Public Document Pack

Joint Commissioning Board

Thursday, 20th June, 2019
at 9.30 am

PLEASE NOTE TIME OF MEETING

Conference Room, CCG HQ, Oakley Road, Southampton

This meeting is open to the public

Members

Dr Kelsey (Chair)
John Richards
Councillor Hammond (Vice-Chair)
Councillor Fielker
Councillor Shields
Matt Stevens

Please send apologies to:

Emily Chapman, Board Administrator,

Tel: 02380 296029

Email: emilychapman1@nhs.net

PUBLIC INFORMATION

Role of the Joint Commissioning Board

The Board has been established by the City Council and Clinical Commissioning Group 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

Public Representations

Save where an Item has been resolved to be confidential in accordance with the Council's Constitution or the Freedom of Information Act 2000, at the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Benefits from Integrated Commissioning

- Using integrated commissioning to drive provider integration and service innovation.
- Improving the efficiency of commissioned services
- Increasing the effectiveness of commissioning – across the whole of the commissioning cycle.

Smoking policy – the Council and Clinical Commissioning Group operates a no-smoking policy in all of its buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Fire Procedure – in the event of a fire or other emergency an alarm will sound and you will be advised by lofficers what action to take.

Access – access is available for the disabled. Please contact the Support Officer who will help to make any necessary arrangements.

Dates of Meetings: Municipal Year 2019/20

2019	2020
21st March	20th February
20th June	
15th August	
17th October	
19th December	

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the Board are contained in the Council's Constitution and the Clinical Commissioning Group Governance Arrangements.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 4 with a minimum of 2 from the City Council and the Clinical Commissioning Group.

Disclosure of Interests

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

AGENDA

Agendas and papers are now available online at www.southampton.gov.uk/council/meeting-papers

1 WELCOME AND APOLOGIES

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Councillor Hammond	N/A	N/A

2 DECLARATIONS OF INTEREST

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Councillor Hammond	N/A	N/A

3 MINUTES OF THE PREVIOUS MEETING/ ACTION TRACKER (Pages 1 - 8)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Councillor Hammond	Decision	Attached

4 MARKET POSITION STATEMENT - OLDER PEOPLE - 2019-2022 (Pages 9 - 36)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chris Pelletier	Decision	Attached

5 5 YEAR HEALTH AND CARE STRATEGY (Pages 37 - 68)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Clare Young	Discussion	Attached

6 INTEGRATED COMMISSIONING UNIT BUSINESS PLAN (Pages 69 - 128)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Stephanie Ramsey	Discussion	Attached

7 BETTER CARE GOVERNANCE (Pages 129 - 140)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Donna Chapman	Decision	Attached

8 JOINT COMMISSIONING BOARD TERMS OF REFERENCE (Pages 141 - 152)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Beccy Willis	Decision	Attached

Wednesday, 12 June 2019

This page is intentionally left blank

Meeting Minutes

Joint Commissioning Board - Public

The meeting was held on 13th December 2018, 09:30 – 10:30
Conference Room, NHS Southampton HQ, Oakley Road, SO16 4GX

	NAME	INITIAL	TITLE	ORG
Present:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	John Richards	JRich	Chief Executive Officer	SCCCG
	Councillor Chris Hammond	Cllr Hammond	Leader of the Council	SCC
	Councillor Dave Shields	Cllr Shields	Cabinet Member - Health and Sustainable Living	SCC
	Councillor John Jordan	Cllr Jordan	Cabinet Member – Children and Families	SCC
	June Bridle	JB	Lay Member (Governance)	SCCCG
In attendance:	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG / SCC
	Richard Crouch	RC	Interim Chief Executive Officer	SCC
	James Rimmer	JRim	Chief Financial Officer	SCCCG
	Beccy Willis	BW	Head of Business	SCCCG
	Jason Horsley	JH	Director of Public Health	SCC/ PCC
	Jo Knight	JK	Service Lead – Finance Business Partnering	SCC
	Amy McCollough	AM	Public Health Consultant	SCC
	Tim Davis	TD	Senior Commissioning Manager	ICU
	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Emily Chapman (minutes)	EC	Business Manager	SCCCG
Apologies:	Mel Creighton	MC	Chief Financial Officer	SCC
	Councillor Lorna Fielker	Cllr Fielker	Cabinet Member – Adult Social Care	SCC

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted. It was agreed that Cllr Jordan would represent Cllr Fielker.	

2.	**Declarations of Interest**	
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship No declarations were made above those already on the Conflict of Interest register.	
3.	**Previous Minutes/Matters Arising & Action Tracker**	
	The minutes from the previous meeting dated 8th November 2018 were agreed as an accurate reflection of the meeting, with the following amendment: - Page 3, item 4 re the last sentence. The Board delegated the decision to the Director of Quality and Integration. **Matters Arising** None raised. **Action Tracker** The outstanding actions were reviewed and the action tracker updated. RC raised that we should link the workforce issues with Hampshire County Council and the work they are undertaking. The Board discussed Brexit. RC updated that work is taking place with emergency services in Local Authorities. There is a meeting scheduled to discuss further, RC to share the details of the meeting. It was suggested that Brexit should be discussed at the Southampton Connect meeting.	**RC** **RC/ JRich**
4.	**Women at risk of repeat removals of children into care**	
	The Committee received the paper on the women at risk of repeat removals of children into care. AM talked through the highlights of the paper. JH raised that these women could be High Intensity Users of emergency services, SR responded that this linkage isn't confirmed. AM confirmed there is a group of 66 women who have had 2 children removed and then quickly had another child, these are the women who this scheme would target. The criteria would be at least 2 children that have been removed, however it would be case by case and the Protection and Court (PAC) team would use their professional judgement. The target is also around 18-30 year old women.	

JRich queried the value of subscribing to Pause to support the programme rather than doing it ourselves. AM responded the value of Pause would be in the first 12-18 months. We have asked Pause to buy into their training; the answer to this has not yet been confirmed. Pause provides expertise and also training, monitoring and learning from other Local Authorities.

The Board discussed the use of the current 2 vacancies for this work. AM confirmed that these posts have been vacant for some time and the Protection and Court (PAC) team feel as though there would be more benefit moving the resources into this project. The Family Nurse Partnership (FNP)post has a case load of around 17-20 individuals so this will have an impact, however number of young people being accepted for FNP has reduced dramatically, also those young people may be eligible for this pilot.

JRich raised that we need to ensure we don't discontinue engagement with women once the pilot stops (e.g. they are mid-intervention). AM responded that it would be unethical to stop and this would be built into the pilot model.

Cllr Hammond raised that this pilot is worth taking a risk, this is morally the right thing to do and he fully supports the pilot.

The Board agreed the following recommendations:

i) An 18 month local pilot service for women at risk of repeat removals is implemented, with a 3 month lead in time to enable recruitment of women from April 2019.

ii) The local pilot service is used to inform how a full-scale service for women at risk of repeat removals will work in practice, with the intention that a business case for a full-scale service is developed and presented to JCB in 2019/20 (and if agreed implemented from 2020/21).

iii) The local pilot service is funded in the following ways:

- Use of full time vacant SCC Children and Families grade 8 post.
- Use of 0.8 fte vacant Family Nurse Practitioner (FNP) NHS Band 7 post (funded by Public Health, SCC)
- £30k additional funding from SCC (committed by Finance, SCC).
- A contribution of £30k from Southampton Clinical Commissioning Group (CCG).

AM left the meeting.

5.	**Community Based Play and Youth Offer**	
	The Board received the papers on the Community Based Play and Youth Offer. TD talked through the highlights of the paper. Cllr Shields queried what type of procurement this would be as there could be a disadvantage to smaller providers, if a larger provider were to submit a bid. TD clarified that the suggestion is a four year agreement. There have been market engagement events will smaller providers and it is suggested that there is a longer Invitation to Tender (ITT) period provided to ensure those providers have time to work on their bids. There is an issue with timescales, so it is suggested that short term grants bridge the funding gap. TD proposed an amendment to recommendation (ii), this should be Director of Quality and Integration. This was agreed to be amended. The Board agreed to: **i)** Delegate authority to the Director of Integration and Quality, following consultation with the Cabinet Member for Community Wellbeing, the Cabinet Member for Aspiration, Schools and Lifelong Learning, and the Cabinet Member for Homes and Culture, to proceed with procurement of City-wide Play and Youth provision to better meet future play and youth requirements. This should include authority to make short term grant awards to bridge any gaps in funding that might otherwise undermine transition to the implementation of the new services during the 2019-20 financial year. **ii)** Delegate authority the Director of Integration and Quality, following consultation with the Cabinet Member for Aspiration, Schools and Lifelong Learning, and the Cabinet Member for Homes and Culture, to proceed with a direct award to the current trustees of Weston Adventure Playground to secure the ongoing maintenance of the building and facilities at the site to a high standard, conditional upon the continuing availability of the facilities as a venue and platform for a range of accessible, affordable play and youth activities.	
6.	**Any Other Business**	
	It was agreed that the January 2019 meeting would be cancelled. The Board also agreed that the Board would move to bi-monthly public meetings. These dates would be published on the SCC/CCG websites. JRich raised that the RSH/Western work is taking place needs to be lined up with SCC budget setting.	**EC** **EC**

7.	**Next Meeting Date**	
	19th June 2019, 09:30 – 11:00, Conference Room, NHS Southampton HQ, Oakley Road, Millbrook, SO16 4GX	

This page is intentionally left blank

Joint Commisioning Board - Action Tracker (Public)					
Date of meeting	**Subject**	**Action**	**Lead**	**Deadline**	**Progress**
13/12/2019	Brexit	RC updated that work is taking place with emergency services in Local Authorities. There is a meeting scheduled to discuss further, RC to share the details of the meeting.	RC	Jan-19	Complete
13/12/2019	Brexit	Brexit should be discussed at the Connect meeting.	RC/JRich	Jan-19	Complete
13/12/2019	Meeting Dates	January 2019 meeting would be cancelled.	EC	Jan-19	Complete
13/12/2019	Meeting Dates	Board would move to bi-monthly public meetings. These dates would be published on the SCC/CCG websites.	EC	Jan-19	Complete

This page is intentionally left blank

DECISION-MAKER:		Cabinet Member for Adult Social Care		
SUBJECT:		Market Position Statement – Care and Support Services for the Ageing Population, 2019 -2022		
DATE OF DECISION:		20th June, 2019		
REPORT OF:		Stephanie Ramsey, Director of Quality and Integration		
CONTACT DETAILS				
AUTHOR:	**Name:**	Dorota Strzelecka	Tel:	023 80 833819
	E-mail:	Dorota.strzelecka@southampton.gov.uk		
Director	**Name:**	Stephanie Ramsey	Tel:	**02380296941/ 07887656829**
	E-mail:	**stephanie.ramsey1@nhs.net**		

STATEMENT OF CONFIDENTIALITY
None
BRIEF SUMMARY
A market position statement (MPS) is a document that summarises supply and demand in a local area, and signals business opportunities within the care market in that area. Whilst they are not mandatory documents, MPS's are considered a 'best practice' means by which local market shaping duties under the Care Act 2014 may be fulfilled. This MPS provides information, intelligence, and analysis of benefit to current and prospective providers of care and support services for older people, and those with similar needs, on behalf of Southampton City Council (SCC) and Southampton City Clinical Commissioning Group (SCCCG).

RECOMMENDATIONS:		
		Following consultation with the Joint Commissioning Board to:
	(i)	Approve the content of the document
	(ii)	Agree the publication of the document
REASONS FOR REPORT RECOMMENDATIONS		
1.	Under the Care Act 2014, all local authorities are advised to produce Market Position Statement as a way of engaging with and communicating with the care market.	
2.	The current SCC and SCCCG MPS has covered the period 2015 – 2018 and is now due for renewal.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
3.	Without an MPS it is difficult to evidence that an open and a transparent approach to market management is being maintained. The market may prove less responsive to local commissioning intentions as a result.	
DETAIL (Including consultation carried out)		

4.	The initial MPS (published in 2015 and covering the period from 2015 to 2018) is now in need of updating. While some of the key messages remain the same, a number of factors have changed. These include the understanding of a relationship with the market, and the ability to promote more meaningful engagement and joint working.
5.	This new MPS is a summary of all key commissioning intentions relating to the ageing population. This includes a wide range of individuals, with a variety of needs (frailty, mental health, dementia, learning difficulties). The MPS outlines the city's vision for future care services and purchasing plans, and has been developed with support from lead commissioners and key stakeholders. It focuses on the role of providers and the opportunities available to them in developing and delivering services, and covers the period 2019-2022. The MPS also encourages providers to consider how changes in client need and preference will impact on their business plans. It makes the case for Southampton as an attractive city within which to invest.
6.	A number of market opportunities are covered within the MPS. These range from the community support offer and support at home to bed based provision. However, the primary focus of the document is to attract investment into the bed-based provision and to develop more capacity in this part of the market. This will include, but it is not limited to, housing with care and complex residential and nursing placements.
7.	The MPS's key messages have been discussed in detail with the provider market as part of the ICU's ongoing programme of market engagement. These include informal discussions with providers, as well as more formal service development processes. The MPS will serve as the basis for ongoing discussions with the care market. This planned and continuous engagement with the market will enable the ICU to realise and maximise the vision outlined in the MPS.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	There are no immediate resource implications that arise from publishing the MPS. However, the MPS does seek to attract investment into the city and encourage development of the right types of care services. These will, on a case by case basis, be subject to standard procurement and governance procedures as required, which will as standard meet best value and quality requirements.
Property/Other	
9.	The MPS aims to incentivise providers to diversify their bed-based service offer, including increasing the local supply of housing with care. This is in line with the local aim of reducing reliance on residential care and investing in a more diverse range of housing solutions for older people. Where opportunities arise to use land available for development, these will be managed through appropriate governance mechanisms on a case by case basis.

LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	Under the Care Act 2014, all local authorities are encouraged to publish their strategic plans and commissioning intentions to allow sufficient time for the provider market to respond to the changes proposed.
11.	Standard procurement regulations will apply for all services developed or purchased based on the direction set by the MPS.
Other Legal Implications:	
	N/A
CONFLICT OF INTEREST IMPLICATIOINS	
	N/A
RISK MANAGEMENT IMPLICATIONS	
	N/A
POLICY FRAMEWORK IMPLICATIONS	
	AS ABOVE.

KEY DECISION?	**Yes**
WARDS/COMMUNITIES AFFECTED:	**All wards, vulnerable people**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Market Position Statement – Equality and Safety Impact Assessment
2.	Market Position Statement – Care and Support Services for the Ageing Population 2019-2022

Documents In Members' Rooms

1.	None
2.	
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**Yes**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**

Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	N/A	
2.		

SOUTHAMPTON CITY COUNCIL

Equality and Safety Impact Assessment

The **Public Sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with Section 17 of the Crime and Disorder Act and will enable the Council to better understand the potential impact of proposals and consider mitigating action.

Name or Brief Description of Proposal	Market Position Statement – Care and Support Services for the Ageing Population, 2019 – 2022

Brief Service Profile (including number of customers)

Market Position Statement (MPS) is a document, produced predominantly by local authorities, to inform the provider market of the future purchasing plans relating to social care and upcoming opportunities for joint working. In case of Southampton, the document will outline plans and vision on behalf of Southampton City Council and Southampton City Clinical Commissioning Group. The publication will encourage a dialogue between the provider market and both of the organisations via the Integrated Commissioning Unit (ICU) to consider how services can be developed to meet future need.

The publication will look at the needs of older people or people whose needs relate to ageing. This may include people with a wide range of needs, which relate to frailty, mobility, physical disabilities, dementia, mental health as well as learning disabilities.

The 2011 Census recorded 30,800 residents in Southampton aged over 65 years. Currently, over 14% of the city's residents are 65 or over, and this is expected to rise to 22% by 2022. A significant number have been diagnosed with dementia, or other long term conditions. This is suggesting an increase in demand for those requiring support with activities of daily living.

Summary of Impact and Issues

The purpose of this document is to stimulate growth in relevant areas of the market; this will include attracting investment into the city and growing capacity in the local care market. The MPS seeks to address the gaps in the provision and encourage a more sustainable approach to market

management. All impacts envisaged are positive, as they encourage the growth of the local supply for care services. We envisage that as a result of the ICU's market management efforts the city will be able to access a range of required placements, including more complex care (both residential and nursing placements). In addition, the city intends to develop more housing with care provision, which in the long term will reduce SCC's reliance on residential and nursing care, and help people maintain their independence. A number of quality assurance work streams detailed in the MPS will also improve the quality of the care delivered locally, and address the challenges facing the sector in the next few years (e.g. issues relating to workforce).
Potential Positive Impacts
A number of positive impacts will include increasing the local supply of complex residential and nursing care placements, developing more capacity in the housing with care market, addressing the gaps in the local provision, improving the experience and quality of care.

Responsible Service Manager	Chris Pelletier
Date	29/05/2019
Approved by Senior Manager	Stephanie Ramsey
Date	29/05/2019

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	The demand will be predominantly for those over 65 years but this is not exclusively the criteria. Younger adults will be included as part of the commissioned services, if their needs are similar of those of older people and if they would benefit from similar services.	The purpose of the market shaping initiatives detailed in the MPS will seek to grow the capacity in the local market for care for older people. We are also looking at ways in which all commissioned services can be inclusive, and be able to accommodate people with a range of other needs. It is envisaged that Potters Court, a new

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		housing with care scheme currently in development, will not be age restricted. We will be appraising the benefits of this approach and consider if this should be replicated in future schemes.
Disability	It is likely that a number of people in this client group will have a disability, relating either to their physical or mental conditions.	Inclusivity will be promoted as a part of the service design, this will include flexibility of support and increased staff awareness and training around additional needs. Housing with care will be specifically designed to better meet the needs of people with disabilities and dementia. We would also like to grow capacity in the market for people with most complex needs, a number of which will have a disability.
Gender Reassignment	No negative impacts identified	
Marriage and Civil Partnership	Provision will need to be able to offer shared as well as single rooms/facilities. No negative impacts identified	Needs assessment will include consideration of requirement for shared facilities
Pregnancy and Maternity	Not applicable	
Race	Commissioning plans relate to all people with needs over the age of 65 (in some instances younger), therefore any services commissioned should be representative of the city's population.	Standard equality and diversity policies and principles will be applied to enable an inclusive mix of people in the services and when planning future services.
Religion or Belief	Commissioning plans relate to all people with needs over the age of 65 (in some instances younger), therefore any services commissioned should be representative of the city's	Standard equality and diversity policies and principles will be applied to enable an inclusive mix of people in the services.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	population.	
Sex	Services commissioned will cater to the needs of all sexes.	No specific impacts identified.
Sexual Orientation	Commissioning plans relate to all people with needs over the age of 65 (in some instances younger), therefore any services commissioned should be representative of the city's population.	Standard equality and diversity policies and principles will be applied to enable an inclusive mix of people in the services.
Community Safety		It is likely that the regeneration programmes which include housing with care will have positive impacts on the community by expanding the service offer available in the area. Regeneration initiatives on the whole tend to have positive impacts on local areas, this includes economic development, improved safety and better and safer design of local areas.
Poverty	Publicly-funded clients are likely to have limited ability to access services outside of locally commissioned care provision, which may reduce their choice around options available to them By expanding on the availability of housing with care accommodation and providing a more robust tenure mix, SCC and SCCCG will be able to offer greater choice to people looking for suitable care options. This will be particularly relevant to capital depleters.	The aim of the document is to develop a strategic direction to ensure that any services purchased or developed as a part of the ICU's commissioning efforts provide good quality, safe and affordable care options for everyone in line with people's expectations. Over the coming years, the ICU will be seeking to develop a more robust picture of the local self-funding market, to ensure compliance with duties under the Care Act, and to better understand how changes to this segment

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		of the market may be affecting the local supply of publicly-funded care. SCC plans to expand on tenure types available as a part of our housing with care provision. This is likely to increase choice for people looking for appropriate care options for when they get older.
Health & Wellbeing	People's health and wellbeing can be compromised if their environment and/or the care delivered is not suitable to meet their needs.	The MPS promotes person-centred approach to care and places special importance on prevention, early intervention, and community-based solutions to care. This will have positive impacts on people's wellbeing and health. The ICU is seeking to increase the supply of housing with care to enable more people access appropriate housing as they get older, and prevent unnecessary moves into residential care. A broader distribution of housing with care will enable a number of residents to stay within their local communities once their ordinary housing becomes unsuitable. The ICU aims to develop more nursing and complex residential care capacity in the city which will enable people to sustain their local links for longer.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Other Significant Impacts	No negative impacts identified	

Market Position Statement

Care and support services for the ageing population

SOUTHAMPTON 2019 – 2022

NHS
Southampton City
Clinical Commissioning Group

SOUTHAMPTON
CITY COUNCIL

Contents

1 Welcome from Stephanie Ramsey, Director of Quality and Integration

The landscape for health and care services has changed significantly over the last decade. The population is ageing, and older people with care and support needs desire greater choice and control over how those needs are met.

