Integrated Commissioning Plan

2019/20 – 2021/22

Southampton City Health & Care Strategy

2019-2023

Health and Care partners across Southampton are currently working together to develop and agree a new 'one city' Five Year Health and Care Strategy.

The strategic framework shown to the right is currently a draft and is planned to be finalised by Autumn 2019.

The ICU, as an integrated commissioning team, is integral to delivering the city's Health and Care Strategy.

Transforming health and care outcomes for the people of Southampton

Our five year strategic framework (2019-2023)

Our Vision

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

Our Goals

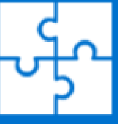
- Reduce health inequalities and confront deprivation
- Give children and young people a strong start in life
- Tackle the city's three 'big killers': Cancer, Cardiovascular and Respiratory
- Improve whole-person care
- Improve mental and emotional wellbeing
- Build resourceful communities
- Reduce variation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

Our Mission

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

Our vision & 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



Integration

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

Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

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 and with 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 and with service users 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 and with 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 2021/22?

- ✓ 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, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

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 work with people to modify the behaviours that can cause ill health, including working with 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 work with 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 work with 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 2021/22?

- ✓ 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 2021/22?

- ✓ 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 prior to and 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 2021/22?

- ✓ 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 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

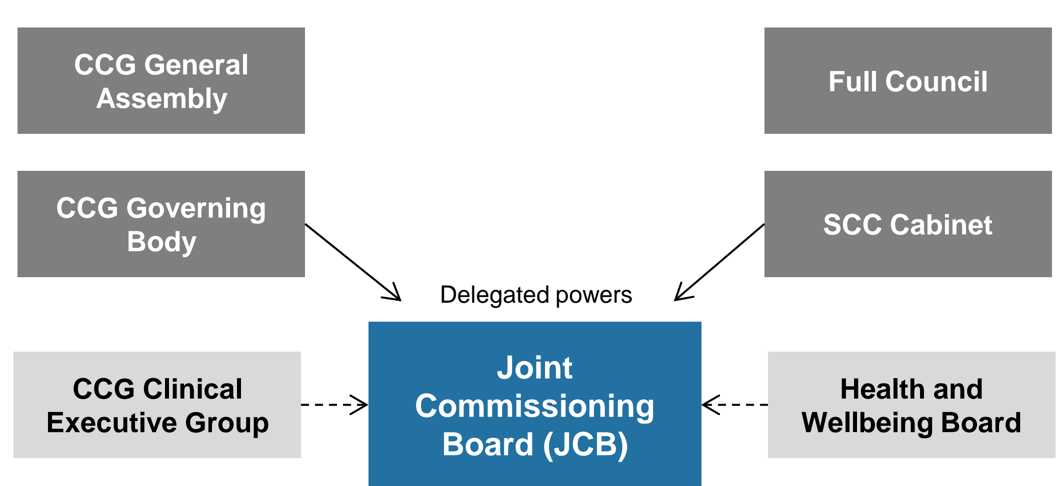
The commissioning process will ensure that the same approach (e.g. service specification and performance monitoring) is applied to all commissioned activity to ensure fairness and that no delivery vehicle is given or gain unfair advantage.

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.

Our key achievements over the last two years

Our key achievements over the last two years

Integration

- **Our ever closer alignment between health and social care** which we describe as our 'One City' approach, in particular the formation of our Joint Commissioning Board (JCB) in 2018 to support local decision making. Our 2018/19 Better Care pooled fund was approximately £111.5 million and is planned to further expand in future years.
- **Further development of cluster teams.** We have continued to strengthen multidisciplinary working in six 'cluster' areas in the city, aligned to GP practice populations. This brings together health staff, housing workers, voluntary sector, and social care to focus on the needs of a single geographical area, using joint assessment and planning approaches, including risk stratification.
- **Our work as a system to reduce delayed transfers of care (DTOC).** We have worked with University Hospital Southampton, Southampton City Council, Solent and Southern Health to continue to significantly reduce delayed transfers of care, with delayed days 5% lower than last year (year to date to end of Dec 19). This has included embedding the national High Impact Change Model for hospital discharge. Discharge to Assess (D2A) is now mainstreamed for all people leaving hospital with reablement or home care needs and is demonstrating a reduction in the need for ongoing care.
- **Introduction of a Case management approach to reducing the need for emergency care.** The Integrated Commissioning Unit (ICU) has worked with Solent NHS Trust to pilot the implementation of case management in each cluster providing intensive support. This has shown to have a significant impact on reducing future need for care: out of the 118 patients referred to the service during the year 2017/2018, there has been an overall reduction of 34% in acute hospital activity in the 6 months post referral compared to the 6 months pre referral. This included a 35.8% reduction in NEL admissions, a 32% reduction in ED attendances and a 33% reduction in SCAS 999 calls.
- **Roll out of Enhanced Health in Care Homes (EHCH) model.** Further to the pilot in 2018/19 with 15 residential care homes, the ICU will be rolling this out across the city in 2019/20. The pilot demonstrated an impact on reducing A&E attendances from the homes by 48%, ambulance call outs by 57% and emergency admissions by 38% over a 16 month period.
- **Development of the Southampton Living Well Service as part of a new model for providing day support to older people.** The ICU has worked with Adult Social Care and the voluntary sector to design and tender a new model of more person centred, community focussed day support for older people which commenced in April 2018. This has helped to transform the traditional model of older person's day care into a more community based offer with a wider choice of activities.
- **Volunteers befriending newly discharged older patients.** We invested in a hospital homecoming project, run by Communicare, which has 200 volunteers who provide befriending services to more than 300 older people, including visiting patients in hospital to check they have food at home and that the heating is switched on ready for their return. As well as providing some social interaction, they may also help with shopping, hoovering and laundry. The project has helped to improve patients' recovery rates, prevented readmissions into hospital and tackled loneliness.

Our key achievements over the last two years

Integration (cont.)

- **Development of services for children with special educational needs and disabilities (SEND).** During 2018/19, the ICU has worked with children's services, schools, health providers and the parent carer forum on a range of developments. Firstly, new specialist short break services will be going live in 2019/20 following a successful procurement, along with a wider range of inclusive mainstream activities funded through grants. Secondly, the ICU has successfully secured capital funding for a young person's learning and development hub to enable young people with profound and multiple learning disabilities to continue their education in Southampton up to the age of 25. The hub went live in September 2018. Lastly, the ICU has worked with a range of partners to develop a new transition pathway and best practice guide which went live in March 2019 and will, once fully implemented, significantly improve young people's and their carers/families' experience of preparing for adulthood.
- **Addressing the needs of people who frequently access urgent care services (high intensity users).** We invested in two schemes to support high intensity users (HIUs). The first was an intensive support service provided by Two Saints, delivering personalised support to a small group of complex patients with very high numbers of multiple A&E attendances. Overall urgent care activity for the group showed a 52% reduction. The second scheme was a pilot to recruit a Paramedic Demand Manager to work with HIUs, GPs, providers and the voluntary sector to put in place a Personal Management Plan (PMP) for call handlers and paramedics to follow. Early evidence for the first cohort of HIUs targeted has shown a 19% reduction in the number of 999 calls made and a 32% reduction in the number of conveyances to A&E.
- **Improvements to mental health crisis care.** We expanded the service hours for the mental health crisis lounge at Antelope House with the service fully staffed and open 4pm–midnight, to maintain consistent service based on demand at peak times of use. The crisis lounge is for people experiencing a crisis in their mental health and offers a safe and calm haven with improved triage, assessment, intervention, advice and support, to reduce admission to A&E.
- **Mental health support in NHS 111.** The CCG, with other commissioners, South Central Ambulance Service and Southern Health NHS Foundation Trust, have been working together on a new mental health triage service for NHS 111. This means that if someone calls 111 with a mental health concern, they will be directed to specialist mental health nurses who can provide specialist support.
- **Improving access to psychological therapies for people with long term conditions.** The Improving Access to Psychological Therapies (IAPT) Steps to Wellbeing Service has been rolled out for people with Diabetes and Chronic Obstructive Pulmonary Disease (COPD) experiencing low mood/depression, anxiety, stress or other common mental health problems.
- **Development of primary care step-down model** providing an enhanced level of support to GP's for people who no longer need support from secondary mental health services.
- **Established an Adult Mental Health Advice and Guidance Service for GPs** to improve access to specialist mental health advice and better communication of health needs between GPs and Community Mental Health Teams.
- **Development of a Locally Commissioned Service offer to Primary Care** to improve physical health care for people living with severe mental illness (SMI).

