | | Update the provider failure policy to ensure work is undertaken to focus on keeping care staff within the sector | | | | | | | | | | | | | |
| | | | | Link with Economic Development initiatives to provide advance planning for new nursing homes and for changes in services in the future. | | | | | | | | | | | | | |
| | | | | Link with University and training providers to ensure training for the supply of staff, nurses etc. are supporting the needs of the market in the future | | | | | | | | | | | | | |

# Abbreviations & Acronyms Glossary

| | |
|---|---|
| **ADHD** | Attention deficit hyperactivity disorder |
| **AMH** | Adult Mental Health |
| **ASC** | Adult Social Care |
| **BCF** | Better Care Fund |
| **BRS** | Building Strength & Resilience Service |
| **CAMHS** | Child and Adolescent Mental Health Services |
| **CCG** | Clinical Commissioning Group |
| **CFC** | Care Funding Calculator |
| **CHC** | Continuing Healthcare |
| **CMH** | Children's Mental Health |
| **CYP** | Children and Young People |
| **COAST** | Child Outreach Assessment Support Team |
| **COPD** | Chronic Obstructive Pulmonary Disease |
| **CORE 24** | Core Mental Health liaison service 24 hours a day, 7 days a week |
| **CQC** | Care Quality Commission |
| **CQUIN** | Commissioning for Quality and Innovation |
| **CQRM** | Contract Quarterly Review Meeting |
| **DP** | Direct Payment |
| **DTOC** | Delayed Transfers of Care |
| **ED** | Emergency Department (accident & emergency) |
| **EHCH** | Enhanced Health Support in Homes |
| **EOL** | End of Life |
| **HIOW** | Hampshire & Isle of Wight |
| **HIU** | High Intensity User |
| **IAPT** | Improving Access to Psychological Therapies |
| **ICU** | Integrated Commissioning Unit |
| **ITT** | Invitation to Tender |
| **JCB** | Joint Commissioning Board |
| **LAC** | Looked After Children |
| **LARC** | Long Acting Reversible Contraception |
| **LD** | Learning Disabilities |
| **LDS** | Local Delivery System |
| **LeDeR** | Learning Disabilities Mortality Review |
| **LIS** | Local Improvement Scheme |
| **LOS** | Length of Stay |
| **LTC** | Long Term Condition |
| **MDT** | Multidisciplinary Team |
| **MECC** | Making Every Contact Count |
| **MH** | Mental Health |
| **MIQUEST** | Morbidity Information Query and Export Syntax (software) |
| **MoU** | Memorandum of Understanding |
| **MUS** | Medically Unexplained Symptoms |
| **NEET** | Not in Education, Employment or Training |
| **NEL** | Non Elective (emergency hospital admissions) |
| **NHSE** | NHS England |
| **PHB** | Personal Health Budget |
| **QIPP** | Quality, Innovation, Productivity & Prevention |
| **SCC** | Southampton City Council |
| **SCAS** | South Central Ambulance Service |
| **SEND** | Special Education Needs and Disability |
| **SHFT** | Southern Health Foundation Trust |
| **SHIP** | Southampton, Hampshire, Isle of Wight & Portsmouth |
| **SMI** | Serious mental illness |
| **SM** | Substance Misuse |
| **SPCL** | Southampton Primary Care Limited |
| **STP** | Sustainability & Transformation Partnership |
| **T&O** | Trauma & Orthopaedics |
| **UHS** | University Hospital Southampton |
| **URS** | Urgent Response Service |
| **WHCCG** | West Hampshire CCG |
| **XBDs** | Excess Bed Days |