In Southampton, we are embracing change and opportunities to further improve the quality of care and outcomes for the city's residents. Personalisation, prevention and integration are key adult care priorities, and we are continuously striving to stimulate growth, diversity, and innovation in local care services.

We believe that the right care, and the right environment for care, can enable people to lead happier, healthier and more independent lives. By sharing our vision and publishing this Market Position Statement, we encourage other organisations to work with us to help shape the future of our city.

2 About this Market Position Statement

This Market Position Statement (MPS) provides information, intelligence, and analysis of benefit to current and prospective providers of care and support services for older people, on behalf of Southampton City Council (SCC) and Southampton City Clinical Commissioning Group (SCCCG).

This MPS focuses predominantly on the needs of the city's older people and, as such, the messages in this MPS are inclusive of people with a range of needs and conditions, including frailty, dementia, challenging behaviour, mental health and learning disabilities. Further publications outlining specific needs of other care groups will be referenced where appropriate.

While we wish to develop and support the market as a whole, the primary aim of this document is to stimulate growth in access to bed-based provision, including significant investment in housing with care, more nursing home provision (particularly complex care) and to confirm access arrangements to specialist residential and nursing care. Other priorities include wider growth of community-based capacity, especially home care services.

As most care is sourced via the independent sector, we need to build on the successful partnerships we have with current providers and develop new strategic relationships across the wider care market. By publishing our commissioning intentions and associated market opportunities, we aim to encourage a productive dialogue with the market and are seeking to incentivise partners to invest in the city.

3 About Southampton

Southampton has gone through major transformation in recent years and has seen significant investment to develop and modernise the city. The PwC report 'Good Growth for Cities 2018' places Southampton in the top three cities in England, having been in the top five for many years, and is one of England's fastest growing cities.

For more information, please see:

www.investinsouthampton.co.uk/

www.pwc.co.uk/government-public-sector/good-growth/assets/pdf/good-growth-for-gities-2018.pdf

A large number of businesses operate from the city, including digital, dockyard industry, and commerce. There are two universities which attract a number of young people and academics to the city each year. This brings its own opportunities for careers and development, and makes population demographics younger in comparison to our statistical neighbours. We are a diverse city with almost 78% of people defining themselves as White British, and 22% as Non-White British (the largest groups being White Other at 7.4%, a significant majority coming from Eastern Europe, and Asian/Asian British at 8.4%). Our care services need to reflect this diverse population.

Against this backdrop, however, the city still has residents living in some of the country's most deprived areas. In 2015, Southampton ranked 53rd out of 326 on the deprivation index (with 1st being the most deprived). Deprivation is a factor in increasing demand for Adult Social Care services.

In addition to this, we are grappling with significant health inequalities within the city. We have seen an increase in the number of people with long term conditions (LTCs), the number of people with more than one LTC, and the increasing complexity of these. This presents a significant challenge to the city, as these numbers are predicted to grow.

And despite the number of people of working age, and young people and families making Southampton their home, our population is getting older, a trend easily visible across the whole of the UK. More than 14% of our residents are 65 or over, and this is expected to rise to 22% by 2022.

This expected growth in population will lead to increased demands on services. Helping people to manage their own needs more effectively, including daily living activities, will be key.

Further information may be found at Public Health Southampton: www.publichealth.southampton.gov.uk/

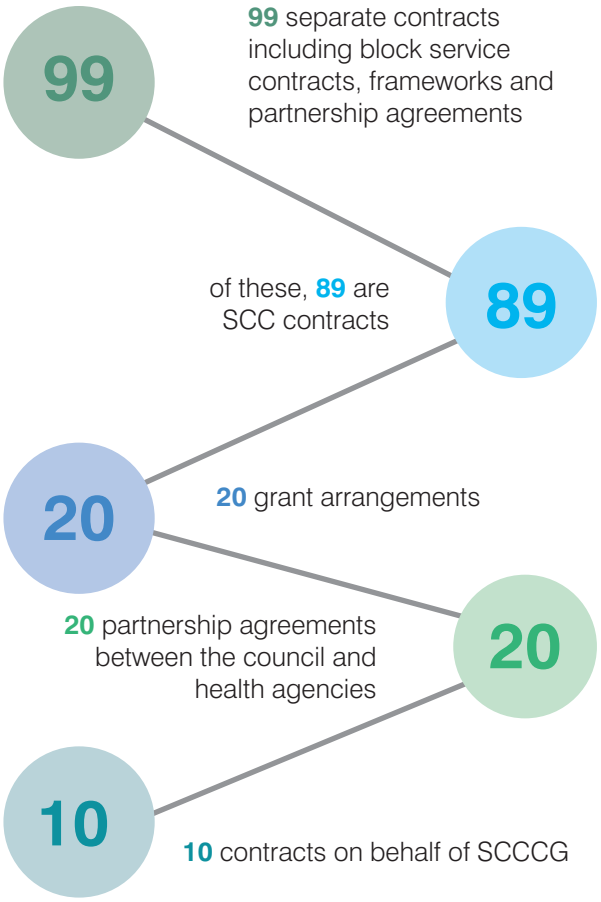
In 2019/20, 38% of the council's budget will be spent on Adult Social Care. This is consistent with the average spend by other unitary councils.

4 Integrated commissioning in Southampton

In Southampton, we joined up our commissioning responsibilities and arrangements between Southampton City Council (SCC) and Southampton City Clinical Commissioning Group (SCCCG), by creating the Integrated Commissioning Unit (ICU) in 2014.

These arrangements include a growing number of joint-funded contracts and partnership agreements, and ensure both organisations are best placed to commission a strong and sustainable care system for the city that continuously improves health and care outcomes for the city's residents through provision of efficient and effective high quality care services.

DIAGRAM 1
Integrated commissioning arrangements - at a glance

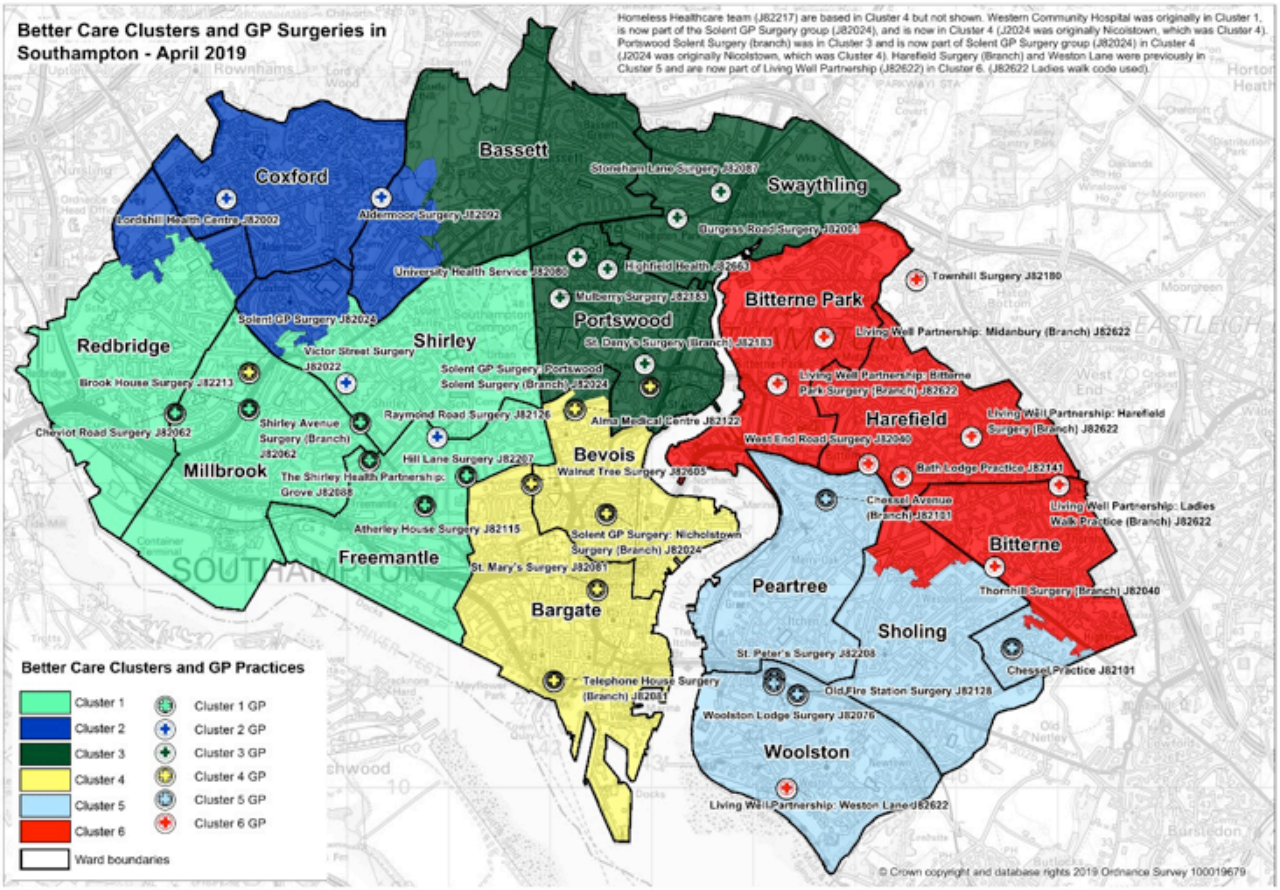


Most notably, both organisations have designed their services to meet the Better Care principles. In short, these seek to change the relationship between people in receipt of services and professionals supporting them, by empowering individuals to take charge of their care. These are:

- Promote, sustain and maximise independence, and discourage dependence on services
- Promote person centred approaches to care – enabling and empowering the individuals to be experts in their care
- Encourage community based interventions, and divert from institutionalised settings of care. This can relate to providing care and support in the community, as well as encouraging people to be more actively involved in the local community, reducing the feeling of isolation
- Promote the principles of preventative measures and timely interventions
- Promote needs-led, person-centred approach and encourage inclusive commissioning of services
- In addition to these, we are also exploring how technology can support people with sustaining independence and with managing their conditions.

In Southampton, we have been implementing this agenda by promoting localised solutions to care through locality (cluster) working. We are also promoting multi-disciplinary and holistic approaches to care. This is undertaken by encouraging joint working between statutory and non-statutory sectors, health and social care, acute and community sectors, mental health and physical health, with a special focus on people with complex needs.

DIAGRAM 2 Locality (cluster) map – including local GP surgeries



In addition, much of the ICU's business focuses on improving the standard and safety of care delivered. We also regularly undertake market management initiatives designed to maintain constructive relationships with providers and support them to respond to the changing needs of the city's residents.

The forthcoming strategic plan, *Transforming health and care outcomes for the people of Southampton,* details how key partners in the city will work together over the next five years to further improve the quality, efficiency, and effectiveness of the local health and care system. Key elements of the plan are detailed in the infographic below:

DIAGRAM 4 Transforming health and care outcomes for the people of Southampton

Our five year strategic framework (2019-2023)

DIAGRAM 3 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 gains an 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.

Southampton City Council and Southampton City CCG have also recently taken their integrated commissioning arrangements a step further through the formation of a Joint Commissioning Board, which steers the business of the ICU and makes delegated decisions on behalf of both organisations.

Southampton published its first Market Position Statement in 2015 (for 2015-2018). In 2018, the ICU published a Market Position Statement for Learning Disability services. A future Statement will focus on Mental Health services.

5 Our strategic direction and commissioning intentions for the next three years

This section details the status of current commissioning arrangements for older people's care and support services. It outlines our intentions for the future of these services, and details potential opportunities for the care market.

In line with the needs-led commissioning principles, it is likely that the services described in this document will be supporting a broad range of individuals. Needs mostly relate to ageing and frailty but also include people with additional needs e.g. mental health, disabilities, and those who would benefit from such services. It underpins the objectives to help people to age well.

For ease of reference, we have applied a tiered approach to outlining the provision, grouped by the complexity of need and support required.

5.1 Universal Offer

There is growing evidence of the positive impact of community approaches on the wellbeing of individuals. By contrast, there is a negative impact that social isolation and loneliness has on health and social care need.

Southampton has a thriving voluntary and community sector. We would like to build on this to achieve an increase in volume and breadth of activity available, in order to encourage broader involvement and inclusivity.

The development of the community and voluntary sector is one of the priorities within the Southampton Better Care plan and a key building block to achieving the vision for individuals and families to be at the centre of their care and support; for provision of the right care and support, in the right place, at the right time; to intervene earlier and build resilience in order to secure better outcomes by providing more coordinated, proactive services; to focus on prevention and early intervention. We are planning for more people to be supported in this less formal way, regardless of their level of need.

We currently operate the Southampton Information Directory (SID), which collates information about local organisations and activities. The directory provides an opportunity for services and groups to share their provision with other services and the residents of Southampton. If you are an organisation providing care in the city or a group providing activities, please make sure that your information is available on the website.

If you would like to view or upload information to SID please go to: https://sid.southampton.gov.uk/kb5/southampton/directory/home.page.

We will also be looking how best to ensure access to high quality, up-to-date information about the city's care and support services is maintained in the long term.

Market opportunities:

We are currently procuring a Community Solutions service comprised of an Integrated Community Development and Community Navigation service. The service will pull together the resources and coordinate various community development activities, including navigation, community development, and voluntary services support, including support to develop services and helping smaller groups to apply for funding. Estimated service value is approximately £0.45m per year, with a contract term of three years with a possible one year extension.

The council runs open, competitive grant schemes throughout the year, as and when funding becomes available. Our grant schemes mainly offer short-term funding for community projects or pilots. Schemes which are open for applications are advertised on our website: www.southampton.gov.uk/people-places/grants-funding/

We do not accept applications for grants outside of our advertised grant schemes.

We also produce monthly funding bulletins and newsletters, which provide information on other funders as well as advertising our own grants. You can sign up to receive the newsletter via our website: www.southampton.gov.uk/people-places/grants-funding/funding-newsletters.aspx

5.2 Support at Home and in Communities

We believe that providing the right care, at the right time is critical to the success of our commissioning vision, based on supporting people to stay independent and part of their communities.

Our most recent procurement for Home Care, built around the principles of the Better Care Agenda, embedded these principles within its service structure. Divided into lots, (Adults and Older People, People with Learning Disability, CHC funded care and Children's), the framework requires the provider market to develop flexible and personalised ways of engaging with individuals receiving support. It seeks creative solutions to meeting their needs. This prioritises holistic and outcome-focused interventions based on success of the relationship between the care provider and the individual. It encourages strengths-based approaches to care, engaging with and encouraging the use of supportive social networks, and providing the right information for clients and for those who care for them. These are aligned to localised multi-disciplinary teams, with a lead provider for each area, to promote further integration.

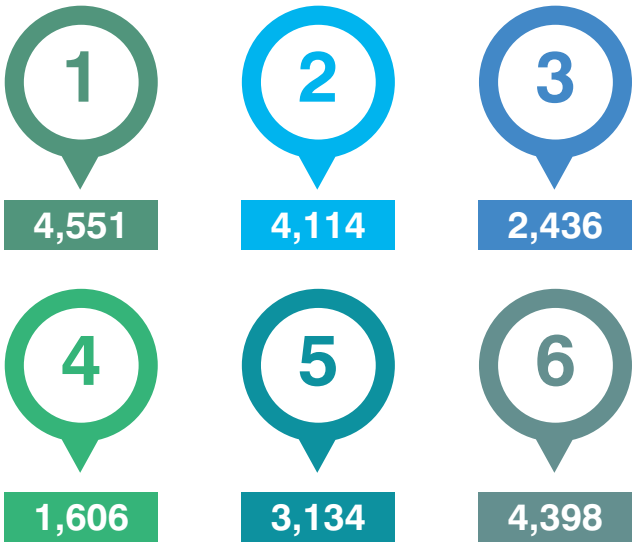
Lead providers for clusters that have housing with care schemes will be also responsible for providing care in these settings, have the opportunity to influence development of the operating model for these schemes, and develop essential partnerships with the community and local organisations in the area.

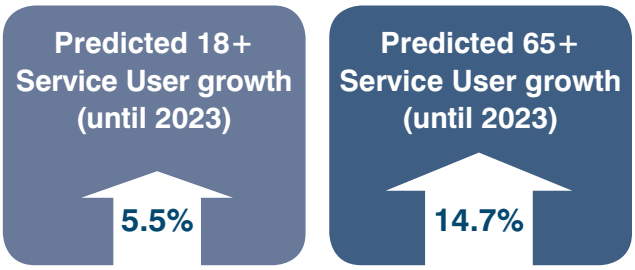
In addition, the ICU will support providers and promote workforce development that encourages capacity building in the market. We envisage that the need for home care will continue to grow, but as more community-based support is available, home care will focus more on people with higher level needs.

Alongside the home care services, we are currently working on remodelling day care provision. In future these will offer more bespoke and personalised support to local customers via a development of Living Well Hubs, based around cluster areas. Its aim is to develop the community presence of day activity provision, link it with local activities, agencies and volunteers, and promote and provide healthy living activities to help people maintain their physical and mental wellbeing. This provision will develop its community based role further to support older people in Southampton over the next few years.

DIAGRAM 5 Home Care demand – 6 cluster areas

Number of hours delivered per cluster per week (April 2019):





Market opportunities:

The current framework went live in April 2019 and will run for the period of four years with a possible two further year's extension. The framework will reopen annually to enable new providers to join. Logging on to the procurement portal will ensure that any interested providers are forewarned of the opening and able to apply. We strongly encourage all interested providers to sign up, as we may not be able to source care from providers outside of the framework.

https://supplysouthampton.esourcingportal.com/

We are particularly looking for home care providers who are able to support people with low level health needs, e.g. requiring enteral feeding or collar care, in the same way that a family member might support them. Jointly with the Urgent Response Team, we are working to develop a "bridging" service. We are actively seeking home care agencies willing to receive training to manage the activity in the long term, and develop bespoke services for people in need.

Throughout this period, SCC and SCCCG will also continue to promote personalised care by strengthening systems that enable residents to access personal budgets and direct payments.

The council is also continuing to fund training to care staff through it quality assurance programme.

5.3 Housing with Care

Individual wellbeing is promoted and protected when people with care and support needs are able to live independently, remain part of their community, and make choices about how their needs are met. As the individual's need for care increases or becomes more complex, remaining in one's own home can become more challenging, but many residents are expressing a preference to avoid and/or delay admission to a care home, so a more diverse range of bed-based care solutions is required.

In line with our commitment to support community based solutions to care, we are keen to invest in housing with care (or 'extra care' housing) and in the coming years we will be seeking to expand the local number of housing with care units significantly. We define housing with care as high quality, lifetime standard housing suitable for people with needs, be it mobility, cognition, or health, and with the right level of 24 hour care on

site to meet their care requirements. We are modelling these services to offer a genuine alternative to residential care and to expand people's choice of options for care in later life. This is particularly relevant to people with complex needs, dementia, and physical needs, but reflects other care groups too, including people with mental health needs and learning disability, and anyone who would benefit from the housing with care environment.