Our key achievements over the last two years

Integration (cont.)

- **Developments in CAMHS.** We have improved access to CAMHS, including targeting long waits. The average time from referral to first contact has reduced from 11 weeks in January 2018 to less than 1 week in December 2018, following the development of the CAMHS Single Point of Access (SPA). Waiting times from referral to treatment have also improved with >95% receiving treatment within 16 weeks in the most recent 3 months compared to <50% in the first 6 months of 2018/19. We have also expanded counselling services in schools to children under the age of 11.
- **Restorative practice.** The ICU, through its work on the CAMHS Local Transformation Plan, has collaborated with the Wessex Children's Mental Health Clinical Strategic Network to secure additional funding from Health Education England (HEE) to roll out restorative practice within the city as part of the city's overall vision to become a Child Friendly City. Restorative practice is a way of working with conflict that puts the focus on repairing the harm that has been done. It is an approach to conflict resolution that includes all of the parties involved.
- **New autism support service** commenced in November 2018, which arranges workshops for parents as well as autistic adults.
- **Transforming care for people with Learning Disabilities (LD).** Work with primary care and other service providers has resulted in a significant increase in the take up of annual health checks for people with a learning disability. We have also established a Life Skills service to support people with a learning disability to develop skills which support their independence. Almost 200 referrals have been made to the service and there has already been successes in supporting people to begin volunteering as an entry point to working towards employment. Additional supported living units have also been commissioned with a new 4 bed unit due to open in April/May 2019
- **Creating an integrated health and social care team to support people with learning disabilities.** Southampton City CCG Learning Disability Continuing Healthcare nurses relocated this year to work alongside colleagues from Adult Social Care and the Community Learning Disability team, to provide an integrated service for service users, their families and carers. Integration and colocation provides the ability to deliver more responsive and joined up care, including joint assessment and care planning, robust risk assessments and care co-ordination leading to an improved quality of service user experience.

Prevention & Earlier Intervention

- **Community solutions.** The ICU has worked with community partners to design a service outline for Community Navigation and Community Development. This design exercise has resulted in a fully specified service which will be procured to start in autumn 2019.
- **Alcohol misuse services.** We invested in recruitment of InReach workers into University Hospital Southampton's Alcohol Care Team, to case-find and refer alcohol misuse patients into community treatment services. Early evidence for the cohort of patients targeted to date has shown a 28% reduction in emergency admissions and is helping people move towards successful completion of alcohol treatment.

Our key achievements over the last two years

Prevention & Earlier Intervention (cont.)

- **Improvements to children and maternity services.** We now have two connecting care hubs running in the city and have implemented a 0-19 Prevention and Early Help Service. We also launched a MyMaternity app to improve access to wider maternity support services in the community.
- **Social workers in schools.** The ICU has been instrumental in its work with Children's Services to secure £450k additional funding as part of a research project with Cardiff University in 2019/20 to trial locating social workers in schools. The project focusses on 3 school clusters in Southampton and will test the benefit of bringing social work closer to the coal face and children and families.

Quality & Safety

- **High quality services.** The city now has all 9 nursing homes rated 'good' by the CQC and of the 50 care homes only 2 are rated 'requires improvement', 1 is rated 'outstanding' and all of the rest are rated 'good'. No care homes are subject to safeguarding sanctions and communication between the care homes and the quality team continues to be good. CQC ratings in our health providers continue to improve with one provider recently rated as 'outstanding'.
- **Recognition of our Continuing Healthcare (CHC) processes.** We have continued to make improvements to the quality of care provided, whilst ensuring we obtain best value for money. Nationally, the contribution from the CCG to the Strategic Improvement Programme has been acknowledged with significant involvement in the newly launched tools to support CHC.
- **Medicines Management.** We have continued work to improve efficiency, such as following new national guidance to reduce prescribing of items of low clinical value and certain over the counter items. We invested in two specialist pharmacists; a care homes pharmacist who has helped to carry out medication reviews and reduce medicines waste, and a pain pharmacist who has supported GPs and patients to reduce reliance on opioid based medication.

Market Management & Development

- **Home care procurement.** Commissioners have worked with providers to develop a new model for Home Care delivery in Southampton. The procurement process was completed early 2019 and the new Framework will start on 1 April 2019.
- **Residential care for looked after children.** Through the Integrated commissioning Unit, Southampton City Council successfully led a consortium of 18 local authorities to commission a new framework agreement for children's residential care. This contract has delivered a number of benefits including access to high quality services (80% of providers on the framework have a 'good' or 'outstanding' Ofsted rating), cost certainty for the next 3 years, cost effective contract management (the consortium have commissioned Bournemouth Council to manage the contract on its behalf), and a platform from which local supply can be grown in line with assessed need).
- **'High cost' placements.** This project was successfully concluded this year, with the team having over the last 4 years undertaken negotiations with 200+ providers of adult residential care placements costing more than £800/ week and achieving savings of £2.6m.

Our key achievements over the last two years

Market Management & Development (cont.)

- **Placement Service.** Part of the Integrated Commissioning Unit, this team sources third party-provided care and support on behalf of Southampton's adult social care and continuing health care teams. The team has now expanded the scope of its service offer to include care home placements for patients awaiting discharge from hospital, and is using this role to ensure timely, safe and effective discharge, and to provide assurance of best value with respect to long term care costs.
- **Housing for people with care and support needs.** We have worked across council service areas and the wider health and care system to ensure that housing for people with care and support needs is everyone's priority. As a result, growth in the local supply of extra care housing will form a key element of the council's strategy for developing 1000 new homes in the city, voids and nominations agreements for supported living services have been standardised to enable us to more effectively stimulate growth and manage risk, a land options appraisal has been undertaken to enable strategic identification of suitable sites for new developments, and construction has commenced at Potter's Court, a new 80+ bed extra care facility due for completion in October 2020.

Our plan on a page for 2019/20

Our priorities

Integration

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Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

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

Our projects

Integration

1. Shape & support new models of care
2. Supporting appropriate timely discharge & out of hospital model
3. Implementing the city's ageing model
4. Enhanced health support in care homes (EHCH)
5. Adult mental health
6. CAMHS transformation
7. Crisis care
8. Learning Disabilities (LD) integration
9. Transforming care for people with Learning Disabilities (LD)
10. Addressing the needs of High Intensity Users (HIUs)
11. Improving the outcomes for children with SEND
12. Personal health budgets
13. End of life and complex care
14. Joint Equipment Service (JES) and wheelchairs reprocurements

Prevention & Earlier Intervention

15. Behaviour Change
16. Alcohol
17. Community solutions
18. Maternity
19. Sexual health and teenage pregnancy
20. Prevention and early help for children and families
21. Housing related support

Safe & High Quality Services

22. Safety and learning culture
23. Antimicrobial prescribing
24. Antidepressant prescribing
25. Quality of internal providers
26. Embed safeguarding across the ICU
27. Continuing Healthcare (CHC)
28. Support for people with Learning Disabilities