We currently have circa 170 housing with care units available across the city, and plan to grow the provision by between 400 and 500 by 2027.

Requirements for housing with care will be similar to those in the community. We envisage our schemes will be working with individuals ranging from very independent to those with more complex needs over longer periods of time. In 2020, we will have developed Potter's Court – a new housing with care scheme offering 84 units of accommodation. The scheme will be the first in the city which is not age-restricted, to cater to the needs of a wide range of individuals. As the care will be sourced from the home care framework, we will be working with providers to develop skills and expertise to support the increasing demand and complexity.

'Connectivity' is a key principle underpinning the way we are commissioning community development initiatives, day opportunities and other supportive interventions alongside housing with care. We are considering, for instance, how future schemes may include co-location of GP practices with other local businesses on site, and we would like housing with care to act as 'community hubs' that directly contribute to the wellbeing of the area around it, regardless of needs or age.

We would also like to improve pathways between housing with care, nursing care and acute care, to enable prompt discharges from hospital, assessments and access to accommodation. Our delayed transfers of care (DToC) do not currently benchmark well nationally, and we wish to improve this by investing in appropriate community provision, including tester flats and step-down provision.

Housing with care needs to be able to accommodate people with needs regardless of tenure, and as such we will be looking for appropriate delivery mechanisms to enable this. We are particularly interested in the affordability of provision, and will actively prioritise and promote schemes that offer good value for money.

Housing with care is a key component of the city's strategy for community regeneration, and growth of such schemes will make a significant contribution to the council's commitment to deliver 1000 homes in the next five years.

Market opportunities:

We would like to grow our housing with care supply in the coming years, and would like to speak to organisations wishing to develop this type of housing in the city.

We would like to expand on the tenure mix of housing with care available in the city.

To progress with developments, we have identified a number of land options available, including prime city centre locations.

We will also support housing with care developments under s.106 quota. We will be able to support developments endorsed by the ICU throughout the planning stages.

We will be reviewing our scheme based activity coordination and support offer across

all housing with care schemes. We invite all providers seeking to promote positive solutions to the activity offer and community engagement in supported housing schemes to work with us.

In addition to specialist housing for older people, we will be also supportive of smaller specialist housing developments to accommodate people with a range of needs, including mental health, physical disabilities, learning disabilities, autism and challenging behaviour. For further information, see: www.southampton.gov.uk/images/ld-market-position-statement_tcm63-405646.pdf).

5.4 Specialist Bed Based Provision (Residential and Nursing)

People with care and support needs are increasingly choosing to stay in their own homes for longer, seeking to avoid and/or delay placement in a care home. The city's supply of housing with care is also growing, giving people with care and support needs a more diverse range of community based support options to choose from. As a result, overall local demand for care home placements has reduced and is projected to further decline.

The exception to this is residential and nursing care suitable for people with cognitive impairments and/ or challenging behaviour, for which commissioners are actively developing and seeking further options for expanding the local supply.

5.4.1 Significant demand for complex and nursing care

We have a growing demand for nursing care. At any one time we have between 290 – 300 individuals in local authority funded nursing care. Of those, about 40% placements are outside of the city. Our preference would be to increase the supply of nursing care available within the city boundary.

We are also seeking to increase access to complex care within the city; this includes patients needing tracheostomy care and ventilation, as well as other needs. We will be looking to secure a number of nursing placements for people with a wide range of needs, predominantly focused around ageing, but which could also include challenging behaviour, dementia, issues relating to mental health, and learning disabilities. We would encourage providers to make reasonable adjustments to cater to the needs of these client groups.

In the coming months, and years, we will be seeking to source more nursing capacity to sit within the community/hospital system pathways. This is to meet rising demand for complex care in a way that ensures people are supported in the most appropriate, and least restrictive way. Our main driver for these will be the appropriateness, sustainability and the affordability of placements.

In line with our vision for community based support and independence, we wish to explore any models of care which can support individuals' reablement and reintegration into the broader community, after a residential or nursing home stay. We believe that the right planning and timely interventions can support individuals currently living in residential and nursing homes to successfully relocate to housing with care (and other step down provision), to enable more independent and presonalised lifestyles and outcomes. This work will also aim to inform people and families of their best choices to keep themselves independent and safe for as long as possible, reducing the likelihood of reliance on the council for funding.

We are rolling out Discharge to Assess (D2A) for people with more complex needs discharged from hospital. Recognising this group of patients will have needs which often go beyond what can be safely managed in their own homes, we are keen to work with local nursing home providers who are able to work with us flexibly to support people for an interim period of time (up to 6 weeks) whilst their needs are fully assessed. We envisage around 2-3 patients a week leaving hospital on the complex D2A pathway.

We are currently working with the care home market to improve hospital discharge, noting that weekend discharge is a particular issue. We are exploring the potential for trusted assessment for care home placements for people leaving hospital and would be keen to hear views from care home providers about how we could improve the quality and responsiveness of discharge from hospital to care home. This is particularly relevant to people with dementia and/or challenging needs seeking to access residential care provision.

In the coming months we will be scoping the ongoing need for the equipment provision which meets the changing needs of our clients. We are keen to learn about similar successful initiatives in other areas of the country.

5.4.2 Quality assurance in local services

The ICU is host to the Quality Assurance team, working directly with all care homes in Southampton to support and develop their quality, safeguarding and care standards. The team has an excellent track record in identifying and improving issues, working collaboratively with homes on managing these, and improving CQC ratings accordingly. The vast majority of our homes have at least a 'Good' rating, and this has been a steadily increasing trend in the recent years.

DIAGRAM 6

Residential and nursing homes in Southampton - CQC inspection results (October 2018)

Good	33	87%
Requires Improvement	3	8%
Not Yet Inspected	2	5%
Total	**38**	**100%**

In addition we run a number of initiatives seeking to boost the overall quality of homes by educating, supporting and up skilling providers in a number of areas, sharing best practice and providing training in relevant areas. Recent training initiatives include hydration training, wounds training, NEWS (National Early Warning Signs), management and training support programmes for nursing home managers, and others.

We run the Enhanced Health in Care Homes (EHCH) initiative. This is designed to reduce unnecessary hospital conveyance and admission from care homes by ensuring that all residents receive a proactive comprehensive assessment of need, and proactive care following an incident or concern. Empowering care home staff and their leadership teams through dedicated training and guidance will result in enhanced quality of the service and regulatory compliance.

In the coming years we will be reviewing a number of Quality and Safeguarding processes, and moving to digitally-driven solutions to monitoring the quality of the

services. We will encourage providers to consider how technology can support day to day business operations. We will encourage the use of a digital self-assessment portal, secure information sharing and email, and connected workplaces (e.g. access to Wi-Fi for visiting professionals).

Southampton City Council has recently become the first council to sign the Residential Care Charter and the ICU will be working with care homes to support the implementation of the charter. We have plans to address future staff shortages within the care sector, and we will be placing significant importance on the development and upskilling of the city's care workforce.

Market opportunities:

We are seeking providers willing to invest in and develop nursing home capacity within the city, particularly for people with more complex needs e.g. dementia, physical disability or mental health. We would like to create partnership opportunities and access arrangements with the right number of partners to meet the growing demand. We have identified potential sites suitable for re-development. We would welcome prospective providers to speak to us.

In addition:

We will continue to build on our current access arrangements to sustainable and affordable nursing provision and will seek active engagement from the market in shaping these proposals. This includes further progression on hub services for people in the community, to enable appropriate access to support.

We will be particularly keen to discuss any service provision which can cater to the needs of people with dementia and physical disabilities, as well as mental health needs and learning disabilities for an ageing population.

We are keen to work with current homes which seek to upgrade and specialise in nursing provision and we can support with either applying for or accessing funding.

We will be keen to scope out and develop provision offering a step-down and reablement service for people currently staying in residential and nursing facilities, to successfully support moves into housing based models of care.

We are keen to hear from providers wishing to support with the development of D2A pathways, or participate in the development of the trusted assessor scheme.

6 Further market development and sustainability initiatives

At the time of writing, the sector is facing a number of uncertainties which have significant implications, such as Brexit, delayed publication of the Social Care Green Paper (and long term funding arrangements), and challenges for the image of the sector as a whole. We will be seeking to support the market to respond effectively to these challenges through partnership working, planning and risk sharing, whenever appropriate.

We are currently undertaking research designed to better understand the costs of care, issues affecting sustainability of the local care market and potential future pressures including inflation and National Minimum Wage. We will be seeking to engage with providers to get their views on this.

We have had relatively low take up of direct payments and personal health budgets. Recent service re-design and procurement will have a positive impact on our performance in this regard, however, we would welcome further discussion with providers on how to improve our results in these areas.

Over the coming years, we will be seeking to develop a more robust picture of the local self-funding market, to ensure compliance with duties under the Care Act, and to better understand how changes to this segment of the market may be affecting the local supply of publicly-funded care.

Over the period of 2019 – 2022 we will be mapping out and planning our market position and publication timetable in relation to other commissioned services and client groups.

7 Ways to get in touch

We hope that the following outline has provided some clarity on our strategic direction. We are always keen to hear from people and organisations who wish to work with us, or find out more about the City.

If you would like to speak to us about this document or discuss joint working opportunities, please contact us at market.development@southampton.gov.uk.

We look forward to hearing from you.

This page is intentionally left blank

DECISION-MAKER:		JOINT COMMISISONING BOARD		
SUBJECT:		TRANSFORMING HEALTH AND CARE FOR THE PEOPLE OF SOUTHAMPTON: OUR FIVE YEAR STRATEGIC PLAN 2019–2023		
DATE OF DECISION:		20 JUNE 2019		
REPORT OF:		JAMES RIMMER, MANAGING DIRECTOR, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	Clare Young	**Tel:**	023 8029 6904
	E-mail:	clare.young4@nhs.net		
Director	**Name:**	James Rimmer	**Tel:**	023 8029 6904
	E-mail:	james.rimmer3@nhs.net		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY This draft strategic plan sets out a high level view of the challenges we face and proposes a framework to guide the activities of all partners over the next five years.		
RECOMMENDATIONS: That the Panel		
	(i)	Considers and provides feedback on the draft strategy.
REASONS FOR REPORT RECOMMENDATIONS		
1.	For Joint Commissioning Board to endorse the current draft of the five year strategic plan.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable.	
DETAIL (Including consultation carried out)		
3.	Work started during the summer of 2018 on the preparation of a new five year strategy for health and care in the City. This involved detailed analysis into the health and wellbeing of the population, linked to deprivation and service use. In discussion with partners, it was agreed to develop a response to these needs that goes beyond the NHS into social care and wider, which can be owned by all of our partners in the City. It remains, nonetheless, a subset of the wider ten year strategy for health and wellbeing led by the Health and Wellbeing Board. The new draft strategy, Appendix One, incorporates feedback from: • Health and Wellbeing Board • Joint Commissioning Board (JCB) • Southampton System Chiefs Group • Southampton Connect	

	• Better Care Steering Board • Health Overview and Scrutiny Panel (HOSP) We have held two partnership conferences on the theme of the emerging strategy, on 29 March and 8 May 2019. A community engagement event was held on 20 November 2018 to support increased public participation in the development of the strategy. Alongside this, opportunities have been taken to share information and invite discussion of the emerging plans with Healthwatch Southampton, the CCG Patients' Forum, Southampton Voluntary Services (SVS) and a wide variety of other community groups. Public involvement will be an ongoing feature of the way we work. The Strategy in its current draft form was endorsed by the CCG's Governing Body on 22 May 2019. Following this, John Richards, former CCG Chief Executive Officer, wrote to all partner organisations involved in the formation of the draft strategy to secure the support of their boards and their commitment to its implementation. A copy of this letter is made available to the Panel in Appendix Two. JCB are asked for feedback. At this time the draft strategy sets out the challenges which require addressing. We will now proceed, subject to support from partners, to incorporate further details on how those challenges will be addressed and how improvements will be delivered over the next five years into the final version of the strategy.
RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	Not applicable.
Property/Other	
6.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	Not applicable.
Other Legal Implications:	
8.	None.
RISK MANAGEMENT IMPLICATIONS	
9.	None.
POLICY FRAMEWORK IMPLICATIONS	
10.	Not applicable.

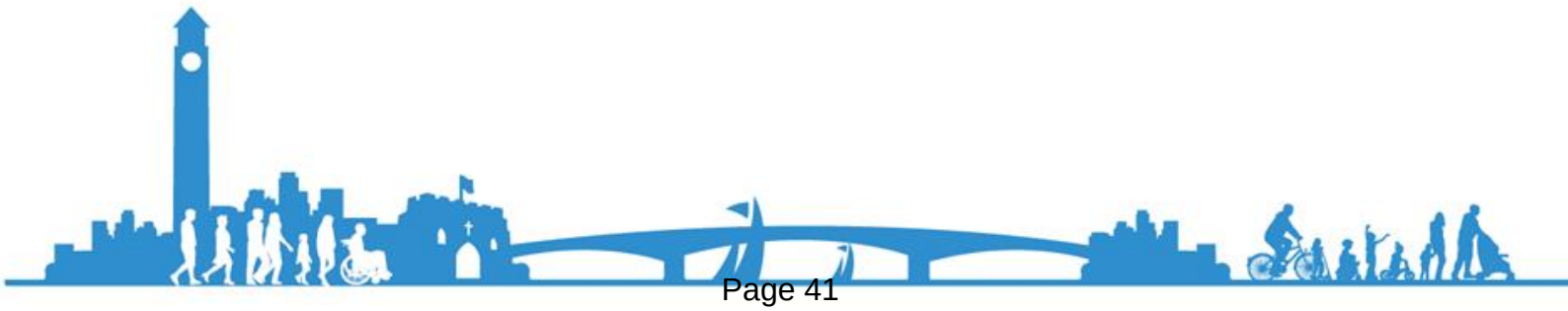
KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION		
Appendices		
1.	TRANSFORMING HEALTH AND CARE OUTCOMES FOR THE PEOPLE OF SOUTHAMPTON: OUR FIVE YEAR STRATEGIC PLAN 2019–2023	
2.	LETTER TO PARTNERS FROM JOHN RICHARDS (DATED 29 MAY 2019)	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)		
1.	None	

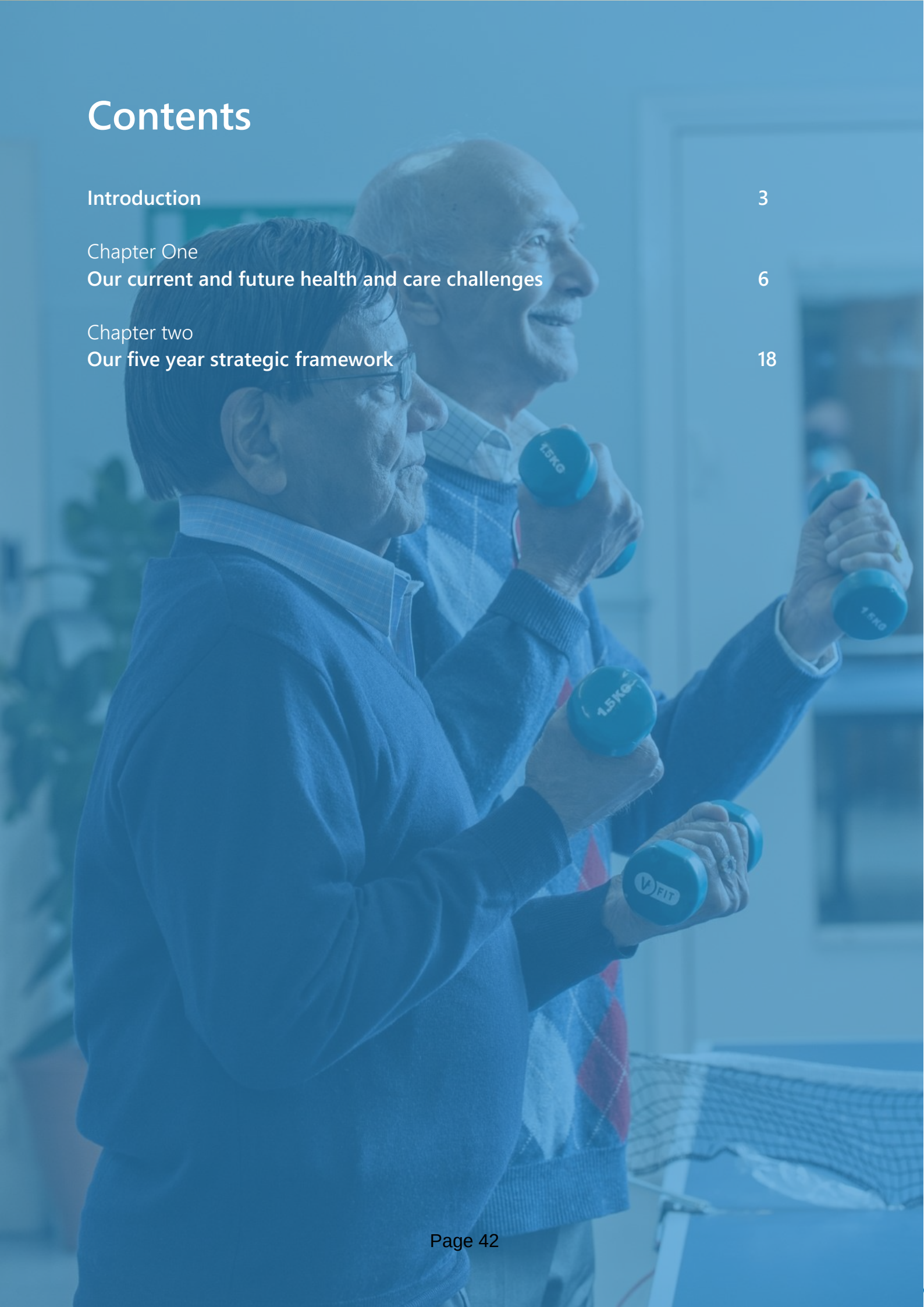
This page is intentionally left blank

Transforming health and care outcomes for the people of Southampton

Our five year strategic plan
2019–2023



Contents



Introducing our five year strategic plan

Work started during the summer of 2018 on the preparation of a new five year strategy for health and care in the City. This involved detailed analysis into the health and wellbeing of the population, linked to deprivation and service use. In discussion with partners, it was agreed to develop a response to these needs that goes beyond the NHS into social care and wider, which can be owned by all of our partners in the City. It remains, nonetheless, a subset of the wider ten year strategy for health and wellbeing led by the Health and Wellbeing Board.

In early 2019, the NHS Long Term Plan (LTP) was published and it has been agreed that Southampton's strategic plan should also be the City's contribution to the wider Hampshire and Isle of Wight five year response to the LTP which is due later in Autumn.

Our strategic plan sets out a high level view of the challenges we face and proposes a framework to guide the activities of all partners over the next five years.

The strategic framework is summarised on page 20, including our proposed vision, goals, mission, programmes and enablers, and principles of working together. These have been widely supported and developed by partners.

The framework incorporates feedback from various system-wide bodies including:

- Health and Wellbeing Board
- Joint Commissioning Board (JCB)
- Southampton System Chiefs Group
- Southampton Connect
- Better Care Steering Board
- Health Overview and Scrutiny Panel (HOSP)

We have held two partnership conferences on the theme of the emerging strategy, on 29 March and 8 May 2019.

A community engagement event was held on 20 November 2018 to support increased public participation in the development of the strategy. Alongside this, opportunities have been taken to share information and invite discussion of the emerging plans with Healthwatch, the CCG Patients' Forum, Southampton Voluntary Services (SVS) and a wide variety of other community groups. Public involvement will be an ongoing feature of the way we work.

Looking back

2018/19 was the final year of the CCG's five year strategy and, similarly, of our two year operational plan. Since summer 2018, we have been undertaking a stocktake of our position and reviewing the outcomes and prospects for our population.

First, we reviewed the outcomes of our CCG strategy published in 2014. There were eight outcome indicators we set:

- Improved patient safety and user experience
- Reduced inequalities in life expectancy
- Reduced avoidable emergency admissions*
- More older people living independently (91 days after reablement)*
- Fewer permanent admissions to nursing and residential homes*
- Fewer delayed transfers of care*
- Reduced injuries dues to falls in people aged over 65*
- 20% productivity improvement in elective care

*Outcomes marked with an asterisk were also outcomes we specified in the Better Care Plan

The results of our stocktake were mostly positive. We considered whether we had done what we said we were going to do, if not why not, and what had we learned in the process.

Whilst we have done relatively well on our own terms as a CCG, we wanted to focus on our challenges as a City.

We looked at what had happened to our population over the last few years. We were able to review how deprivation across the city has affected health, such as disease prevalence, and utilisation of healthcare services in the city (for example, emergency hospital admissions). This revealed a stark picture of growing inequalities across the city and gaps in life expectancy.

We also reconfirmed that the City performs poorly by comparison with our statistical neighbours and nationally. For example, Southampton is ranked second worst of our 10 comparator CCGs and 35th worst out of all 201 CCGs in terms of inequalities in the rates of emergency admissions for certain urgent care sensitive conditions. This gives us a powerful indicator of where we need to focus over the next few years.

The analysis into rates of emergency admissions is particularly useful as an indicator of need (assuming people are only admitted to hospital as emergencies if they are seriously unwell) as opposed to demand (which may be influenced by the convenience of access, for example, to A&E). We found that the most deprived areas of the city were also the places with the highest rates of emergency admissions. These admissions are probably a good indicator of where we are failing to prevent ill health or to provide planned care interventions that could have avoided an emergency admission.

Thus, if we can target what we do to focus on improving access to prevention and earlier, planned intervention in these areas of the city, we may reduce the inequalities gap and improve health outcomes overall.

Our analysis also enabled us to see at a detailed population level how varied health and healthcare usage is across the City. We were able to break down admissions by age, gender and ethnicity for different health conditions (e.g. cardiac, respiratory, diabetes and mental health). This analysis provides each of the six health and care clusters with rich data about the particular challenges for their local populations.

We have also been able to look at population and long term conditions projections for the period ahead to help predict future healthcare demand, and demand for social care.

Broadening the scope

It has become apparent that to understand what is happening to our population in the city, we need to look wider than just health. The picture of increased deprivation and its palpable impact on health, and of widening inequalities between different communities, raises challenges about the resilience of the population as a whole. It also means we have to take a system-wide perspective in our plan for the next five years.

First, this plan has to be a plan for social care too. It is true that the quality and capacity of social care provision has an important impact on the health service. It is also argued that whilst initiatives to fund directly, or transfer funding

from the NHS to social care, have tended to be focussed on initiatives to get people home from hospital, this may have skewed social care priorities. This means that the years of reductions to local government funding of social care have cut even deeper into the provision of 'core' social care which helps to keep people healthy and independent.

But social care is not just there to support the NHS. It has a huge value in its own right as part of the fabric, the social solidarity, of society as a whole.

Evidence suggests there has been a serious deterioration in the mental and emotional wellbeing of people living in the City, whereby mental wellbeing is now increasingly a factor in people's presenting needs across every aspect of healthcare. So, the plan has to be a plan for health and wellbeing.

Furthermore, we know that communities themselves, and wider civil society (including police, fire and rescue, probation, education, employment support, housing and so on) have a huge role to play in the determinants of health and wellbeing. The plan has to be relevant to and owned by communities and partners right across the City as a whole.

The NHS often struggles to comprehend the meaning of 'place', assuming instead our health planning is all about hospitals and healthcare institutions. This would be to miss the point on so many levels. This is why we are passionate about our One City approach: the importance of engaging, mobilising and galvanising a wide range of partners including citizens themselves, to develop and be part of implementing the plan for the next five years and beyond.

Looking Forward

This has generated some constructive discussions with our health and care partners and a shared intention to develop a new five year strategy for health and care in the city as a whole. At the end of March 2019, we held a partnership conference to take stock of our emerging city strategy and to invite partners to own and commit to its development.

In January 2019, we received the new Long Term Plan from NHS England which has been prepared in response to the Prime Minister's announcement in May 2018 of a five year funding settlement of £20 billion in return for which it is clear that the Government expects to see NHS provider finances restored to balance, NHS Constitution standards performance recovered, and other improvements.

Alongside the development of the new five year strategy for the city as whole, we agreed that 2019/20 would be the right time to also review the CCG's primary care strategy. With the recent publication of the new GP contract, including ambitious plans for investing in new workforce and the development of primary care networks (PCNs), primary care development will be a major focus this year.

The October 2018 Planning Letter sets out the expectation that local areas will prepare their five year plans during the first half of 2019, due in Autumn.

2019/20 begins the new period in our work to improve health and wellbeing in the city.

Chapter One

Our Current and Future Health and Care Challenges

Deprivation & Health Inequalities in Southampton

Deprivation

The Index of Multiple Deprivation (IMD) measures deprivation for small areas at a neighbourhood level. In Southampton, there are 148 small neighbourhoods, of which each has a deprivation ranking.

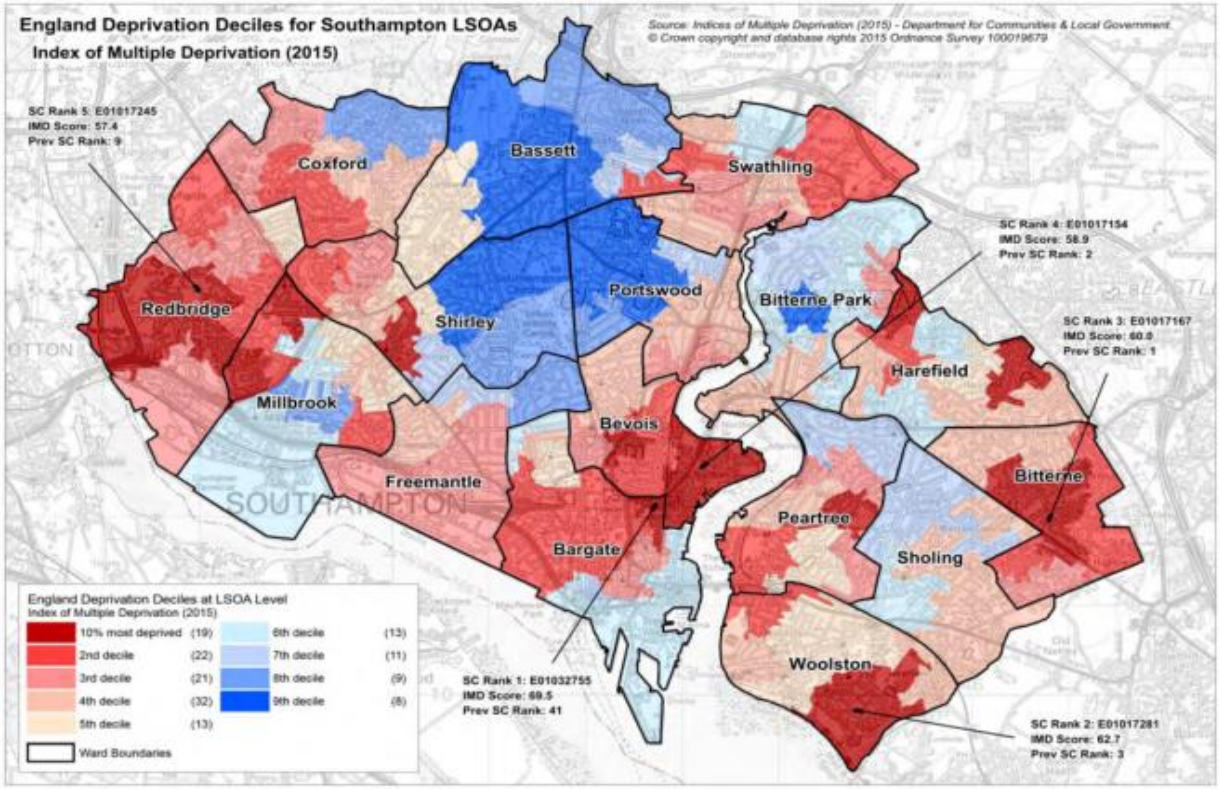
The map below show levels of deprivation across the city. The darker shades of red indicate areas in Southampton which fall into the 10 per cent most deprived neighbourhoods nationally. The darker shades of blue indicate areas in Southampton which fall into the least deprived neighbourhoods nationally.

In Southampton, 19 of the 148 neighbourhoods fall into the 10 per cent most deprived neighbourhoods nationally.

Overall, Southampton is ranked the 54th most deprived local authority out of 326 local authorities in England.

There is a common misconception that deprivation means how affluent an area is. To some extent this is true, however the IMD measures seven domains which contribute to deprivation (weightings in percentages):

- Income (22.5 per cent)
- Employment (22.5 per cent)
- Education (13.5 per cent)
- Health (13.5 per cent)
- Crime (9.3 per cent)
- Barriers to housing and services (9.3 per cent)
- Living environment (9.3 per cent)



Health Inequalities

"Inequalities are a matter of life and death, of health and sickness, of wellbeing and misery. The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health. Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age."
The Marmot Review, 2010

In Southampton, deprivation and health inequalities are inextricably linked – inequalities in health result from inequalities in society. In a fair society, health outcomes would be equal for people living in the most and least deprived areas of the city. However, there is a social gradient in health – the lower a person's social position, the worse his or her health. The existence of health inequalities in Southampton means that the right of our residents to the highest attainable standard of physical and mental health is not being enjoyed equally across the population.

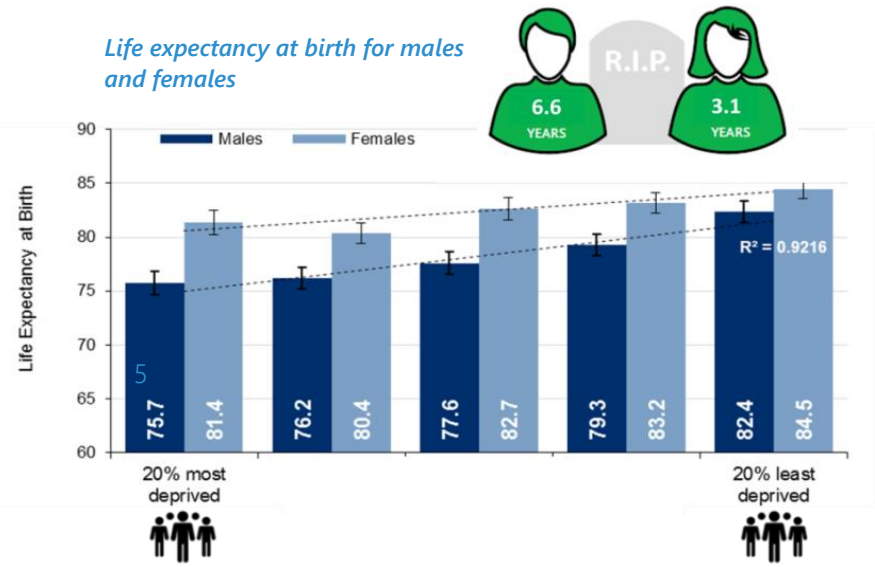
The social gradient in heath in Southampton is demonstrated in the following graphs which show that inequalities in health are related to inequalities in social status.

Inequalities in Life Expectancy

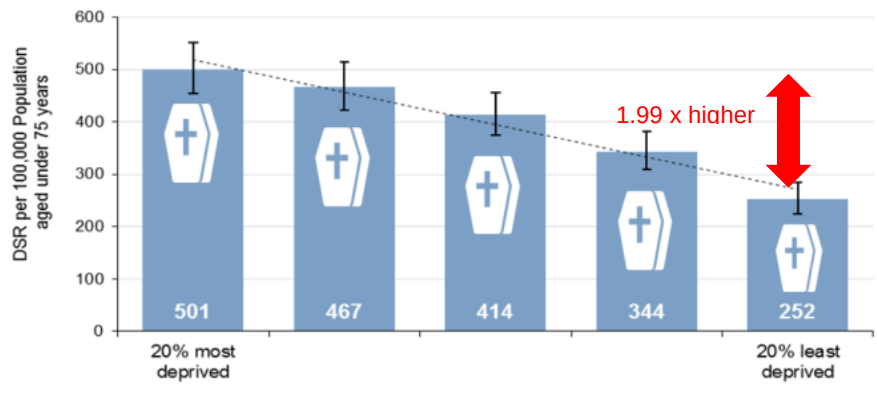
In Southampton, people living in the most deprived areas of the city **die earlier** than those living in the least deprived areas. Males living in the most deprived areas of the city are likely to die 6.5 years earlier than males living in the less deprived areas of the city. Females living in the most deprived areas of the city are likely to die 3.1 years earlier than females living in the less deprived areas of the city.

Premature deaths (defined as deaths under the age of 75 years) from all causes are twice as high in the most deprived areas of the city than the least deprived areas of the city.

Life expectancy at birth for males and females



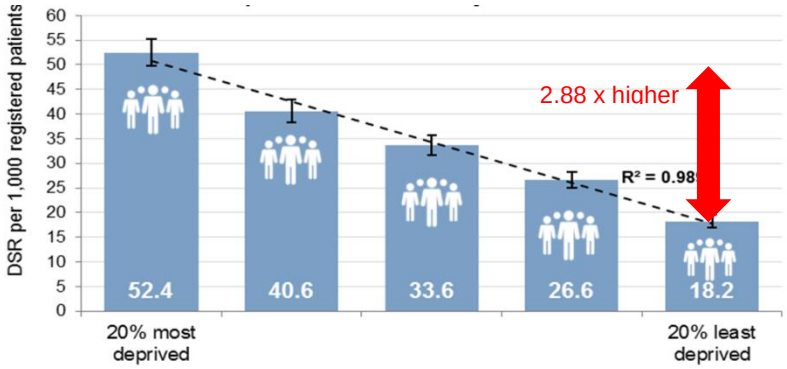
Premature deaths from all causes



Inequalities in Long Term Conditions

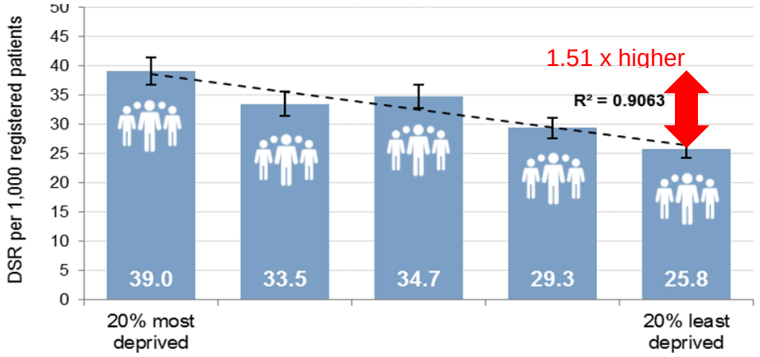
Prevalence of Chronic Obstructive Pulmonary Disease (COPD) is nearly three times higher in the most deprived areas of the city compared to the least deprived areas.

Chronic Obstructive Pulmonary Disease (COPD) Prevalence



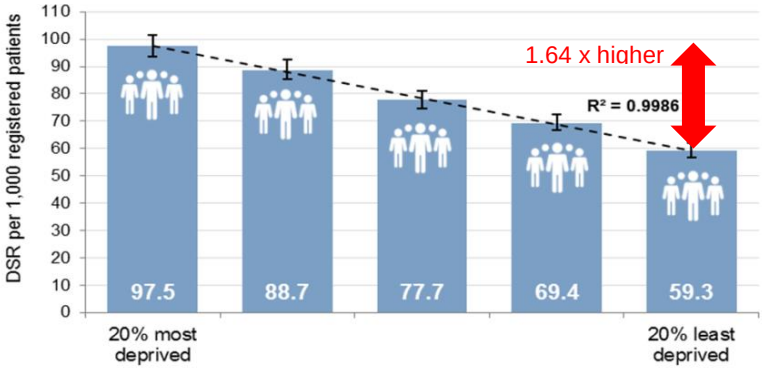
Prevalence of Coronary Heart Disease (CHD) is one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Coronary Heart Disease (CHD) Prevalence



Prevalence of Diabetes is over one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

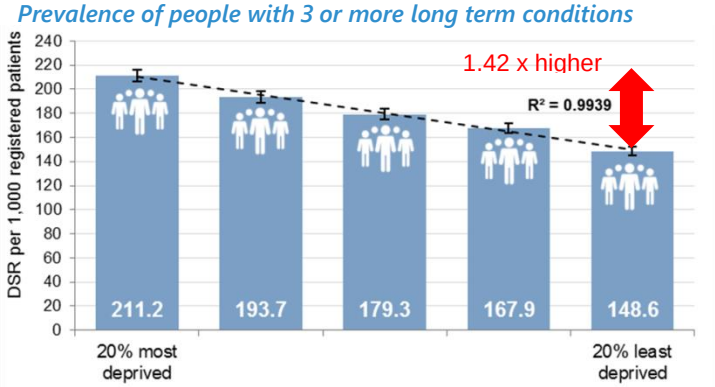
Diabetes Prevalence



Inequalities in Multi-morbidity

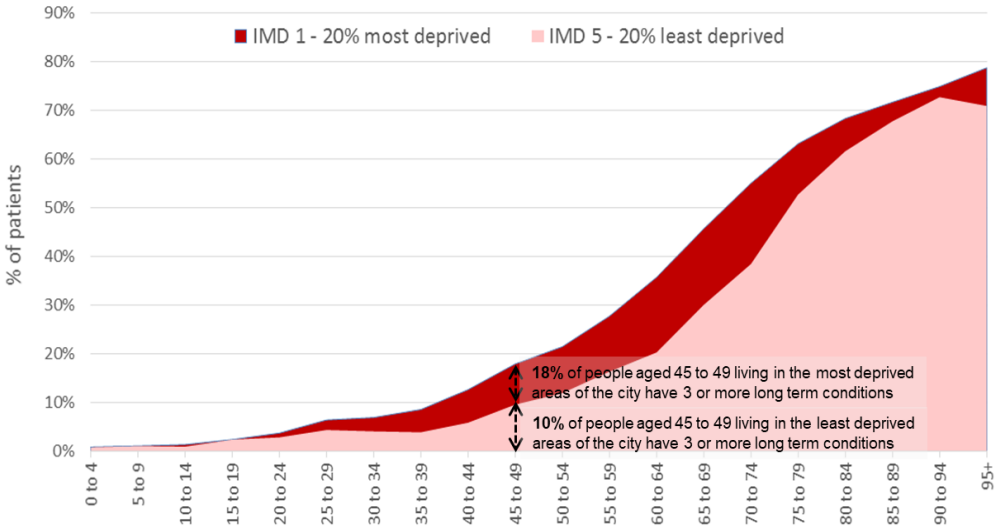
The prevalence of people living with multiple long term conditions (multi-morbidity) is higher in the most deprived areas of the city compared to the least deprived areas. For example, prevalence of people with three or more long term conditions is nearly one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Prevalence of people with 3 or more long term conditions



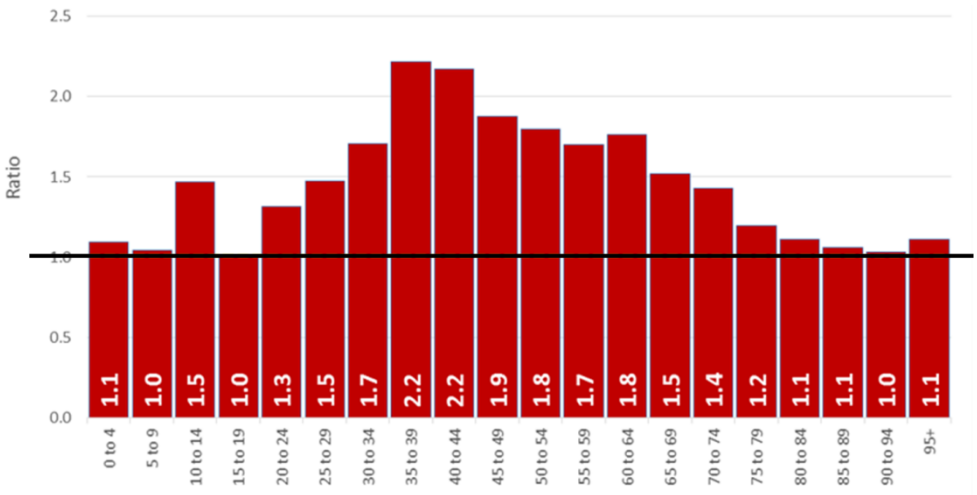
This graph shows the proportion of people in Southampton with three or more long term conditions, by age group. Importantly, it shows the proportions by deprivation group. For example, 10% of people aged 45 to 49 living in the least deprived areas of the city have three or more long term conditions, compared to 18% in the most deprived areas.