Managing & Developing the Market

29. Home care implementation
30. Housing with care
31. Nursing home and complex residential care market capacity
32. Children's residential care
33. Market sustainability assurance
34. Provider workforce development
35. Market position statement refresh
36. Kentish Road
37. Independent foster care
38. Procurement service improvement

Our key measures of success

Integration

- Reduce DTOC rate (rate per day and % of beds)
- Reduce emergency hospital admissions
- Reduce permanent admissions to residential homes
- 75% of people with LD receiving a physical health check
- % reduction in A&E attendances & emergency hospital admissions for Top 100 HIUs
- Children's wheelchairs - 92% seen within 18 weeks
- CAMHS - 95% of routine assessments within 12 weeks
- 60% of people with an SMI receiving a full annual physical check
- 57.4% of people experiencing psychosis will be treated within 2 weeks of referral
- Reducing the number of beds occupied by patients with a length of stay >21 days
- % of clients in rehab/reablement who do not need ongoing care

Prevention & Earlier Intervention

- Reduce number of emergency admissions as a result of falls
- % of clients completing and not re-presenting
  - Opiates
  - Non-opiates
  - Alcohol
- Access to psychological therapies
  - % of people with common mental health conditions accessing with
  - % of people who complete recovery
- % of pregnant women who cease smoking time of delivery
- Proportion of those referred to navigation service which have support plans generated
- % of woman who uptake LARC (all 4 methods) - All Ages
- % of HIV tests completed as part of an STI screen

Safe & High Quality Services

- >85% of CHC assessments taking place in an out of hospital setting
- >80% of CHC assessments completed within 28 days
- <45 cases of Healthcare Associated Infections: Cdiff
- Zero cases of Healthcare Associated Infections: MRSA
- % of Providers with a CQC rating of 'good' or above published in month
- Prescribing (placeholder)
- Sepsis – primary care engagement (placeholder)

Managing & Developing the Market

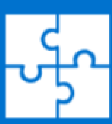
- ≥90% contract reviews on schedule
- Care placement - >90% placements sources via Team
- 14 days (10 working days) average waiting time from referral received to Home Care start date
- 14 days (10 working days) average waiting time from referral received to residential/nursing placement start date
- Total number of home care hours purchased per week
- % home care clients using a non framework providers

Integration

Integration

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

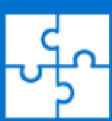
Project	Description		2019/20 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 Q1	Q2	Q3	Q4
1. Shape & support new models of care	Working with providers to shape and support new models of care, including further strengthening integrated local leadership and workforce development.	***Locality and Primary Care Network (PCN) Development***	Continue to support implementation of the operating model for local, person-centred care															
			Work with primary care to align the development of primary care networks and clusters															
			Support system wide organisational and workforce development which promotes more integrated person centred care															
			Support the development of an estates plan that supports local, person-centred coordinated care															
			Ensure strong engagement with the Better Care vision through communication strategy															
			Ensure opportunities are fully embraced to embed the strengths based model of Adult Social Care and housing and the children and families extended locality model into local integrated teams															
		Commissioning for better outcomes	Continue to review and develop commissioning arrangements to ensure that they promote person centred integrated care (promoting collaboration between providers, focus on system wide outcomes and incentivisation of the shift from acute to community based care)															



Integration

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

Project	Description		2019/20 (Apr – Mar) / 2020/21 (Q1 – Q4)
2. Supporting appropriate timely discharge & out of hospital model	Developing 3 hospital discharge pathways designed to simplify and streamline current processes, and fully implement the High Impact Change Model.	**Pathway 1 (Simple)** – for the majority of people where the discharge is managed by the hospital ward.	Training of discharge officers in "Trusted Assessment" completed and signed off System operational Continue to work with UHS to improve the basics, e.g. transport, TTOs and comms.
		Pathway 2 (Rehabilitation and Reablement) – for people who need care or additional support in the home, primarily supported by the integrated Urgent Response Service or commissioned homecare or residential care packages.	Increased reablement capacity fully recruited to within URS, inclusive of low level health activity (minus diabetes) "Move on" homecare sourced for PEG and RIG Care URS operationalise PEG and RIG activity "Move on" homecare sourced for collar care and pain patches URS operationalise collar care and pain patches activity Evaluate low level health activity Seek to negotiate inclusion of diabetes activity "Move on" homecare sourced for diabetes care URS operationalise diabetes care
		Pathway 3 (Complex) – people who require a complex assessment process (e.g. Continuing Health Care (CHC)) or have complex difficult to source care needs	Work up detailed implementation plan for Pathway 3 D2A preferred option JCB final approval of Pathway 3 D2A preferred option Phased Implementation Pathway 3 D2A preferred option Continue to embed early discharge planning for all pathways



Integration

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

Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4

3. Implementing the city's ageing well strategy (page 1 of 2)

Implementing Southampton's vision of a great city to grow old in, where people can live safely in their own homes as they grow old, are supported to maintain their health and independence for as long as possible, and are supported by responsive joined-up health and social care services when they need them.

Promote whole population approach to ageing well

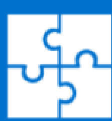
- Framework for Ageing Well developed and redrafted following feedback
- Wider System engagement to promote the framework
- Proposal developed to use social marketing to produce targeted messaging to specific segments of the population
- Ageing citizen forums networked and engaged to promote the framework and to create a social movement in adopting health lifestyles and personal future planning

Prevention & early intervention

- Living Well Service to work with Local Solutions groups to map community asset and activity opportunities
- Living Well service to launch activity provider and luncheon club affiliate scheme
- Procurement of community solutions and community navigation
- Eat Well Service is launched, mapping of a food offer in each cluster
- Explore with support from Incredible Edible development of opportunities to grow food in deprived neighbourhoods
- Intergenerational activity and food offer
- Explore Meal Sharing Scheme
- Network of residential care catering support to improve nutrition & hydration
- Home Care providers supported to identify people to improve nutrition & hydration
- Continue to increase direct referrals to the falls exercise prevention offer for individuals with low risk
- Escape Pain exercise of arthritic pain launched
- Escape Pain evaluation of pilot
- New provider of Falls Exercise launches new service
- Network of exercise and dance providers established to promote falls prevention and other health conditions
- Development of a community transport & shop mobility offer for the City
- Explore piloting expansion of the Welcome Home Service to include a daily phone call check service to vulnerable people, to identify early illness and provide practical support from neighbours

Integrated locality team development

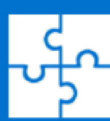
- Development of Operational Model for Integrated Locality Team (to include core functions, pathways, interfaces, workforce development, infrastructure support)
- Partnership agreements/commissioning arrangements in place
- Roll out implementation



Integration

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

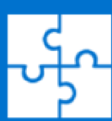
Project	Description		2019/20 (Apr – Mar) / 2020/21 (Q1 – Q4)
3. Implementing the city's ageing well (page 2 of 2)	Implementing Southampton's vision of a great city to grow old in, where people can live safely in their own homes as they grow old, are supported to maintain their health and independence for as long as possible, and are supported by responsive joined-up health and social care services when they need them.	***Single point of triage***	Scope opportunities and options for a single point of triage
			Implement single point of triage (depending on scoping work)
		Risk stratification for frailty & falls	Review as part of Better care risk stratification process/tools including frailty tools (primary care/acute), Clarity Tool (ACG) and Keele Falls Risk
			Pilot and evaluate use of Keele Risk Stratification tool to identify and better support patients at risk of falling, with CIT primary care clinicians
			Subject to outcome of pilot, commence wider roll out of Keele tool
		Community interface with ambulance service & acute front door	URS pathway commences to take same day discharge referrals from hospital front door (SDEC)
			Clinician commences on SCAS Clinical Desk with bi-monthly service improvement sessions (Plan/Act/Study/Do)
			Implementation of community initiated Home IV pathway, focussing initially on care homes
			Work with West Hampshire CCG and providers to scope rapid response model for the system
			Develop joint spec for Same Day Emergency Care (SDEC)
		Telecare for falls prevention	Pilot Commences with referrals from CIT/ Primary care/ Wellbeing Team/ UHS Frailty Unit
			Referrer bi-monthly stakeholder meetings commence with service improvement focus (Plan/Act/Study/Do)
			Review of first phase referrals
		Fracture liaison pathway	Targeted comms to increase the profile of the FLS across the hospital: all patients who fall and fracture are captured through direct referrals from the Virtual Fracture Clinic and inpatient wards (orthopaedic and MOP)
			Improvement work to ensure all patients seen within appropriate timeframe
			Improvement work to ensure effective referral to onward services: CWT, CIS, falls exercise
			Improve data capture, monitoring and evaluation through the FLS database
			Ensure bone medication compliance: 16 week and 52 week follow up, appropriate follow up with primary care
			Establish links with the National Osteoporosis Society for ongoing patient care / referral to patient groups