Proportion of people with 3 or more long term conditions, by age group



This graph demonstrates a similar trend. It shows how many times higher the prevalence is for people living in Southampton with three or more long term conditions in the most deprived compared to the least deprived areas. For example, it shows that for the 35 to 39 year old age group, prevalence of multi-morbidity is more than two times (x2.2) higher in the most deprived areas of the city compared to the least deprived areas.

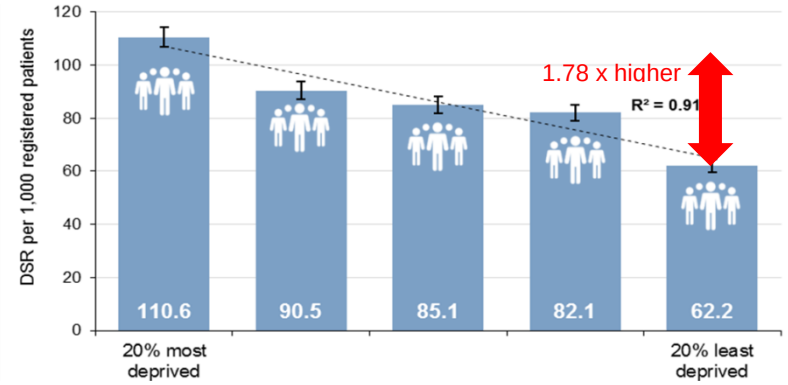
Proportion of people with 3 or more long term conditions, by age group: how many times higher in the most deprived areas of the city



Inequalities in Mental Health

Prevalence of Depression is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

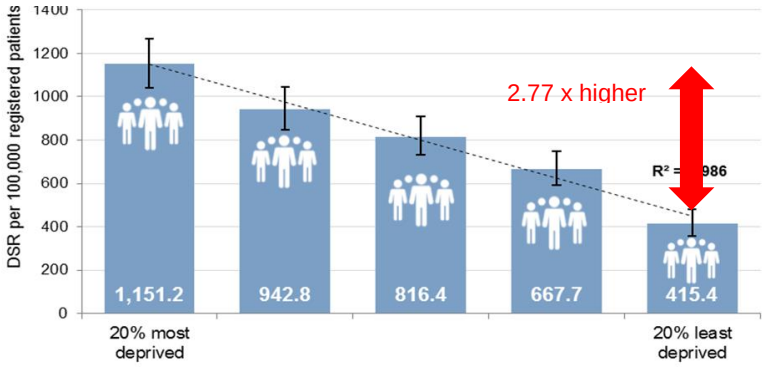
Depression Prevalence



Prevalence of Schizophrenia is nearly three times higher in the most deprived areas of the city compared to the least deprived areas.

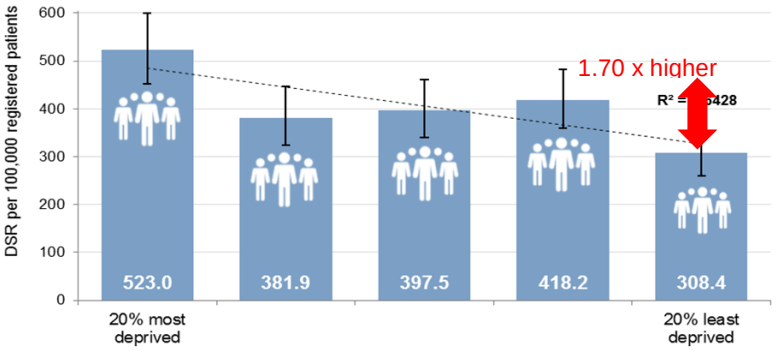
.

Schizophrenia Prevalence



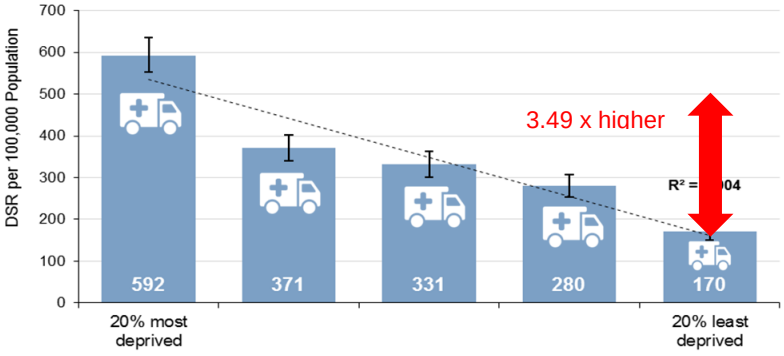
Prevalence of Bipolar Disorder is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Bipolar Prevalence



Emergency admissions as a result of intentional self-harm are three and a half times higher in the most deprived areas of the city compared to the least deprived areas.

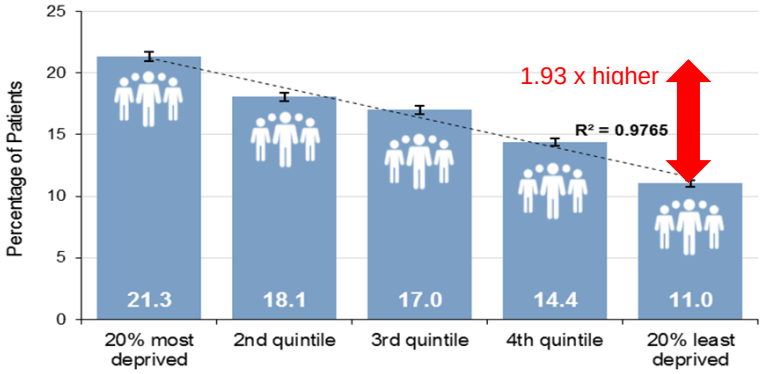
Intentional self-harm emergency admissions



Inequalities in Health Behaviours

Prevalence of Smoking is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

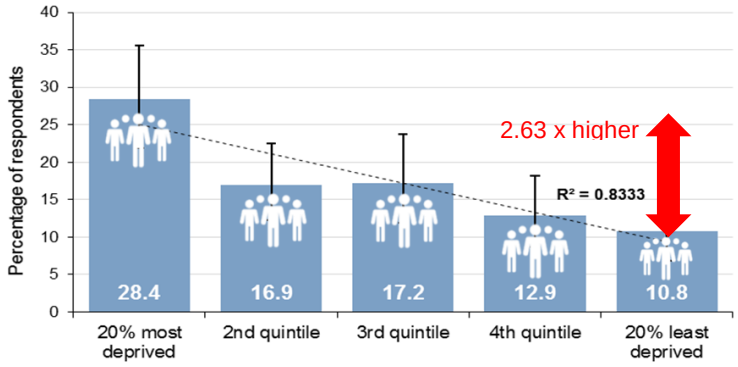
Smoking Prevalence



Prevalence of inactivity is over two and a half times higher in the most deprived areas of the city compared to the least deprived areas.

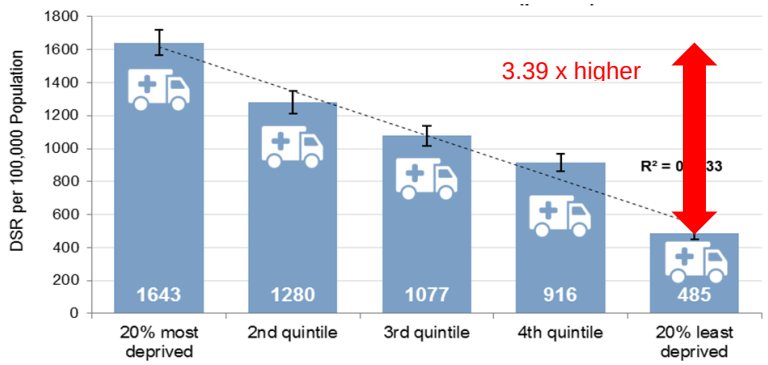
.

Inactivity Prevalence



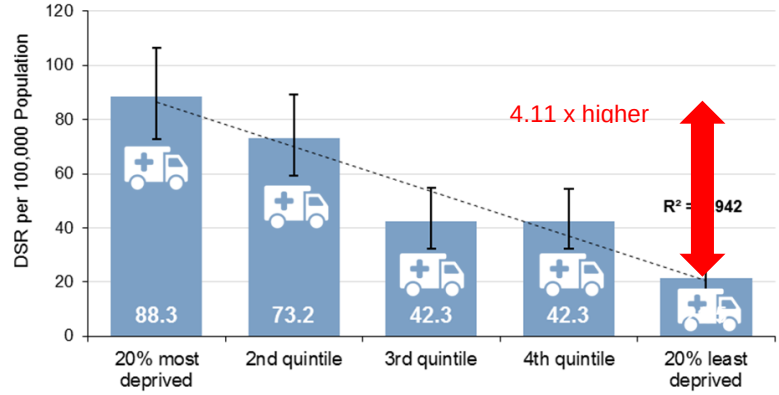
Emergency admissions from alcohol-specific conditions is nearly three and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Emergency admissions from alcohol-specific conditions



Emergency admissions as a result of poisoning from illicit drugs are over four times higher in the most deprived areas of the city compared to the least deprived areas.

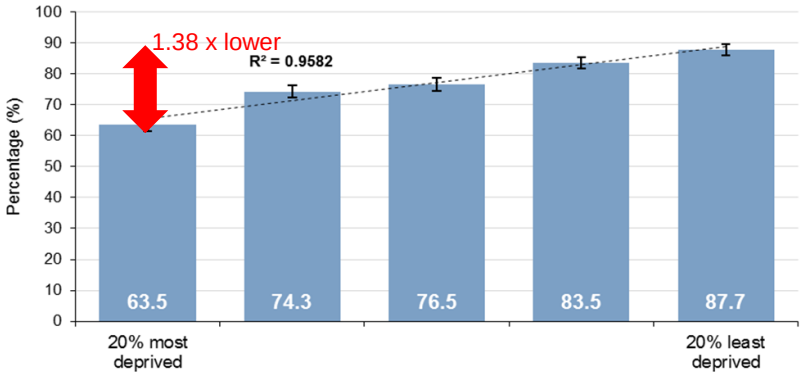
Emergency admissions from poisoning of illicit drugs



Inequalities in Healthy Start in Life

Prevalence of mothers breastfeeding is almost one and a half times lower in the most deprived areas of the city compared to the least deprived areas.

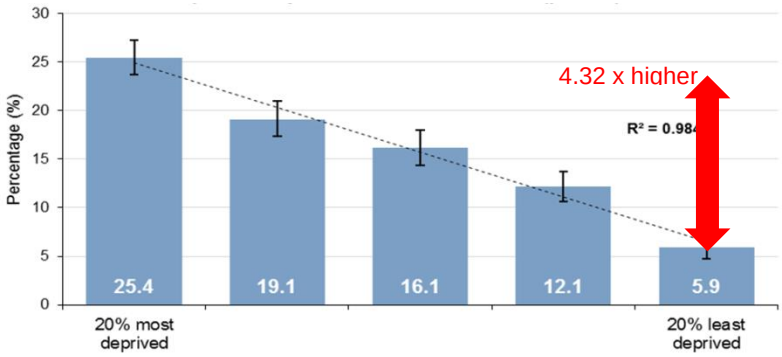
Breastfeeding Prevalence



Prevalence of mothers smoking during pregnancy is over four times higher in the most deprived areas of the city compared to the least deprived areas.

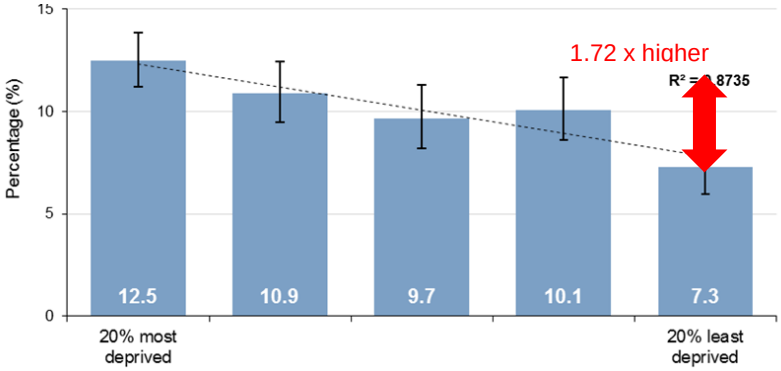
.

Smoking during Pregnancy Prevalence



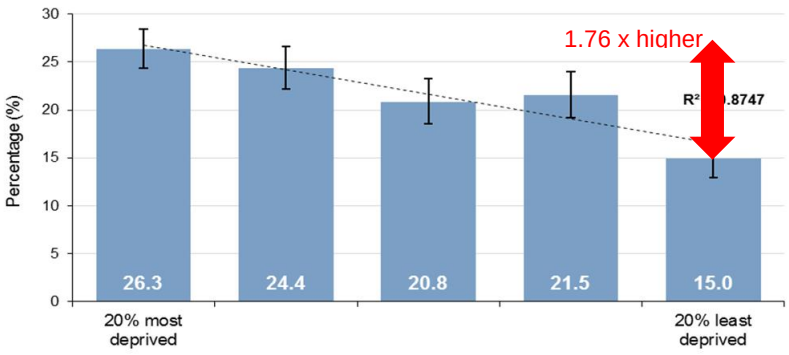
Prevalence of children considered to be obese in Year R is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Year R Obesity Prevalence



Prevalence of children considered to be obese in Year 6 is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

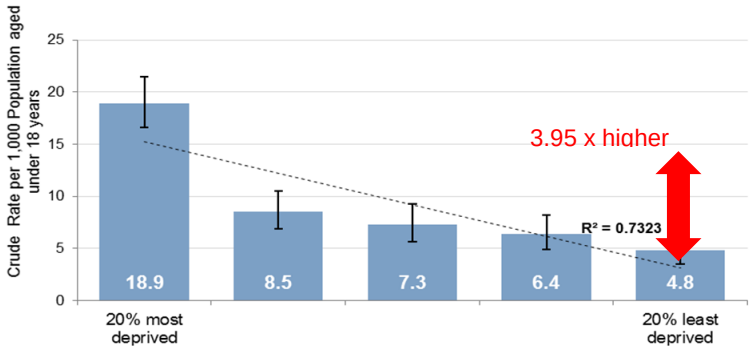
Year 6 Obesity Prevalence



Inequalities in Wider Determinants of Health

The rate of looked after children (children in care) is nearly four times higher in the most deprived areas of the city compared to the least deprived areas.

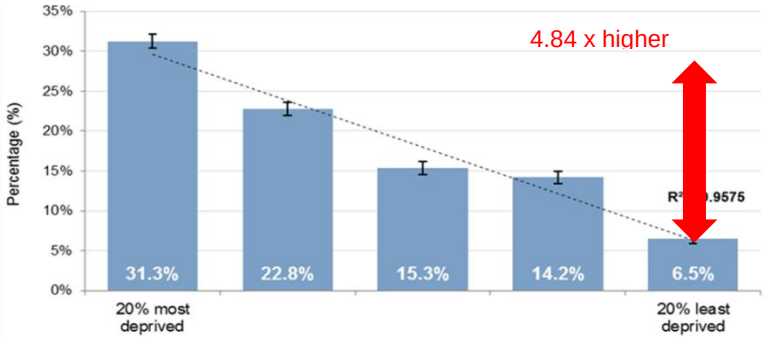
Rate of looked after children



Prevalence of children living in poverty is nearly five times higher in the most deprived areas of the city compared to the least deprived areas.

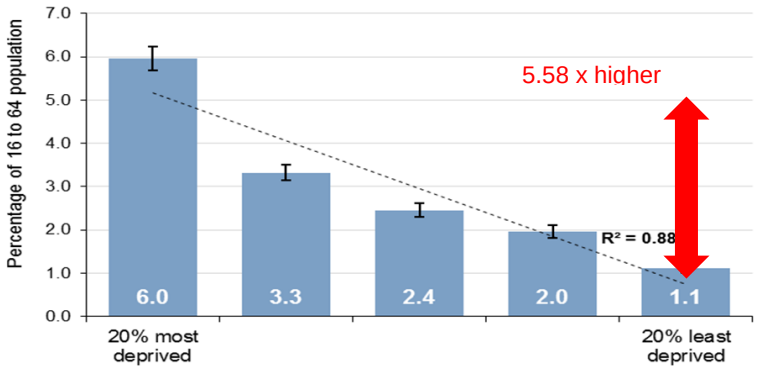
.

Children living in poverty



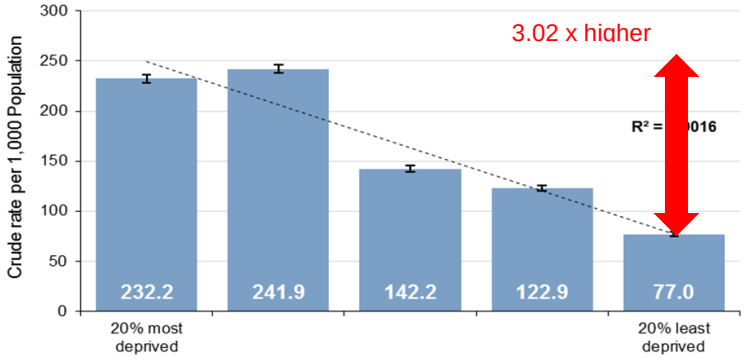
Prevalence of people claiming out of work benefits is five and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Claimants of out of work benefits (aged 16 to 64)



Prevalence of police recorded crime is three times higher in the most deprived areas of the city compared to the least deprived areas.

Police recorded crime

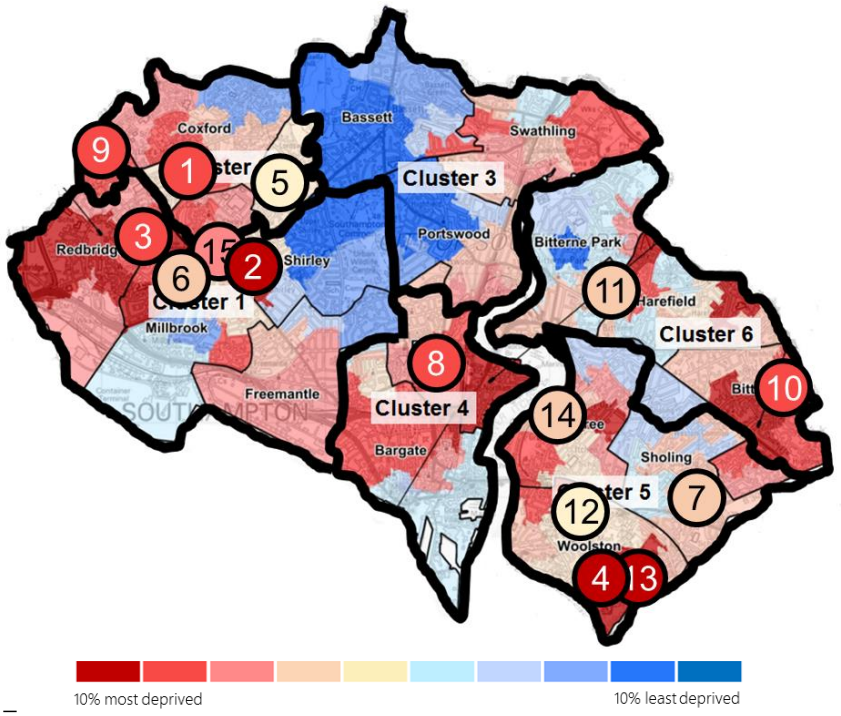


How is deprivation affecting healthcare usage?

In Southampton, there is a strong link between deprivation and rates of urgent healthcare usage. We have found that areas of the highest deprivation are also the places with the highest rates of emergency admissions.

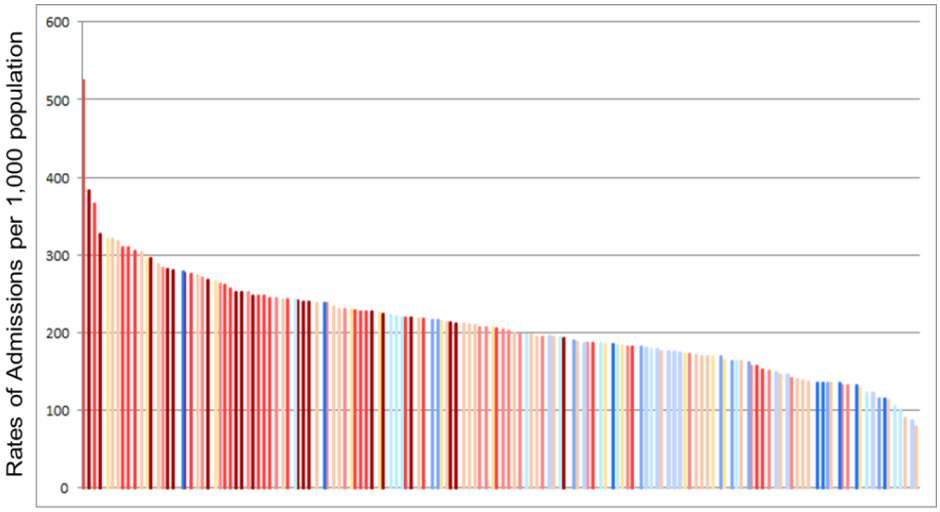
The map on this page shows the 15 neighbourhoods in the city with the highest rates of emergency admissions per 1,000 population. The graph then shows the rates of emergency admissions for all 148 neighbourhoods in Southampton – this shows that the more deprived areas of the city have (red shades) have higher rates of emergency admissions than the less deprived areas of the city (blue shades).

The analysis is particularly useful as an indicator of need (assuming people are only admitted to hospital as emergencies if they are seriously unwell) as opposed to demand (which may be influenced by the convenience of living close to the hospital).



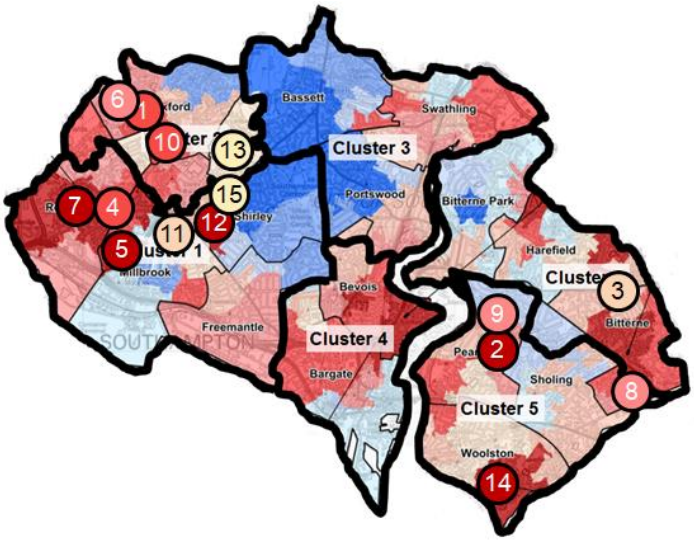
This analysis is also a good indicator of where we our local health and care system is failing to prevent ill health or to provide planned care interventions that could have avoided an emergency admission.

Thus, if we can target what we do to focus on improving access to prevention and earlier, planned intervention in these places, we may reduce the inequalities gap and improve health outcomes overall.

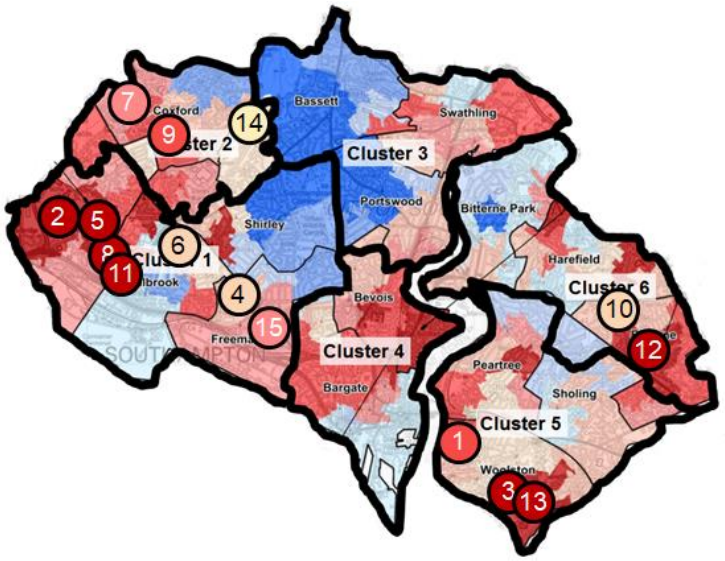


Our analysis has also enabled us see which areas of the city have the highest rates of emergency admission for certain conditions. A few examples are shown below and show a similar trend that the highest rates of emergency admissions are from more deprived areas of the city.

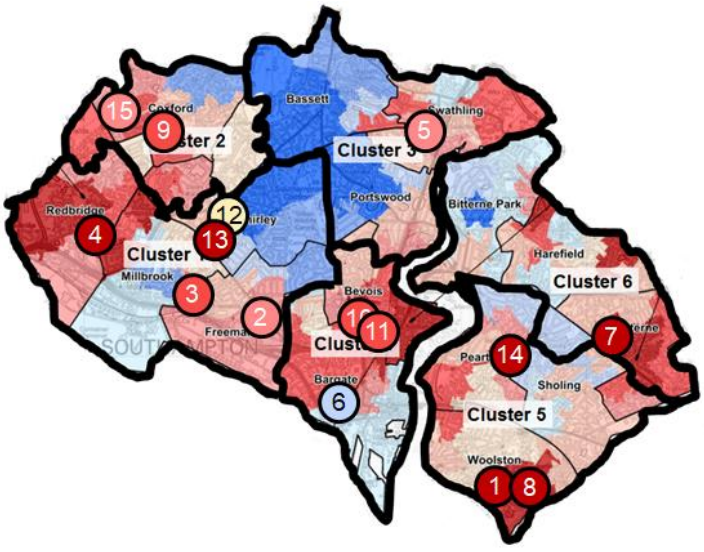
Emergency Admissions for Chronic Obstructive Pulmonary Disease (COPD)



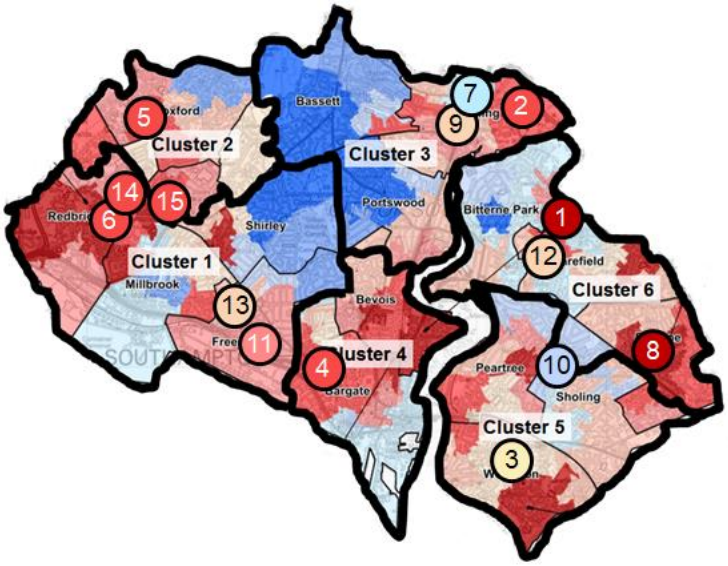
Emergency Admissions for Abdominal Pain



Emergency Admissions for Acute Mental Health Crisis



Emergency Admissions for Cellulitis



Future Health and Care Challenges

Population growth

In Southampton, it is estimated that between 2018 and 2024, the city could have 12,300 more residents. This is equivalent to a 4.8 per cent increase.

By age group:

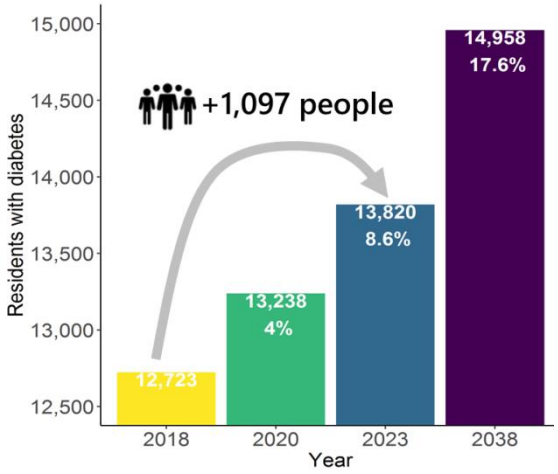
2,730 more children and young people (5.5 per cent increase)

4,530 more working age adults aged between 18 and 64 (2.7 per cent increase)

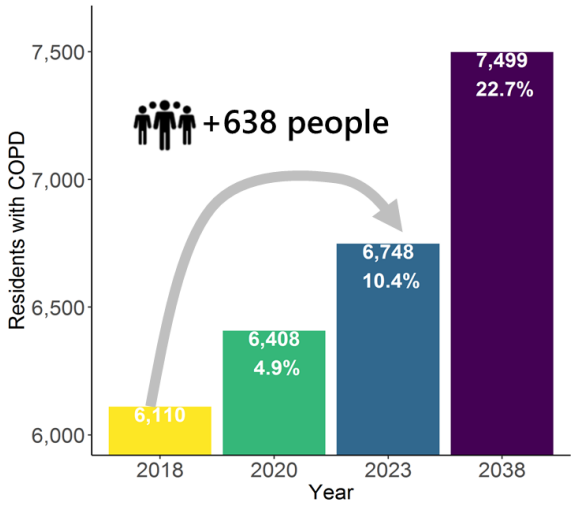
5,030 more older people aged over 65 (14.5% increase)

The age group with the biggest percentage increase will be the older population, and we know that a growing and ageing population will add more pressure onto the city's health and care services.

1,097 more people with diabetes



638 more people with COPD

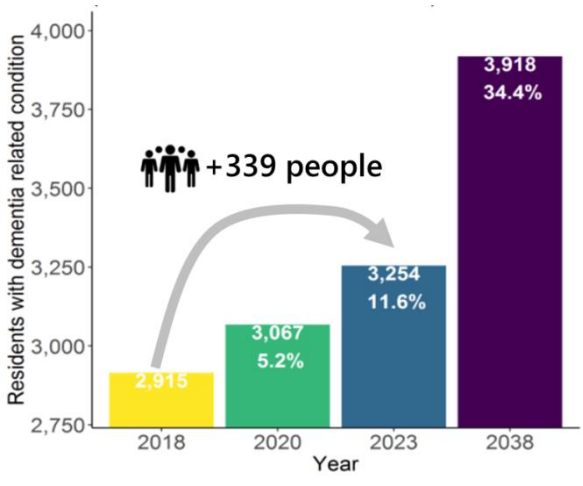


Long term conditions

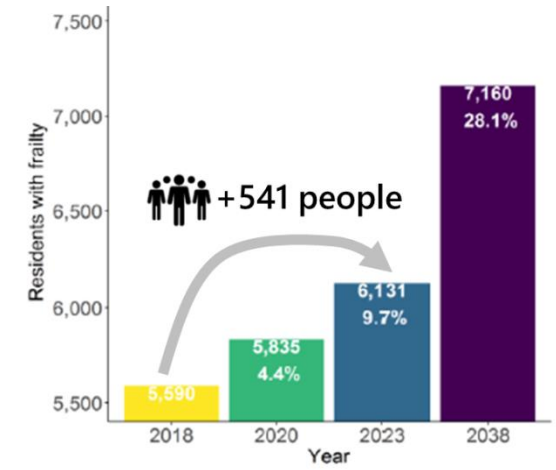
By combining population estimates with current trends in long term conditions, we have been able to forecast increases in long term conditions for our population.

The graphs show the forecast increases in the number of residents with long term conditions, against a baseline of 2018.

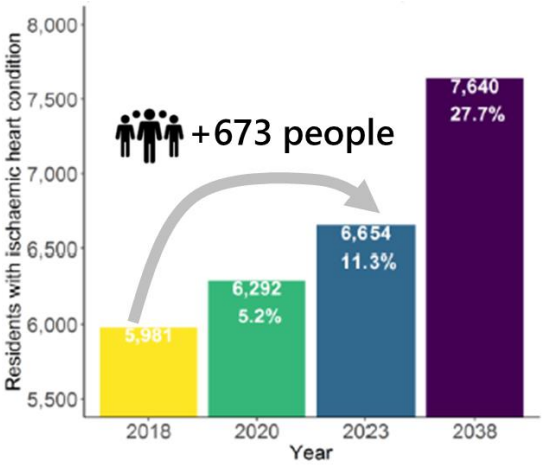
339 more people with dementia



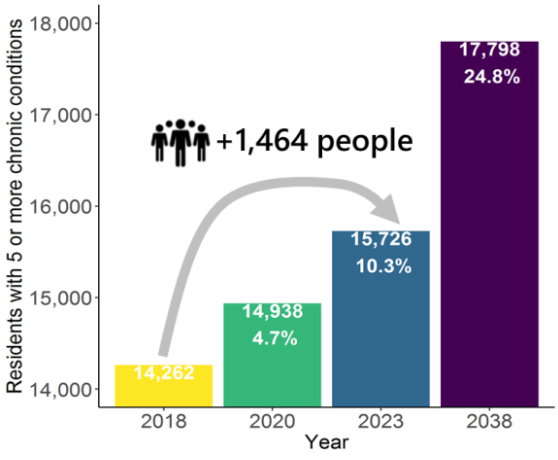
541 more people with frailty



673 more people with coronary heart disease



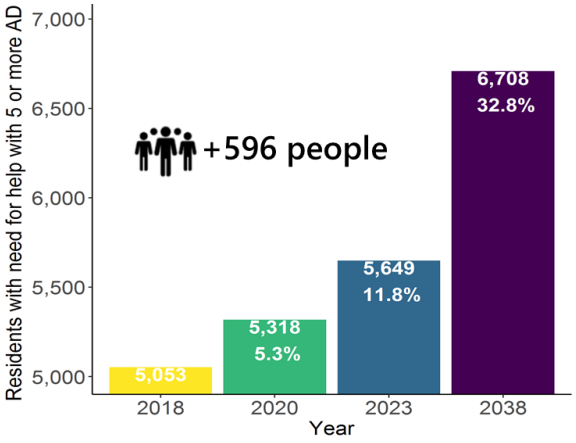
1,464 more people with five of more long term conditions



Adult social care

By combining population estimates with current trends in adult social care demand, we have been able to forecast increases in people needing adult social care support.

The number of people needing home care support with five or more activities of daily living (such as bathing, using the stairs, getting dressed) is estimated to increase by 596 people between 2018 and 2023.



Chapter Two

Our five year strategic framework

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**
- **A strong start in life for children and young people**
- **Tackle the city's three 'big killers': Cancer, Circulatory diseases and Respiratory diseases**
- **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 Goals

Reduce health inequalities and confront deprivation. Whilst most of the wider determinants of health are beyond the scope of health and care services, the data we now have about the distribution and characteristics of social deprivation across the City means we can get much more scientific about the way we target our limited resources to where they can have the maximum benefit.

A strong start in life for children and young people. Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. We want Southampton to be a city where children and young people get a strong start in life, are able to fulfil their potential and become successful adults who are engaged in their communities.

Tackle the city's three 'big killers'. In Southampton, the three big killers – cancer, circulatory diseases and respiratory diseases – account for most deaths. The Department of Health estimates that two thirds of premature deaths among under-75s in England are preventable. We want to take stronger action on improving prevention and encouraging healthy lifestyle changes to reduce smoking, obesity and alcohol consumption.

Improve whole-person care. In Southampton, by age 45-49 a quarter of our population have two or more long term conditions. Multi-morbidity is higher in the most deprived areas of the city. This means that our services need to fundamentally change, from treating single illnesses, towards supporting people in a more joined up way to live with their long term conditions.

Improve mental and emotional wellbeing. This is summed up well by the phrase, 'No Health Without Mental Health'. Mental health services are a high priority. Beyond this. mental and emotional wellbeing is demonstrably now such an all pervasive issue that our approach has to be about recognising the mental health dimension of everything we do and seeing it as an indispensable part of every interaction that health and care professionals, and citizens have with each other.

Build Resourceful Communities. This is about 'Getting Behind People'. Individuals and communities have 'agency' and are willing and able to help themselves; the job of public services might be more about 'standing behind. For example, in 2014/15, the residents of Newtown mobilised themselves to stop 'Immigration Street', but the support of every part of the public sector and business community (Southampton Connect) made them feel strong enough to make it happen.

Reduce variation in quality and productivity. Tackling unwarranted variation to improve outcomes and achieving excellence in quality of care.

Better Care Southampton

Our aim is to further enable the delivery of the One City vision: specifically a place-based approach that is fully inclusive of City partners, not just the NHS. This is about partnership, not structure. It is also easy to overlook the obvious and to assume the existence of an implicit consensus means that improvement and change will happen. Just because 'Better Care' is the bedrock of our established approach, we need to be realistic about how much remains to be done to achieve its aims.

Integration is one of those terms so overused that we are at risk of losing its meaning. We also need to recognise that integration is only a means to an end, not an end in itself.

The Southampton integration vision has evolved and is well established locally, characterised by strong and inclusive partnerships built painstakingly over several years. It is essentially very simple, based on Better Care, which has given us a strong sense of united purpose around care that is joined up and co-produced with people.

The original 2014 Better Care Southampton plan was based on the notion of integrated person centred care, with outcomes for people derived from the national 'I statements' and structured around a 'three legged stool' concept:

- cluster based teams, embedded in communities, of integrated primary, community, social and mental health care
- integrated discharge, rehabilitation and reablement (realised in 2016 by the creation of the Urgent Response Service)
- building community capacity

This has shaped our work programme ever since.

The compelling case for integration hinges in the fact that the City has 123,000 people (46%) living with a long term condition. Whilst multi-morbidity increases substantially with age, this is not just a problem of old age. By the age of 45, half the population has at least one long term condition. This means that our services need to fundamentally change, from treating single illnesses towards prevention and early intervention outside of hospital, but also towards supporting people in a more joined up way to live with their long term conditions.

We see integration as a means to improve people's outcomes, not an end in itself. No-one has to participate, but neither do they have a veto. Our approach is about working together effectively rather than pursuit of organisational goals. Similarly we do not feel constrained by any particular contractual tools and inter-organisational arrangements may be facilitated by both informal and formal arrangements to manage risk and express accountability in the interests of the people of the city

Integration is not the same thing as collaboration, neither does it equate to the absence of competition or an end to procurement. Some legal changes to competition requirements might be helpful but even the Health and Social Care Act 2012 already places on all parties a duty to provide services 'in an integrated way'.