Integration

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

Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
4. Enhanced health support in care homes (EHCH)	Roll out of EHCH (piloted in 2018/19) city-wide	**SPCL roll out**	Roll out of EHCH activity to all Care Homes			Roll out to specialist care homes (e.g. MH and LD)												
								Consider future support for Nursing Homes and Extra Care							Roll out agreed offer to Nursing Homes/Extra Care as appropriate			
		Contractual arrangements						Finalise future contractual arrangements				Evaluation undertaken/ future service development agreed		Future service agreed				
														Current pilot contract runs out				
															Implement mainstream contract			



Integration

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

Project	Description		2019/20: Apr–Mar (Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar); 2020/21: Q1, Q2, Q3, Q4
5. Adult mental health (page 1 of 2)	Implement Mental Health Matters (MHM) and Five Year Forward View (FYFV) for Mental Health to improve local services and meet national targets. Review arrangements for integrated community mental health teams and develop improvement plan.	***Mental Health s75***	Undertake a review of the existing integrated mental health service to maximise the opportunities to improve outcomes for individuals and providing value for money for both health and social care ◆ Identify lead to undertake a review of the existing s75 ◆ Present review with options appraisal to ICUMT
		Long term conditions	Continue to Increase access to Improving Access to Psychological Therapies (IAPT) service with phased expansion into new long term condition pathways ◆ Medically Unexplained Symptoms (MUS) service commences at UHS targeting High Intensity Users ◆ Pain pathway commences
		Navigation service	Continue to deliver Adult Mental Health and Dementia navigation pilots until the new city wide navigation service is in operation Implement city wide navigation service to include Mental Health and Dementia ◆ Contract commences
		Peer support	Continue to work with the STP on developing Wessex wide peer support framework ◆ Await outcome of STP work to inform commissioning intentions for peer support framework and capacity building activities
		ADHD Diagnosis and support	Agree new ADHD service specification, demand/capacity modelling, pathway and mobilisation plans with SHFT ◆ Implementation of new service
		Comprehensive physical health checks	Improve SMI physical health outcomes and standards of care by ensuring at least 60% of adults on the SMI register receive the full list of recommended physical health assessments as part of a routine check at least annually (NICE CG185 and CG178) with appropriate evidence based interventions and follow up ◆ Review achievements of the Locally Commissioned Service (LCS) and identify additional support that may be needed to help increase physical health promotion in this population ◆ Make changes to LCS as required for 2019/20 and offer to Practices to sign-up Explore development of Mental Health facilitator pilot to undertake elements of the physical health check and offer brief intervention and behaviour change support to individuals, posts to work in an integrated way within CMHT and Primary Care Consider use of point of care testing units to deliver aspects of the health check on the spot Work with the recovery college offer to cover healthy lifestyle aspects e.g. nutritional advice

Integration

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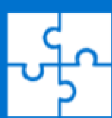
Project	Description		2019/20: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar / 2020/21: Q1, Q2, Q3, Q4
5. Adult mental health (page 2 of 2)	Implement Mental Health Matters (MHM) and Five Year Forward View (FYFV) for Mental Health to improve local services and meet national targets. Review arrangements for integrated community mental health teams and develop improvement plan.	***Rehabilitation and reablement review***	Work with the STP to co-produce and propose an effective Mental Health rehabilitation and reablement pathway to improve physical, mental health and social outcomes for people who have or who are at risk of becoming seriously mentally unwell Identification and assessment of OAPs locked rehabilitation clients, demand through forensic services, appropriate models of care for client group and development of proposal for repatriation ◆ Undertake needs analysis to understand current demand, flow and issues. Benchmark best practice ◆ Co-produce pathway and develop formal recommendation for commissioners
		Rehabilitation pilot	Continuation of Rehabilitation outreach pilot Evaluation report to include the agreed outcome measures to be used to further inform STP review
		Primary care mental health	Continuation of Primary Care step down pilot Evaluation report to include the agreed outcome measures ◆ Agree future commissioning intentions ◆ Implementation of enhanced primary cate mental health model Improve the practice team knowledge, skills and confidence in supporting/managing Mental Health in Primary Care through regular training and education
		Personality disorder	Continue to work with SHFT to develop pathways for adults with Personality Disorder
		Suicide strategy	Continue to work with partners to implement the suicide prevention strategy
		Mental health network	Work with VCSE to develop a metal health network for the city
		Emotional dysregulation	Mapping and gap analysis Work with current providers to better meet this populations' needs
		Reduce out of area beds	Work with secondary care provider to reduce acute in-patient LOS closer to the national average and eliminating the use of additional bed capacity



Integration

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

Project	Description		2019/20: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar · 2020/21: Q1, Q2, Q3, Q4
6. CAMHS Transform-ation	Implement CAMHS Transformation plan to improve local services and meet national targets.	***Achievement of National Access Target - Improve recording of the mental health services dataset (MHSDS)***	No Limits to migrate IT Systems and development work to enable provider to upload to MHSDS Solent MHSDS Project Group continue to progress actions outlined within Project Plan to enable accurate upload to MHSDS No Limits upload & Solent fully upload to MHSDS MHSDS Data validated via national reporting and national target achieved
		Local Transformation Plan Refresh	Update activity, finance and workforce information within LTP Engagement with key stakeholders to refresh plan LTP refreshed
		Promoting resilience, building strong prevention and early intervention services	Explore opportunities for further integration and streamlining pathways within our Early Help offer and agree model and working with schools to embed the principles of the green paper Co-design new peer support model with CYP and wider stakeholders in partnership with NHS England Embed and implement a city wide quality assured PSHE/RSE curriculum linking with subject leads in schools No Limits to have fully developed co-ordination function of counselling offer
		Improving access – 'no wrong door'	Multiagency SPA with No Limits and Yellow Door in place Map current prevention and early help provision and ensure that this is well publicised and easy to access for referrers, children, YP and families
		Care for the most vulnerable and reducing health inequalities	Review impact of BRS model reconfiguration within 6 months Development of a clear SEMH offer of support to schools, aligned to the recommendations from the SEND Strategic Review
		Improving crisis care	Evaluate the CAMHS Psychiatric Liaison Nurse post in ED with West Hampshire CCG including recommendations New Care Models provision specified in relation to how this will operate in Southampton Crisis pathway review completed specifically in relation to 24/7 response/support and core 24 standards, Liaison Psychiatry and place of safety requirements
		Improving the transition to adulthood	Develop specific transition tool for YP leaving CAMHS who do not require AMH or ALD services Explore/scope 0-25 service
		CAMHS workforce development	roll out restorative practice training to staff working with CYP with emotional & mental health issues and Senior Leaders to attend Restorative Practice training when data agreed

Integration

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

Timeline: 2019/20 (Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar); 2020/21 (Q1, Q2, Q3, Q4)

Project	Description		Activities and milestones
7. 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 mental health crisis response for adults and older adults with services resourced to offer intensive home treatment as an alternative to an acute in-patient admission.
			Complete and review self- assessment against Crisis Resolution and Home Treatment Team (CRHTT) CORE fidelity criteria
			◆ Development of business case and action plan to achieve CORE fidelity by March 2020
			◆ Service meeting CORE fidelity
		Crisis lounge	Complete evaluation of Crisis Lounge including outcomes to inform future sustainable service model development
			Future commissioning intentions for Crisis Lounge which will include the location and staffing model for the service
			◆ Implementation of the new Crisis Lounge model (outcome of location decision may impact on milestone date)
		NHS 111 24/7 Mental Health Support	Continue with NHS 111 pilot with regular review of KPIs
			◆ Pilot evaluation to be completed and shared with HIOW CCGs
			◆ Funding decision for on-going funding
		Core Mental Health Liaison Services 24/7	◆ Evaluation of triage model pilot from winter period to improve 1 hour assessment target for the emergency department to inform future model
			With partners explore options of co-location and development of a single integrated team bringing together Psychiatry Liaison, Psychology and Alcohol Care Team within UHS
			Identify the number of regional and supra regional beds within UHS to develop the core ward service and additional resource required to meet access standards for inpatients (24 hour response to urgent referrals from inpatient wards)

Integration

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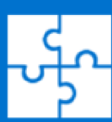
Project	Description		2019/20 (Apr – Mar) / 2020/21 (Q1 – Q4)
8. Learning Disabilities integration	Creation of an integrated health and social care team to support people with learning disabilities in Southampton, putting the individual at the centre		Developing governance processes and operating procedures Embedding new working practices to ensure clients are reviewed, meeting local and national standards Phase 2 implementation – integrate and co-locate the 3 teams Section 75 Longer term premises options to achieve one site base
9. Transforming care for people with Learning Disabilities (LD)	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.	*Southern Health service review*	Review Southern Health LD services with key objective to improve access to health services and reduce health inequalities. Agree service model Implement new service model
		LD 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
		Market position statement	Review LD Market Position Statement
		LD housing	Development of 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
		LD respite	Complete review of Weston Court respite service
		Life skills	Continue to support LD life skills team to increase access to employment, volunteering and meaningful activity Review internal & external LD day service market and develop future options
		JSNA	Finalise LD specific JSNA Implement recommendations from JSNA



Integration

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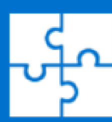
Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
10. Addressing the needs of High Intensity Users (HIUs)	Develop systems and interventions to better meet the needs of people who frequently present in crisis to ED, primary care and hospital	***Two Saints Support Service pilot***	◆ Complete NHS Grant Agreement for extension of pilot for 2019/20, to include extended caseload and refreshed referral sources															
			◆ Recruitment of second full-time support worker															
			Engagement with Cluster 6 to support additional referrals into the service in 2019/20															
			Engagement with SCAS to support additional referrals into the service in 2019/20															
			Increase number of referrals into the service from PC / VAST and SCAS															
								◆ Review referral numbers and activity and work to resolve and issues to support the service in their engagement across the identified referral routes										
										Evaluate the 2nd year of the pilot and prepare BC to inform future commissioning intentions									
												◆ Present findings of the evaluation at SMT						
		Medically Unexplained Symptoms (MUS)/Functional Illness pilot	Agree service specification and performance indicators to complete contract for the pilot during 2019/20															
						Monitor and evaluate pilot through-out 2019/20 – outcomes to inform future commissioning intentions												
						◆ Service go live												
												◆ Evaluation to inform future commissioning intentions						



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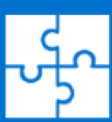
Project	Description		2019/20 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 Q1	Q2	Q3	Q4
11. Improving the outcomes for children with SEND	Continue to develop services to improve outcomes for children/young people with SEND.	***Early years***	Finalise model of more integrated, person centred support in the early years			Implementation												
			Review specialist EY provision with view to implementing greater integration across health/social care/education, addressing key gaps							◆ Agree model of specialist provision		Plan and commence implementation						
		Therapies/ orthotics	Implement integrated therapy and orthotics offer															
		Autism				Review Autism Assessment and Support Services, taking account of SEN Strategic Review recommendations, Inclusion Charter and work of Autism Strategy Group												
		Health offer to schools	Develop offer to "Complex" schools aligned to special school reconfiguration proposals						Develop offer to mainstream schools in partnership with Education Services, linking with review of outreach offer									
			Review offer to PMLD schools, in line with special school reconfiguration proposals					Develop offer to "SEMH" schools aligned to special school reconfiguration proposals										
		Transition	Support implementation of transition guide and pathway developed in 2018/19					Review transition therapy team										
		Short breaks	Implementation of new short breaks offer															

Integration

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

Project	Description		2019/20 (Apr – Mar) / 2020/21 (Q1 – Q4)
12. Personal health budgets	Ensure the delivery of all new Continuing Healthcare home-based packages (excluding fast track), using the personal health budgets model as the default delivery process in all CCGs	*CHC*	Review, refresh and refine all relevant literature, policy and pathways to ensure full alignment with personal health budgets being the default delivery process for home based CHC eligible care packages Review and address training needs within the CHC team to ensure confident delivery of PHBs by CHC front line staff as normal (default) business in this cohort of CHC eligible population ◆ CHC champions and lead operational manager in situ, additional initial training scoped and delivered with planned ongoing refreshers and updates Review capacity challenges, scoping range of potential solutions (whilst this may include increased capacity potentially also refinement of working practice, increased use of digital solutions) ◆ Clear view of capacity challenges with potential options to address appraised and recommended ◆ Embed and refine Monthly review of progress, numbers and updates of as part of wider normal business and PHB reporting to SMT/CHC oversight, CCG Clinical Governance (including clear understanding of exceptional cases where default delivery process is declined)
	Work with providers to develop the skills and competencies of professionals to develop Care & Support plans applying a personalised care approach in order to offer PHB's to End of Life patients eligible for Fast-track; Personal Wheelchair Budgets for clients having a new assessment and for individuals in receipt of Section 117 aftercare.	*Beyond CHC*	◆ Soft launch Work with provider (Millbrooks) to progress the offer of a Personal Wheelchair Budget (PWB) for individuals having a new wheelchair assessment. Work collaboratively with provider (SHFT), social workers and CHC mental health nurse's to develop and implement the offer of a PHB for clients in receipt of Section 117 aftercare Work with provider (NHS Solent) to develop a process to implement the option of a PHB for patients eligible for CHC fast-track funding
13. End of life and complex care	Working with providers to shape and support new models of high quality end of life care provision to support people to have the best opportunities in their last years of life.	*Bereavement service*	Implement a full psychology and bereavement service at Countess Mountbatten to support patients, family members and carers psychological needs pre and post bereavement ◆ Evaluation of mobilisation of the service ◆ Launch event ◆ Explore service offer wider than CMH patients/families
		Hospice at home	Develop and implement an agreed model of hospice at home provision ◆ Launch
		Nurse led unit	Establish most effective and efficient clinically safe model
		Training and education	Expanding the offer of EOL training to front line staff
		CMH service development	A 3 year plan and is subject to service development and fundraising, CMH will be contracting direct with commissioners from 1st April 2019