Better Care Southampton

Better Care has evolved since 2014 from a programme into an all-pervading approach. Thus, at the heart of our strategy is the Better Care Southampton Programme, which has three main areas of focus:

- **Promoting independence and wellbeing**
- **Timely and appropriate access to care and support**
- **Proactively joining up care across health and social care, physical and mental health and primary and secondary care.**

Workstreams:

- Maternity
- Sexual Health and Teenage Pregnancy
- Improving outcomes for children with SEND
- Prevention & early help for children & families
- Addressing the needs of high intensity users (HIUs)
- Transforming Care for people with Learning Disabilities
- Community Solutions
- Housing related support and homelessness
- Personal health budgets
- Implementing the city's frailty model
- Enhanced Health Support in Care Homes (EHCH)
- Supporting appropriate timely discharge & out of hospital model
- Home Care
- Housing with Care
- End of Life and Complex Care

Start Well

Children and young people get the best start in life, providing the foundation to ensure they are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives.

Live Well

Individuals and communities thrive and are resilient with access to health and care services, good jobs, affordable housing, leisure activities, lifelong training, education and learning.

Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks.

Die Well

Supporting people to have the best opportunities in their last years of life, by reconceptualising death and dying to be part of the norm by discussing and capturing end of life wishes.

Our Programmes & Enablers

A key next step in evolving the strategic plan will be the development of high level plans for each programme. Currently, the programme descriptors and workstreams below are draft.

Behaviour Change & Prevention

Encourage people to make healthier lifestyle choices and drive reductions in demand on health and care services caused by smoking, alcohol and obesity

- Smoking
- Alcohol
- Obesity

Primary Care

Build a model of general practice that will be the strong, effective and sustainable foundation of our integrated health and social care system

- Access
- High quality and sustainable services
- Collaboration

Social Care

Work with individuals, their carers and wider communities in a more inclusive way to promote independence, focussing on strengths as opposed to a deficit model

- TBC

Mental Health

Improve mental wellbeing and provide support at the right time to avoid people getting into crisis

- Adult mental health
- Child and adolescent mental health
- Crisis care
- Dementia
- Suicide

Cancer & Long Term Conditions

Increase earlier detection and treatment of cancer, and transform clinical pathways to improve productivity and provide care closer to home

- Cancer prevention & earlier diagnosis
- Long term conditions pathways

Urgent & Emergency Care

Redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place, first time

- NHS 111 development
- Urgent treatment centre
- Emergency response (999)
- Same Day Emergency Care (SDEC)
- Eye A&E & minor eye conditions service (MECS)

People & Workforce

Training health and care staff together so that they develop common approaches, and focusing on behaviours and attitudes just as much as skills. Thus enabling Healthy Conversations, both with people and between professionals.

Digital

Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care

- People powered
- Connected systems, shared information
- Digital-first access

Estates

Ensure we have the right type of buildings (size, configuration, flexibility, cost) in the right locations across Southampton

- TBC

Working together to transform outcomes

Our mission

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

Health and care organisations in the city have committed to work together to deliver the strategy. The vision we share for health and care in the city has evolved out of strong and inclusive partnerships between commissioners, providers, communities and citizens, built painstakingly over a number of years.

How we'll work

- **Promoting independence.** Supporting self-care and strengths-based approaches.
- **Co-production.** Communicating and engaging with residents and encouraging participation.
- **Population health management.** Understanding our population and planning for the future.
- **Simplifying processes.** In other words, a complete reversal of a 'gatekeeping' approach to services, instead stripping out the steps that add no value to the 'patient/client'. Thus, 'right place, right contact, first time', enabling better productivity and efficiency in service provision.
- **Moving from urgent care, to planned care.** By putting better anticipatory care in place, we spend less time reacting to a problem and more time preventing it.
- **Tackling unwarranted variation.** Actively using benchmarking tools like Public Health Fingertips, Dr Foster, RightCare and Getting it Right First Time (GIRFT) to improve outcomes.
- **Getting the basics right.** Working in partnership is not a substitute for successful, efficient, well run organisations.
- **Financial Strategy, based on the following principles:**
  - Good planning, not heroic assumptions.
  - Risk reduction, not risk transfer. Reducing system cost, not cost shunting. Also, improving payment mechanisms but recognising they are not the answer.
  - Investment in change: recognising that change costs money and has to be funded.

Our values

This page is intentionally left blank

Southampton City Clinical Commissioning Group

NHS Southampton City CCG
NHS Southampton HQ
Oakley Road
Millbrook
Southampton
SO16 4GX
Tel: 02380 296904
www.southamptoncityccg.nhs.uk

Sandy Hopkins, Chief Executive, SCC
Dr Ali Robins, Chief Executive, SPCL
Paula Head, Chief Executive, UHSFT
Sue Harriman, Chief Executive, Solent NHS Trust
Dr Nick Broughton, Chief Executive, SHFT
Will Hancock, Chief Executive, SCAS
Dr Nigel Jones, Chief Executive, SMS
Jo Ash, Chief Executive, SVS
Sandeep Sesodia, Chair, Southampton Connect

29th May 2019

Dear Colleague,

Transforming Health and Care for the People of Southampton:
Our five year strategic plan 2019-2023

Further to our recent discussion at Southampton System Chiefs, I am writing to share with you the current version of our draft strategy for the City which we have developed in partnership. This version has been developed following the partnership conferences held on 29 March and 8 May. I would like to thank you all for the contributions you have made to getting us to this point.

I should be most grateful if you would now ensure that this document is taken through the appropriate internal governance processes to ensure your organisation owns the approach and is able to approve the strategic framework set out in Chapter 2.

The CCG Board considered the strategy at its meeting on 22 May and I have been asked to write to our key partners accordingly. The covering paper for the CCG Board is also attached for your information.

We will also need to consider how best to secure the buy-in of other key partners, including schools, communities, independent providers of social care and the wider voluntary sector. This could be a topic for Southampton Connect to consider.

Clearly, there is still further work needed to develop high level plans, a roadmap and supporting documents (such as the primary care and social care plans, for example). Once the high level plans for each segment have been developed, the system will then need to look at how best to ensure oversight of delivery. I believe that we should ensure that such oversight is streamlined and unbureaucratic, as annual operating plans will contain specific actions and resource plans for implementation. I want to thank you in advance for the contributions your organisation will make to these and, of course to the successful delivery of the strategy.

We intend this strategy for Southampton will be a key component of the overall Hampshire and Isle of Wight response later this year to the NHS Long Term Plan, and hope you will be able to join me in commending this approach to our STP colleagues.

We would be most grateful to receive your confirmation that the strategy has been considered by your Board and interested to receive any feedback. Please link with Clare Young to close this loop: clare.young4@nhs.net

With best wishes,

Yours sincerely

John Richards

Cc:
David French, David Noyes, Barry Day, Richard Crouch, Jane Hayward, Richard Samuel, Lena Samuels. Maggie Macisaac, Cllr Chris Hammond, Cllr Lorna Fielker, Cllr Dave Shields, Cllr Darren Paffey. Heather Hauschild.

Encs; covering paper and strategy document from 22 May board.

NHS Southampton Headquarters Oakley Road Southampton SO16 4G
Tel: 023 8029 6904 Fax: 023 8029 696
www.southamptoncityccg.nhs.u

DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		Integrated Commissioning Plan 2019/20 to 2021/22		
DATE OF DECISION:		20 June 2019		
REPORT OF:		Stephanie Ramsey, Director of Quality and Integration		
CONTACT DETAILS				
AUTHOR:	**Name:**	Clare Young	Tel:	023 80725604
	E-mail:	Clare.young4@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	023 80296941
	E-mail:	stephanie.ramsey1@nhs.net/ Stephanie.ramsey@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
Not applicable
BRIEF SUMMARY
The Integrated Commissioning Plan outlines the commissioning strategy and outcomes to be achieved by the Integrated Commissioning Unit for Southampton City Council and Southampton City Clinical Commissioning Unit between 2019/20 and 2021/22.
The workstreams identified are to achieve improved prevention and earlier intervention, increased integration, ensure that people are provided with safe, high quality care in all providers and to manage and develop the health and care market. The plan outlines workstreams, milestones, key measures of success and outcomes. The work includes significant transformational change, both within and across organisations, to meet the outcomes of the Southampton City Health and Care Strategy and achieve system wide change. Many of the workstreams include achievement of savings or are enablers to reduce demand and support savings indirectly.
RECOMMENDATIONS:

	(i)	The Board is asked to approve the Integrated Commissioning plan
	(ii)	The Board is asked to note the key measures of success and agree that these will be used to report effectiveness of the plan

REASONS FOR REPORT RECOMMENDATIONS	
1.	The plan has been developed based on the Joint Strategic Needs Assessment, national guidance, needs assessments, market analysis and feedback from consultation and engagement with residents and patients, politicians and clinicians and stakeholders.
2.	A large number of the schemes are key elements of the Southampton Better Care plan transformational change. They support priorities in the Council Strategy, especially children and young people in Southampton get a good start in life and people in Southampton live safe, healthy, independent lives. They also form the core of the CCG operating plan and the emerging Southampton City Health and Care Strategy 2019-2023. The workstreams and outcomes contribute to the Health and Wellbeing Strategy outcomes:

	• People in Southampton live active, safe and independent lives and manage their own health and wellbeing • Inequalities in health outcomes are reduced • Southampton is a healthy place to live and work with strong, active communities • People in Southampton have improved health experiences as a result of high quality, integrated services
3.	The Terms of Reference agreed by Full Council and CCG Governing body requires the Joint Commissioning Board to approve and monitor the development and implementation of the Integrated Commissioning Plan to ensure it meets agreed priorities, objectives, savings and performance targets and aligns commissioning arrangements with partners' financial and business planning cycles.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
4.	Prioritisation was undertaken to identify most appropriate workstreams
DETAIL (Including consultation carried out)	
5.	The plan, attached in Appendix 1, outlines shared commissioning workstreams based on where a partnership approach will improve outcomes and promote greater efficiencies.
6.	There are four main priority areas: • Integration - Working together across health and social care to deliver integrated, person centred, joined up care and support for people in Southampton • Prevention & Earlier Intervention - Strengthen prevention and early intervention to support people to maintain their independence and wellbeing • Safe & High Quality Services - Ensure that people are provided with a safe, high quality, positive experience of care in all providers • Managing & Developing the Market - Support commissioning activities that facilitate a strong provider market that is able to respond to an increasingly diverse customer group
7.	Each priority outlines objectives and what success will look like .There are a number of workstreams supporting each priority. These are summarised on page 16 of the Appendix 1 along with key measures of success. The work outlined incorporates all aspects of the commissioning cycle from needs and market analysis, through service redesign, procurement and change implementation through to contract management and review. This is demonstrated within the milestones.
8.	For each priority a number of indicative measures of success have been identified. These will form the basis of the performance report presented to JCB, along with exception reporting on the achievement of key milestones. A significant number of these are national requirements for the Council, CCG or both.
9.	A number of the workstreams are focussed on transformational change across a wide range of health and care within the city, such as the development of the out of hospital model or mental health system changes.

	There is also collaborative work with other local authorities and CCG's, such as sexual health. In some aspects Southampton is leading region wide work, such as developing a framework for children's residential care.
10.	A majority of the workstreams contribute to the achievement of savings to impact on spend across children's, adults and public health budgets within the Council and on CCG QIPP priorities. In some places this is direct savings, such as Transforming Care for people with learning disabilities, Housing Related Support, children's residential care or high cost placement negotiations. In others it is an enabling activity that will reduce demand elsewhere such as addressing the needs of high intensity users, care technology and community navigation.
11.	A review of progress over the past two years is provided. Actions and outcomes have included: • ever closer alignment between health and social care, including the introduction of a Case management approach to reducing the need for emergency care and a Enhanced Health in Care Homes (EHCH) model pilot which 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 to transform the traditional model of older person's day care into a more community based offer with a wider choice of activities. • Development of services for children with special educational needs and disabilities (SEND) – including short break services, 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 and development of a new transition pathway and best practice guide. • Addressing the needs of people who frequently access urgent care services (high intensity users and improvements to mental health crisis care and improving access to psychological therapies for people with long term conditions. • Development of primary care step-down model providing an enhanced level of • Improved access to CAMHS, including targeting long waits and 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. • A new autism support service commenced and there has been an 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. Additional supported living units have also been commissioned with a new 4 bed unit due to open in April/May 2019

	• The ICU has worked with community partners to design a service outline for Community Navigation and Community Development which has now been procured and will start in 2019. • The city now has 8 out of 9 nursing homes rated 'good' by the CQC and of the 51 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'. • Commissioners have worked with providers to develop a new model for Home Care delivery in Southampton. • 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. • 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.
RESOURCE IMPLICATIONS	
Capital/Revenue	
12.	The total value of the pooled fund for Better Care is just over £115.7M. This is split £79.3M from the CCG and £36.4M For the Council this includes elements of the ICU budget as well as adult, children's and public health budgets. The ICU council net budget for 2019/20 is £16.6M which comprises contracts and staffing costs. In the CCG the elements specifically related to the ICU work, not including prescribing costs is over £114M. Significant elements of this are included within the Better Care pooled budget
Property/Other	
13.	Not applicable
LEGAL IMPLICATIONS	

Statutory power to undertake proposals in the report:	
14.	We work with legal and procurement colleagues to ensure all actions are taken within standing orders
15.	Care Act 2014 – responsibilities for commissioning sufficient services and market management
Other Legal Implications:	
16.	None
CONFLICT OF INTEREST IMPLICATIOINS	
17.	N/A
RISK MANAGEMENT IMPLICATIONS	
18.	A separate risk register is maintained for the ICU and is incorporated into the Joint Commissioning Board Performance Report. Key risk areas in relation to the achievement of the Plan include: • Delayed transfers of care - increasing complexity of clients will increase delayed transfers resulting in failure of plans, non-achievement of Better Care targets and impact on savings. It could compromise quality of care and outcomes for clients. Mitigation includes a whole System Discharge action plan • Workforce - there are significant concerns across the City in relation to the recruitment and retention of staff. This is a focus of Better care work. • Wheelchair service waiting lists leading to individuals at risk of harm in delay in service and reputation. This is across the whole contract with many CCG's and there is a detailed action plan in place to improve outcomes • Capacity of the care market to meet increasing needs and support additional schemes to improve discharge - to mitigate this the ICU is working proactively with the care market and utilising alternative mechanisms such as retainers and block contracts to provide increased stability
POLICY FRAMEWORK IMPLICATIONS	
19.	The scope of integrated commissioning fully supports the achievement of priorities in the Council Strategy, and in particular, children and young people in Southampton get a good start in life, people in Southampton to live safe, healthy, independent lives. These are also the basis of the Southampton Better Care plan. They also form the core of the CCG operating plan and Southampton City Health and Care Strategy 2019-2023

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	

1.	Integrated Commissioning Plan 2019/20 to 2021/22

Documents In Members' Rooms

1.	None

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No – will be done for each scheme as appropriate**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**

Other Background Documents
Other Background documents available for inspection at:

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	

Integrated Commissioning Plan

2019/20 – 2021/22

Southampton City Clinical Commissioning Group

SOUTHAMPTON CITY COUNCIL

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

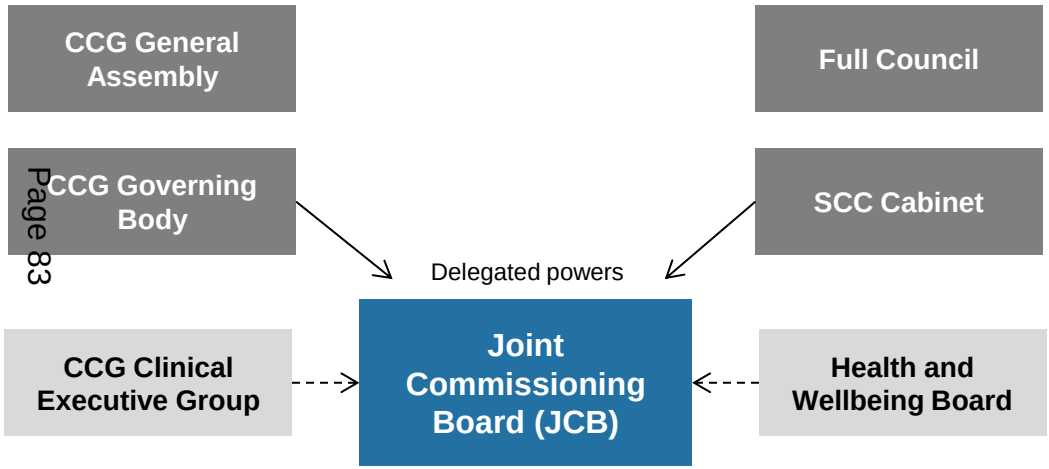
The commissioning process will ensure that the same approach (e.g. service specification and performance monitoring) is applied to all commissioned activity to ensure fairness and that no delivery vehicle is given or gain unfair advantage.

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

	Integration	Prevention & Earlier Intervention	Safe & High Quality Services	Managing & Developing the Market
Our priorities	Working together across health and social care to deliver integrated, person centred, joined up care and support for and with people in Southampton	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	Ensure that people are provided with a safe, high quality, positive experience of care in all providers	Support commissioning activities that facilitate a strong provider market that is able to respond to an increasingly diverse customer group
Our projects	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	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	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	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	• 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
		• 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
			• >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)
				• ≥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											2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	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											2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	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									Evaluate low level health activity					
				URS operationalise collar care and pain patches 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 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 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	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 Q1	Q2	Q3	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	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

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
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											2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	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															

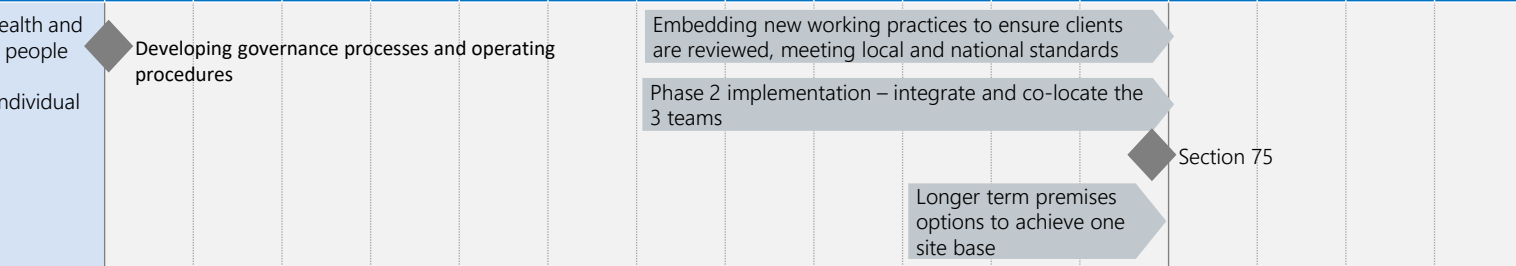
Integration

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

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

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



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
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					

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
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 →															