Integration

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

Project	Description		2019/20	2020/21
14. Joint Equipment Service (JES) and wheelchairs reprocurements and integration of housing, equipment, adaptations and other related services	Reprocurement of the JES and the Wheelchair service	***Joint Equipment Store***	Review of current service and future options (Apr); ◆ Agree future model and re-procurement process and timescales (May); Reprocurement process (timescales subject to agreement at CLCMC) (May–Dec); ◆ Award contract (Jan); ◆ New contract in place (Mar)	
		Wheelchairs	Review of current service model, data collection and finances (Apr–May); Patient and Public Engagement to inform development of service specification. Initial and follow-up events (Apr–Jun); ◆ Hold Market Warming event (May); ◆ Prepare and confirm service specification (Jul); ◆ Invitation to tender (ITT) (Feb)	◆ Award contract (Q3); ◆ Contract Mobilisation (Q3/Q4); ◆ Contract commencement (Q4)
	Integration of housing, equipment, adaptations and other related services	***Housing integration project***	Scope project (May–Jun); Opportunities reviewed for greater integration with reference to national best practice and local feedback (Jun–Oct); ◆ Proposals (Oct); Implementation plan (Nov–Mar)	

Prevention & Earlier Intervention

Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

Timeline: 2019/20 (Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar); 2020/21 (Q1, Q2, Q3, Q4)

Project	Description	Workstream	Activities
15. Behaviour Change	Joint work with Public Health to review current services and develop options for future commissioning. Implement interim arrangements for target groups and service pathways whilst long term vision to meet the city's needs is developed.	**Termination of contract**	Terms of termination agreement agreed and signed by both parties
		Communications	• Comms prepared for service users and stakeholders to inform interim service arrangements • Comms prepared for SCC councillors • Comms prepared for media enquiries
		Smoking cessation for the general public	Pharmacists contacted for expressions of interest for uptake of the Locally Commissioned Service (LCS) LCS for pharmacies – expression of interest invited and full spec and contract Pharmacies undertaken smoking cessation training Mobilisation of smoking cessation contract Monitor impact of Locally Commissioned Service
		Smoking cessation support for pregnant women	Agree Smoking cessation support for pregnant women proposal with UHS S75 funding agreement in place Midwife training in smoking cessation Roll out Midwife-led smoking cessation across 13 community hubs Review arrangements and future funding Embed smoking cessation into role of Midwife Support Workers Roll out PGD for Midwife prescribing of NRT Introduction of joint smoking cessation clinics with partners
		Tier 2 Weight Management	Implement interim weight watchers (WW) service
		Re-procurement	Service Review commissioner & Public Health Needs assessment and agree priority pathways Co-design process Stakeholder event to explore model Market warming Tender process Implement

Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

Project	Description		2019/20	2020/21
			Apr – Mar	Q1 – Q4
16. Alcohol	Pilot the expansion of the current Alcohol Care Team (ACT) at UHS from a 5-day a week service, to a 6-day a week service, including extended hours into the evenings on weekdays and Saturday morning provision.	**Enhanced Alcohol Care Team at UHS**	Establish steering group to oversee development of delivery plan and consider the development of medically supported ambulatory alcohol withdrawal) (Apr–May) Confirm WHCCG and HCC funding commitment to offer enhanced access to all patients, review plan if no commitment received (Apr–May) Team recruitment and training (Apr–Jun) ◆ Commence enhanced provision (Jul) ◆ Commence UHS based medically supported ambulatory alcohol withdrawal (TBC) (Sep) Review Alcohol Admissions data (Apr–Mar)	◆ Complete 1st Year Report (Q1)
	Pilot increased provision of community In Reach to ensure that the increased number of people being assessed by the ACT have access to community based treatment and support.	**Enhanced provision of InReach from Substance Use Disorder Services (SUDS)**	Establish steering group to oversee development of delivery plan (Apr–Jun) ◆ Commence InReach provision (Jul)	◆ Complete 1st Year Report (Q1)

Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
17. Community Solutions	Complete the procurement of a community solutions service which builds on community assets to increase local services which people can access easily.	**Procurement**	ITT Period	Evaluation and notification of result	Contract award				Contract commencement									
		Service evaluation				Development of Social Return on Investment Measures						Implement new measures and generate baseline						
		Place based giving scheme development										Codesign process for placement based giving scheme			Model agreed and ratified		Implementation of PBGS	
		Social prescribing	Development of Social Return on Investment Measures						Implement coordinated model based upon codesign work – cluster leadership groups									

Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

Project	Description		2019/20 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 Q1	Q2	Q3	Q4
18. Maternity	Continue to work with UHS to deliver the commitments in the long term plan, in particular; improvements in safety to reduce maternal and neonatal deaths, continuity of care, choice and personalisation and promotion of breast feeding and smoking cessation.	**Local implementation of Better Births Maternity service improvements**	Refresh of local Maternity Service specification to incorporate Better Births requirements and local service developments. (Apr–Jun)															
			Development of SHIP-wide Maternity financial dashboard (Apr–Sep)															
			Development of SHIP-wide Maternity performance dashboard (Apr–Jun)															
			Development and implementation of local Maternity Voices Partnership (MVP) (Apr–Oct)							Develop business case for future of MVP (Nov–Dec)								
					Development and implementation of accredited infant feeding scheme (Jun–Q1)													
		Local Maternity service improvement strands	Development of local pathways for smoking cessation in pregnancy (Apr–Aug)															
						Evaluation of local pathways for smoking cessation in pregnancy (Jul–Mar)												
			Development of links to wider smoking cessation support options for partners / others living with women in pregnancy (Apr–Dec)															
			Implementation of maternity self-referral pathway for local women (Apr–Jun)															

Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
19. Sexual health & teenage pregnancy	Carry out a refresh of the Southampton Sexual Health Improvement Plan, including teenage pregnancy.	**Strategic planning**	Refresh of Southampton Reproductive and Sexual Health Improvement Plan (including Teenage Pregnancy)															
			Reflect and report on 2017 Q4 Teenage Pregnancy outturn												Reflect and report on 2018 Q4 Teenage Pregnancy outturn			
		Key service improvements	Participation in Sexual Health Transformation programme to deliver service efficiencies and improve demand management															
			Improve access pathways for Long Acting Reversible Contraception (LARC) in primary care and maternity services															
						Procurement of HIV Home Testing service												
		Population planning & needs assessment	Refine processes and policies relating to residents accessing out of area sexual health services.															
			Implement and develop use of Pathway Analytics data to support transformation and out of area patterns of service use.															

Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
20. Prevention and early help for children and families	Continue to work with Children's Services and Solent NHS Trust to develop an enhanced locality model of integrated prevention and early help for children 0-19 and their families.	**Strategic planning**	Work with SCC and partners to refresh Southampton Prevention and Early Help Improvement Plan, including monitoring arrangements.															
			Work with 0-19 Prevention and Early Help service to integrate Breastfeeding support service planning and commissioning into the S75 budget from 31 March 2021.															
		Key service improvement initiatives	Procurement of 0-19 Southampton Play and Youth Offer						Mobilisation of 0-19 Southampton Play and Youth Offer								Review progress in development of Play service reach	
												Establishment of Southampton 0-19 Play and Youth service forum					Review progress in development of Youth service reach	
			Implementation, roll out and review of Southampton PSHE / RSE support offer															
			Working with Children and Families to procure Family Group Conference service									Mobilisation of Family Group Conference service					Implementation of statutory RSE and Health Education in Southampton schools	

Prevention & Earlier Intervention

Strengthen prevention and early intervention to support people to maintain their independence and wellbeing, supporting and helping communities to be resilient, and supporting self care and strengths-based approaches

Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
21. Housing related support (HRS)	Implementation of new Housing Related Support service for adults and children including integrated access arrangements.	**Commissioning plans**	◆ Seek extension of HRS contract for 1 year															
				◆ Options paper outlining emerging service options covering their cost and impact.														
					◆ Complete write up of HRS Phase 2 findings and present to ICU MT					◆ Briefing to Cllrs on future proposals for HRS			◆ Develop commissioning intentions for HRS services (from April 2021)					
		Future homeless services	◆ Stakeholder event exploring the concept of Housing First					◆ Stakeholder engagement sessions/events to inform future commissioning plans in relation to Young people services, move on options, intensive outreach services										
			◆ Engagement of social landlords to explore Move on Options															
					◆ Develop proposals with social landlords and housing colleagues to increase Move on options													
		Safeguarding					◆ Implement HRS safeguarding actions (as set out in action plan)											
		Rough sleeping	◆ Implement new Low Threshold Bed service (new pilot project)															
				◆ Implement new schemes funded through Rapid Rehousing programme (MHCLG)														
						◆ Secure funding for the continuation and expansion of H-VAST (Homeless Vulnerable Adult Support Team)												

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

<table>
<tr><th rowspan="2">Project</th><th rowspan="2" colspan="2">Description</th><th colspan="12">2019/20</th><th colspan="4">2020/21</th></tr>
<tr><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td rowspan="10">22. Safety and learning culture</td><td rowspan="10">Actively promoting an open learning and safety culture.</td><td>Quality improvement visits</td><td colspan="12">Continuation of local delivery system wide quality improvement events which have supported innovation and sharing of learning between commissioners and providers</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Quality visits</td><td colspan="12">Leading and participating in quality visits and gaining assurance through participation in Providers internal governance meetings</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Nursing & residential homes</td><td colspan="12">Continued quality improvement in the nursing and residential home sector, as part of our enhanced health in care homes programme</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Serious incident process</td><td colspan="6">Further development of robust monitoring processes of serious incidents including the achievement of the 60 day reporting requirements, and further development of assurance panels to review the learning and the implementation of action plans.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Quality reporting</td><td colspan="3">Further development of our approach to reporting, focusing on safety, outcomes and experience, enabling improved identification of themes</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Quality assurance framework</td><td colspan="4">Development of a Quality Assurance Framework to support improving quality across all contracts.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Primary Care</td><td colspan="6">Embed the process for the monitoring and management of Primary Care services.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Workforce</td><td colspan="12">Continuing to work with Providers in monitoring and mitigating risk associated with workforce within services in Southampton.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Patient experience</td><td colspan="12">Working with providers to improve patient experience in services</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Clinical effectiveness</td><td colspan="12">Embed a culture of outcome focused quality improvements</td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">23. Antimicrobial prescribing</td><td rowspan="2">The Antibiotic Quality Premium</td><td rowspan="2">GP Training and support</td><td colspan="12">GP training at TARGET around antimicrobial prescribing – TARGET dates tbc</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="12">Provide support and feedback to GPs at GP surgery specific meetings to challenge inappropriate prescribing</td><td></td><td></td><td></td><td></td></tr>
</table>

Safe & high quality services

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

Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
24. Antidepressant prescribing	Reducing antidepressant prescribing whilst supporting clinically effective mental healthcare.	**Steps to wellbeing – GP engagement**	Continue to link GPs with STWB to ensure appropriate referral, patient expectation managed and service utilised more															
		Audits				Patients over 65 on SSRI and SNRI's, review correct dose for age and cardiac co-morbidities Patients on Antidepressants for more than 4 years – review patients who may no longer require antidepressants following reactive episode												
25. Quality of internal providers	Develop a model of monitoring and assurance of children's social care providers.	**Ongoing development of assurance processes for Holcroft, LD respite services, URS, Glen Lee and Shared Lives**	Monthly meetings with the provider service managers for these teams in SCC including review of action plans															
		Development of assurance processes for Adult Social Care teams that can be shared with the ICU	Monthly meetings with the Quality Lead and Operational head of service for ASC Support the development of the improvement plan		Monitoring the improvement plan													
		Ongoing monitoring of the quality assurance processes in children and young people's social care teams	Monthly meetings with the quality assurance lead															
26. Embed safeguarding across the ICU	Reinforce the safeguarding framework to provide assurance across the ICU.		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		2019/20: Apr · May · Jun · Jul · Aug · Sep · Oct · Nov · Dec · Jan · Feb · Mar — 2020/21: Q1 · Q2 · Q3 · Q4
27. Continuing Healthcare (CHC) (Page 1 of 2)	Ensure that less than 15% of all full assessments for NHS CHC funding take place in an acute hospital setting	**CHC Assessments**	Continued collaboration with system partners to develop, refine and embed discharge to assess approach as normal business in hospital discharge Develop process for timely senior review of any cases where the above does not occur, confirming either appropriate rationale or lessons learned by exception. Wherever possible, funding patients to community placement via either discharge to assess or other shared funding arrangements and work with patient, families and local authority colleagues to complete assessments within 4-6 weeks. Refine and embed process for robust senior manager oversight, support and escalation routes to support early resolution of delayed discharge (where it relates to Fast track, CHC or other sub-care pathways transacted or influenced by the CHC team). Increased and bespoke support and education offer to support acute hospital colleagues in delivery of consistent, accurate messaging and CHC process ◆ Embedded case specific and monthly review of performance and lessons learned. ◆ Refined complex discharge pathway (including CHC) ◆ Clear roadmap to implemented trusted assessor approach to CHC assessment in acute setting ◆ Fully agreed, resourced and implemented future discharge to assess in Southampton with clear single escalation pathway within all organisations
	Ensure that in more than 80% of cases with a positive NHS Continuing Healthcare (CHC) Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist. In addition, ensure there are no referrals breaching 28 days by more than 12 weeks in each reporting quarter, or by Q4 2019/20.	**CHC Assessments**	Implement and transition to new CHC recording and reporting database ◆ Improved recording and reporting outcomes from new database, improved oversight of 28 day target ◆ Web based application portal that will prompt but also drive professional behaviour to support improved quality of information on submission and reduce applications with incomplete information Develop, implement and embed new process controls (alongside the implementation of a new recording and reporting database) ◆ Developed and implemented new process controls if required Proactive engagement of community and primary care partners to identify potentially CHC eligible population sooner (currently often after multiple acute hospital admissions) ◆ Further strengthening links with community and primary care, including targeted support to community teams and more direct involvement in existing community process ◆ Strengthening training and support offer to community and primary care, both generally and bespoke to specific teams (for example, District Nurses Increase visibility to community and primary care partners, including involvement in virtual wards and ultimately primary care Continued engagement with and implementation of practice standardisation and improvement via the NHSE strategic improvement programme

Safe & high quality services

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

Project	Description		2019/20 Apr–Mar	2020/21 Q1–Q4
27. Continuing Healthcare (CHC) (Page 2 of 2)	Develop plans to incorporate Continuing Healthcare strategic improvement programme opportunities into QIPP for 2019/20 through continued standardisation of process and adoption of best practice including the implementation of digital solutions, use of CHC SIP tools and guidance, and use of the CHAT assurance tools.	**CHC QIPP**	Apr–Mar: Maintain and accelerate direct involvement and engagement with the NHSE CHC SIP programme, well positioned to incorporate continued standardisation of process and adoption of best practice. Apr–Jun: Implement and transition to new CHC recording and reporting database Apr–Mar: Further develop new CHC recording and reporting solution with clear plan for continued product development in line with CHC SIP tools/guidance/best practice Apr–May: Populate CHAT assurance tool and embed into normal business/management Milestone (Jun/Jul): Building on existing foundations drawn from active engagement in the CHC SIP programme, developing plans to incorporate CHC SIP and CHAT tools into normal business	Milestone (start of Q1): Implementation of additional product developments for the recording and reporting system
28. Support for people with learning disabilities		**Standards**	Apr–Mar: Supporting Providers to achieve the Learning Disability Improvement Standards for NHS Trusts.	
		Contracts	Apr–Mar: Monitoring the Learning Disability elements within Provider contracts	
		Quality improvement	Milestone (Apr): Facilitation of a Learning Disability specific Multi-provider Quality Improvement event Milestone (Oct): Facilitation of a Learning Disability specific Multi-provider Quality Improvement event	
		Service redesign	Apr–Mar: Participation in the Learning Disability service redesign - Commissioning work stream	

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		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
29. Home care implementation	To implement a Home Care offer that is of high quality, responsive and efficient for Southampton's residents, and for CHC those registered with a Southampton GP practice, who meet the eligibility criteria. Provision will be person centred, strength based and become part of overall health and care delivery through strong partnerships with key services in care and support delivery and includes innovative solutions throughout the life of the contract.	Implementation of new framework	Implementation of Lead provider role															
			Implementation of contingency arrangements – lead provider role															
			Development of new service evaluation process – co designed															
				Implementation of new contract monitoring arrangements														
		Procurement of cluster 2 lead provider role		ITT for cluster 2 area lead provider role.														
						Evaluation and award												
									Contract start date									
		Engagement of lead providers in system working	Introduction of new arrangements to system groups															
				Lead providers in system groups – explore role														
						Implement new stakeholder arrangements												
			Care Technology linking between Lot A and Lot B providers															
		Specialist work	Scoping of need for adults who require care or support linked to EMI and/or substance misuse															
						Develop and implement plan for adults who require care or support linked to EMI and/or substance misuse												
								Winter planning										
			Low level health needs (excluding Diabetes support)															

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		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
30. 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.	Planning for opening of Potters Court	Provide strategic and commissioning steer to the Potters Court project board to ensure that the scheme can meet the demand for more complex care adequately															
					◆ Strategic brief agreed and signed off													
			Implementation of communications plan to promote accommodation based support															
			Review Potters Court engagement plan which seeks to identify and address current issues around extra care settings, including allocations process, boosting the demand, and reviewing service delivery															
								Developing a monitoring system whereby commissioning, care, and housing feedback can be collected and monitored holistically and effectively										
												Implementation of monitoring system (where agreed)						
								Review activity coordination offer available in the housing with care settings										
		Planning for housing with care capacity in the future	Review strategic direction, including numbers required to meet the needs adequately.															
					◆ Business case produced for future developments produced and agreed by JCB													
			Review financing options relating to the development of the RSH site and the Bitterne regeneration project															
				Publish and promote finding on the benefits of extra care housing to the broader health and social care systems														
		Managing access to Potters court									Develop plan with Care Managers to ensure housing with care becomes an initial option of choice for care managers seeking appropriate placements to people with needs							
													Managing the plans for identifying appropriate clients and placements in Potters Court					

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		2019/20: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar	2020/21: Q1, Q2, Q3, Q4
31. 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.	Formalising arrangements for spaces within homes	Agree specific arrangements with some homes for the longer term, where this provides guaranteed access for complex bed spaces for a price that reduces costs to the council and CCG. Development of specifications to meet needs and access arrangements Continue to support the market in meeting complex needs through joint work with the QA team, hydration strategy and training. Develop options for equipment provision to support greater needs being met in homes Develop plans for longer term investment and capacity management. Paper to JCB	
		Options for new capacity	Continue to develop options for investing in new spaces, utilising finance information to develop the long term financial case Take forward identification of land options to consider realistic opportunities for investment by the market, including RSH site Utilising the MPS to identify agencies with potential to invest Working with the market on design options for new and existing schemes	
32. Children's residential care	Annual re-opening of the framework agreement	Framework re-opening	Regional commissioning consortium to review and agree priorities for the framework re-opening exercise Regional commissioning consortium to approve tender documentation Advert published Tender submissions evaluated New Framework commences	Repeat annual re-opening exercise

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		2019/20 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 Q1	Q2	Q3	Q4
33. Market sustainability assurance	Understand financial pressures on the care sector and develop approaches to support their management.	**Finance**	◆ Implementation of the agreed increases to the Published Rate levels.															
			Management of process for requests for inflation increases from other agencies.															
						Understand continued pressures within the market leading to sustainability issues for the city												
	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.	**Future rate levels**	Review of rate levels in other local authority areas, including processes for managing rate increases.															
				Develop plan for rate reviews, determining a greater reflection of need levels, and financial requirements														
					Consider the role and impact of self-funding market on the care market in the city													
					Discussion with the market													
					Development of future structure for determining rates, including Finance input					◆ Report to JCB								
										Implementation of new rate structure								
							Understanding future pressures within the market place, including inflation, National Minimum Wage increases etc, and potential impacts across provider services, to inform future financial planning.										
													Planning for future rate changes					
													Working with the market on inflation changes for 2020/21					

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		Activity	Timing (2019/20: Apr–Mar; 2020/21: Q1–Q4)
34. 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.	**Workforce planning – building on fixed term role within the TCP**	Produce a workforce strategy seeking to address the independent sector workforce needs, training and development.	Jun – Sep 2019/20
			Review opportunities to influence the development of SCC workforce supporting ASC clients	Apr – Sep 2019/20
			Produce future care workforce vision and assessment of needs to enable effective change management of the local market	Jun – Sep 2019/20
			Produce career progression pathways within the care sector and join up resources supporting staff development	Sep – Mar 2019/20
			Review current workforce initiatives across the city to identify gaps in provision and to join up resources across organisations – including ensuring initiatives are identified and coordinated	Apr – Jun 2019/20
			Implement STP and TCP plans relating to LD workforce development across the SHIP area, with a special focus given to Southampton	Apr – Sep 2019/20
			Develop sustainability plan to ensure workforce development plans are implemented in the long-term – once the fixed term post ends	Jul – Sep 2019/20
35. Market position statement refresh	The Market Position Statement signals to providers operating within the local care market how commissioners will work with them to shape the local market over the next 3 years in a manner that is best suited to the needs of the local population and sustainable within the context of available resources.	**Producing MPS for 2019-21**	Development of the Market Position Statement – Structure and content.	Apr – Jun 2019/20
			◆ Market Position Statement to the JCB for agreement	Milestone: Jul 2019/20
			◆ Market Position Statement published	Milestone: Jul 2019/20
			Provision of opportunities for dialogue with the market – email account, telephone and meeting opportunities	Jul 2019/20 – Q1 2020/21
			Review opportunities for further dialogue with the market across all care groups (including Children's Services, Mental health, others)	Aug – Dec 2019/20
			Potential further publications supporting market engagement initiatives and providing updates, where required	Jan 2019/20 – Q1 2020/21

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		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
36. Kentish Road	Develop a vision for the future of the site that continues to offer respite to people with learning disabilities and that also maximises the value of the wider site by complementing the respite service with other services for people with learning disabilities, including housing and life skills services provision	**Site vision development**	Stakeholder engagement															
				Selection of preferred option														
				Capital/ revenue costs estimated														
				Funding mechanism identified														
				Business case completed														
					Capital Board approval													
						Cabinet and/ or Full Council approval of proposed site vision												
							If site vision approved, next stage delivery plan to be developed											
37. Independent foster care	Annual re-opening of the framework agreement, and consideration of options beyond expiry of this contract	**Framework re-opening**							Regional commissioning consortium to review and agree priorities for the framework re-opening exercise									
											Regional commissioning consortium to approve tender documentation							
												Advert published						
													Tender submissions evaluated					
														Award approval				
															New framework commences			
																	Repeat annual re-opening exercise	
		Replace existing contract with new contract solution						SCC review of options										
									Establish SCC/ regional consortium/ preferred option									
										Develop project plan/ governance based on preferred option								
											Specification/ procurement methodology development, market engagement							

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		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
38. Procurement service improvement	Develop fit for purpose approach within SCC procurement of contracts for health and care services	**Service improvement**			Transfer of staff/ responsibilities from Capita to SCC Vacancies filled by procurement business partners with sufficient knowledge, skill, and experience in the health/ care category Review/ develop category-specific procurement policy/ procedure as required to supplement emerging SCC procurement strategy				Develop/ implement suitable training on procurement processes for commissioning unit personnel						Review and evaluate extent to which benefits of in-sourcing procurement function are being fully realised/ maximised			

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