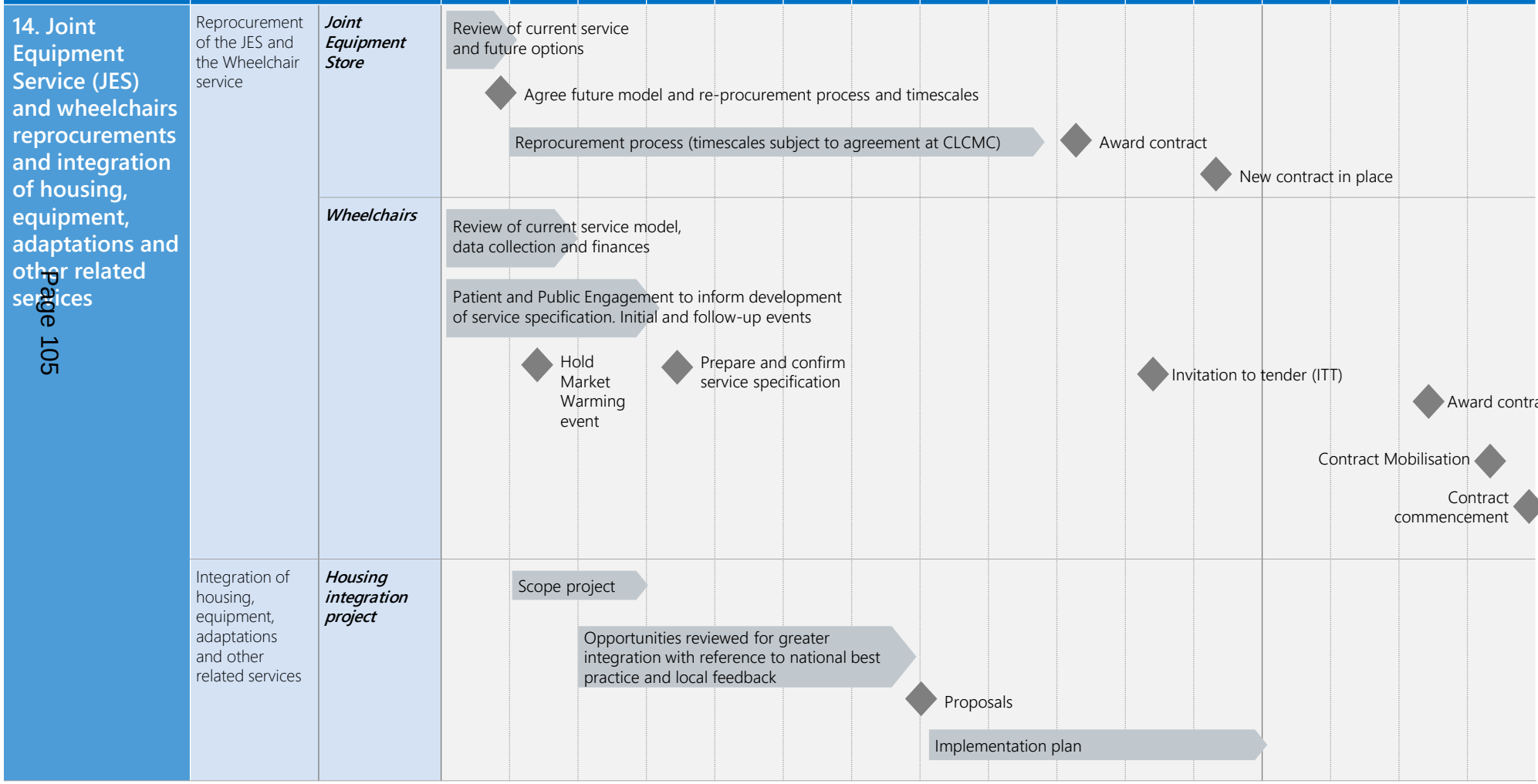
Integration

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	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 Q1	Q2	Q3	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						Explore service offer wider than CMH patients/families			
									Launch event									
		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



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

Project	Description		2019/20												2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4
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												Embed smoking cessation into role of Midwife Support Workers			
				◆ S75 funding agreement in place														
				Midwife training in smoking cessation											Roll out PGD for Midwife prescribing of NRT			
				Roll out Midwife-led smoking cessation across 13 community hubs												Introduction of joint smoking cessation clinics with partners		
														◆ Review arrangements and future funding				
		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	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	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)															
			Confirm WHCCG and HCC funding commitment to offer enhanced access to all patients, review plan if no commitment received															
			Team recruitment and training			◆ Commence enhanced provision												
								◆ Commence UHS based medically supported ambulatory alcohol withdrawal (TBC)										
			Review Alcohol Admissions data												◆ Complete 1st Year Report			
	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			◆ Commence InReach provision									◆ Complete 1st Year Report			

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											2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	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.															
			Development of SHIP-wide Maternity financial dashboard															
			Development of SHIP-wide Maternity performance dashboard															
			Development and implementation of local Maternity Voices Partnership (MVP)								Develop business case for future of MVP							
					Development and implementation of accredited infant feeding scheme													
		Local Maternity service improvement strands	Development of local pathways for smoking cessation in pregnancy															
						Evaluation of local pathways for smoking cessation in pregnancy												
			Development of links to wider smoking cessation support options for partners / others living with women in pregnancy															
			Implementation of maternity self-referral pathway for local women															

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

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

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											2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	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											2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	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**	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.															
			Implement and transition to new CHC recording and reporting database															
			Further develop new CHC recording and reporting solution with clear plan for continued product development in line with CHC SIP tools/guidance/best practice															
			Populate CHAT assurance tool and embed into normal business/management															
						◆ 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												
														◆ Implementation of additional product developments for the recording and reporting system				
28. Support for people with learning disabilities		**Standards**	Supporting Providers to achieve the Learning Disability Improvement Standards for NHS Trusts.															
		Contracts	Monitoring the Learning Disability elements within Provider contracts															
		Quality improvement	◆ Facilitation of a Learning Disability specific Multi-provider Quality Improvement event															
										◆ Facilitation of a Learning Disability specific Multi-provider Quality Improvement event									
		Service redesign	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

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								Repeat annual re-opening exercise			
								New Framework commences										

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
33. Market sustainability assurance	Understand financial pressures on the care sector and develop approaches to support their management. Develop new approaches to the published rate levels, recognising complexity of care provided, and costs associated. Manage all approaches together with High Cost Placement work and the skills and knowledge of the Placement Service.	**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												
		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					

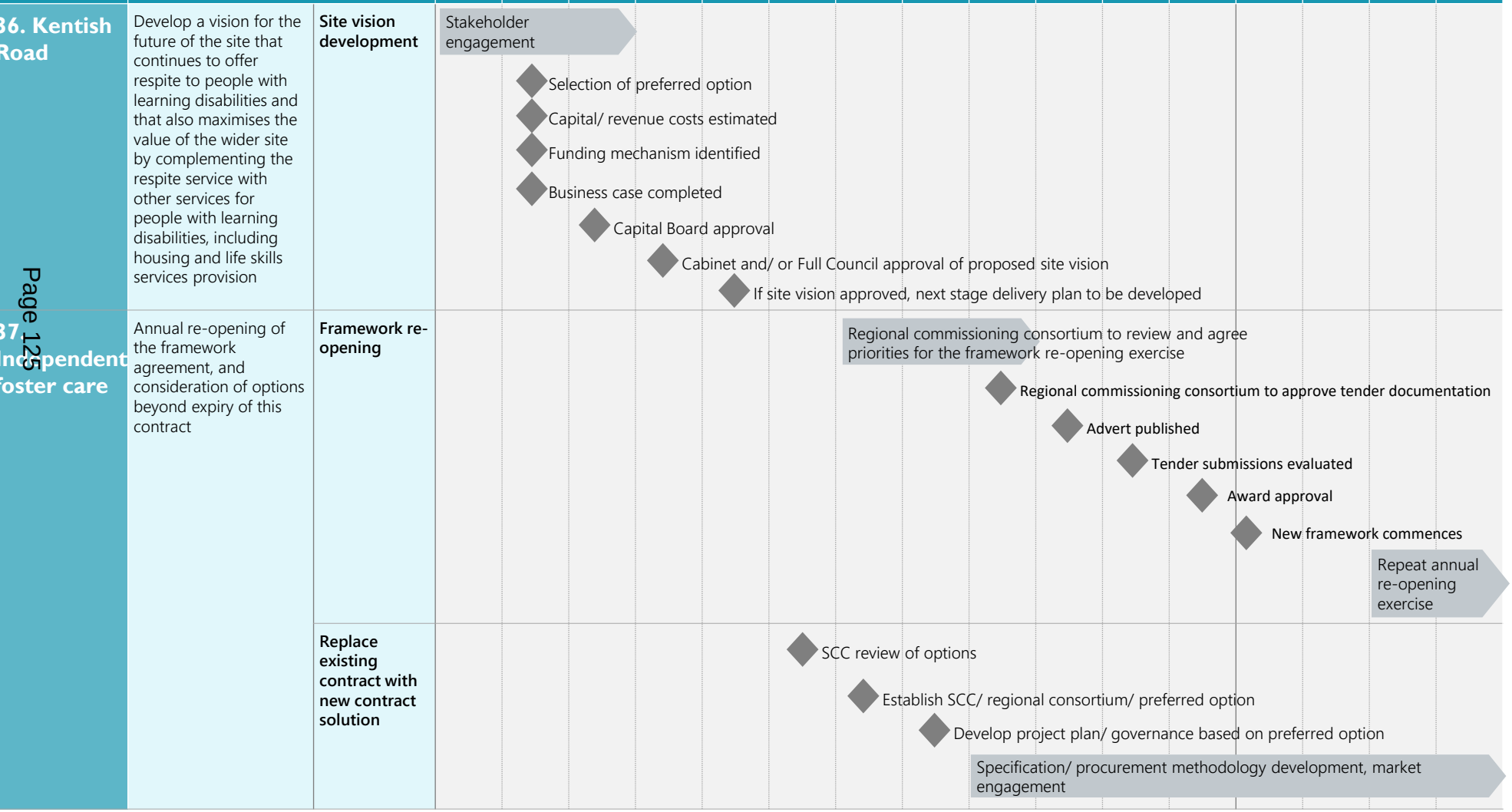
Managing & developing the market

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

Project	Description		2019/20											2020/21			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	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.															
			Review opportunities to influence the development of SCC workforce supporting ASC clients															
					Produce future care workforce vision and assessment of needs to enable effective change management of the local market													
								Produce career progression pathways within the care sector and join up resources supporting staff development										
			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															
			Implement STP and TCP plans relating to LD workforce development across the SHIP area, with a special focus given to Southampton															
						Develop sustainability plan to ensure workforce development plans are implemented in the long-term – once the fixed term post ends												
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.															
						◆ Market Position Statement to the JCB for agreement												
						◆ Market Position Statement published												
						Provision of opportunities for dialogue with the market – email account, telephone and meeting opportunities												
							Review opportunities for further dialogue with the market across all care groups (including Children's Services, Mental health, others)											
												Potential further publications supporting market engagement initiatives and providing updates, where required						

Managing & developing the market

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



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			

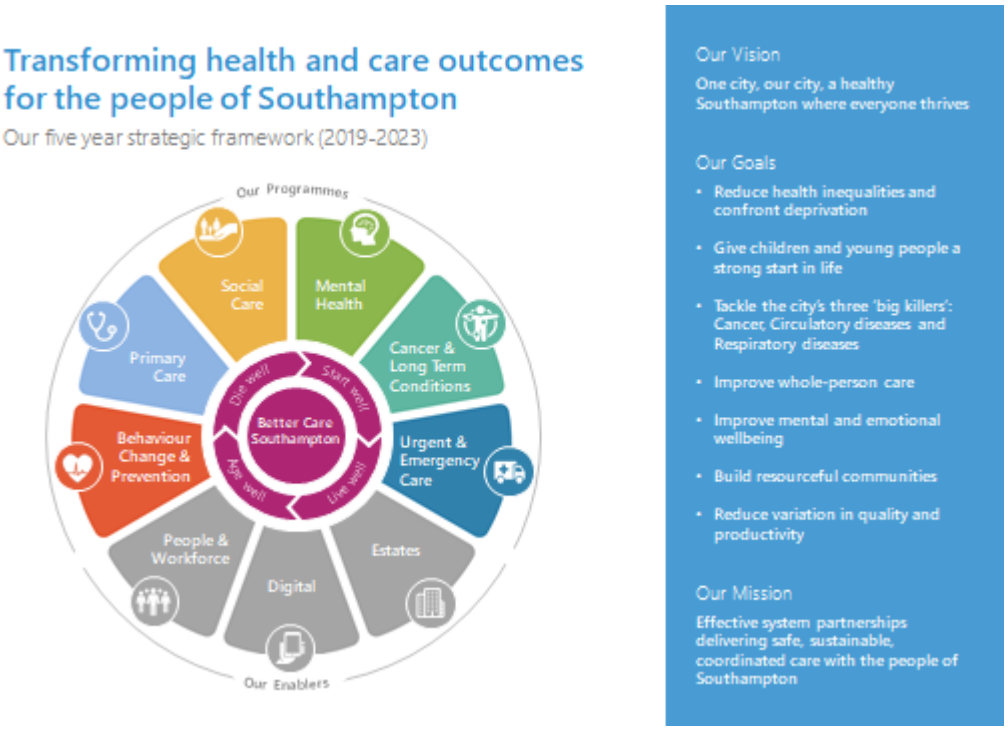
Abbreviations & Acronyms Glossary

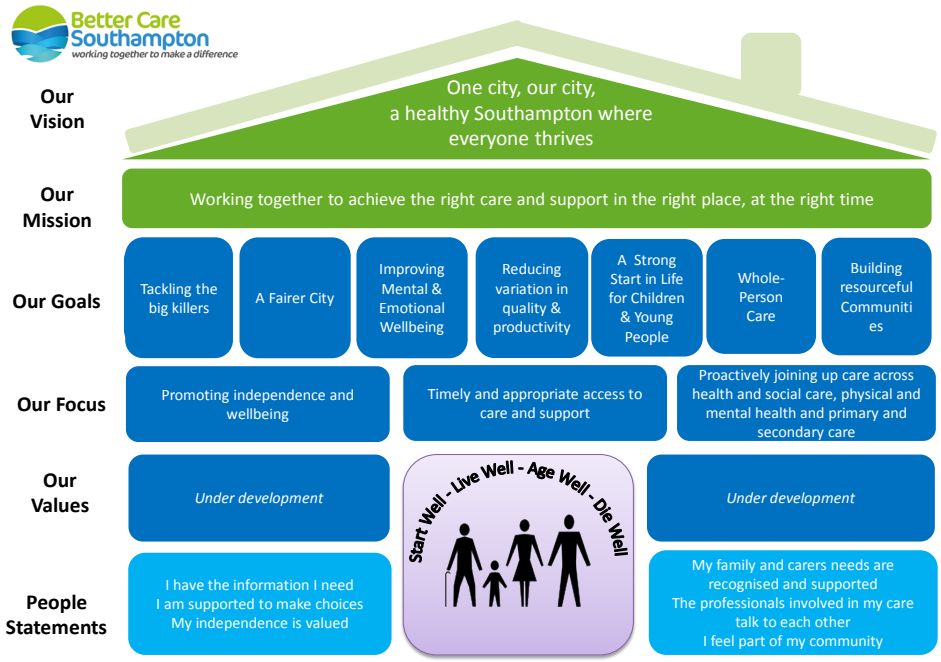
ADHD	Attention deficit hyperactivity disorder
AMH	Adult Mental Health
ASC	Adult Social Care
BCF	Better Care Fund
BRS	Building Strength & Resilience Service
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CFC	Care Funding Calculator
CHC	Continuing Healthcare
CMH	Children's 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

This page is intentionally left blank

DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Better Care Southampton Governance**		
DATE OF DECISION:		**20th June 2019**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Donna Chapman	Tel:	02380 296004
	E-mail:	d.chapman1@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	02380 296941
	E-mail:	Stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY		
Not applicable		
BRIEF SUMMARY		
In the light of the city's new five year strategic framework (2019-2023): Transforming health and care outcomes for the people of Southampton the governance structure for Better Care has been reviewed. This was required to ensure development, implementation and oversight of the whole spectrum of priorities identified and to adapt to wider changes within health and care.		
RECOMMENDATIONS:		
	(i)	That Joint Commissioning Board approves the proposed governance model for Better Care Southampton
REASONS FOR REPORT RECOMMENDATIONS		
1.	To provide joint leadership across the whole health and care system to meet the challenges within the five year strategic framework (2019-2023): Transforming health and care outcomes for the people of Southampton a change was required to Better Care Governance. There is a requirement to incorporate priorities that had not been part of the Better Care remit previously. Better Care has evolved since 2014 from a programme into an all pervading approach. This is why it has been placed at the centre of the five year strategic framework.	
2.	The aim of the five year strategic framework is to further enable the delivery of the one City Vision; specifically a place-based approach that is fully inclusive of all city partners. In delivering this vision it has also been recognised that there needs to be a much stronger link between city wide strategic leadership and frontline service delivery and that changes to the membership of the Better Care Steering Board were needed to facilitate this.	
3.	National changes to primary care with the development of Primary Care Networks requires a review of the role of clusters that the whole Better Care approach has been developed upon. There is also a need to consider how Southampton as a place fits within the ambition for the Hampshire and Isle of Wight STP to develop as an integrated Care system. There are a number of challenges that all health and care organisations in the city are facing, such as workforce and digital, which would benefit from a more joined up approach.	

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
4	A number of options were considered but were rejected as they did not incorporate the whole range of priorities, led to too many groups being established which would be time consuming and replicative, missed the links between front line service delivery and strategic leadership or did not involve all stakeholders.
DETAIL (Including consultation carried out)	
5	Through a range of partnership events the city has developed a five year strategic framework (2019-2023): Transforming health and care outcomes for the people of Southampton: 
6	In light of this the governance structure for Better Care has been reviewed. This has been undertaken through a range of engagement events led by the Better Care Board and involving a wide range of stakeholders.
7	The proposed revised structure can be seen in Appendix 1 and the Terms of Reference for both the main board and the subgroups can be found in Appendix 2. The Terms of Reference for the sub groups is an outline and will be adapted to meet the requirements of each specific group.
8	The main changes to the governance are: • Restructure and rationalisation of the Better Care Steering Board subgroups to align with the life course approach used in the 5 Year Health and Care strategy: start well, live well, age well, die well • A move to 3 localities (as opposed to 6 clusters) to enable better alignment with Primary Care Networks (PCNs) and local health and care delivery structures, where localities of 80,000 – 100,000 populations provide a footprint which offers better economies of scale for organising services around than 6 clusters of 30,000 – 50,000

	could offer. This does not preclude working at sub-locality/neighbourhood level where it makes sense to do so. • Inclusion of the locality leads on the Better Care Steering Board to strengthen connectivity between strategic planning and local service delivery.
9	The Better care Southampton Board will set strategic direction and oversee the successful development and delivery of integrated, person centred, strengths based services in Southampton through which the Southampton five year Health and Care Strategy will be delivered. The subgroups will design and implement the change required in specific areas (i.e. enabling workstreams and service areas).
10	As the subgroups develop plans that will contribute to the achievement of the strategy these will be overseen and monitored by the Better Care Southampton Board through regular reporting mechanisms.
11	This is a system wide approach to change which will be underpinned by a partnership agreement. This will outline expectations on working as a Southampton "system" but does not have any formal impact on each organisation's own unique accountability. Ways of working/ground rules have been included in the Terms of reference to support this approach.
12	The Better Care Southampton board will be accountable to the Joint Commissioning Board and it is proposed that the minutes of the meeting are made available.
13	The vision for Better Care has also been refreshed to mirror the 5 Year Health and Care strategy: 
14	Underpinning the delivery of the 5 year plan, 3 key areas of focus have been identified for Better Care: • Promoting independence and wellbeing • Timely and appropriate access to care and support as close to home as possible

	• Proactively joining up care across health and social care, physical and mental health, primary and secondary care.
RESOURCE IMPLICATIONS	
Capital/Revenue	
15	The pooled fund for Better Care is just over £115.7M. This is split £79.3M from the CCG and £36.4M from the Council.
Property/Other	
14	Not applicable
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
15	The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006
Other Legal Implications:	
16	None
CONFLICT OF INTEREST IMPLICATIOINS	
17	None
RISK MANAGEMENT IMPLICATIONS	
18	Each of the subgroups will develop a risks and issues log for the programmes of work they are accountable for. These will be summarised into an overall risks and issues log for Better Care which will be presented to Joint Commissioning Board quarterly.
POLICY FRAMEWORK IMPLICATIONS	
19	This will support delivery of outcomes in the Council Strategy (particularly the priority outcomes that "People in Southampton live safe, healthy and independent lives" and "Children get a good start in life") and the CCG Operating Plan, which in turn complement the delivery of the local HIOW STP, NHS 5 Year Forward View, Care Act 2014 and 5 Year Health and Care Plan.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION

Appendices	
1.	Better Care Governance
2.	Better Care Southampton Terms of Reference

Documents In Members' Rooms

1.	None
Equality Impact Assessment	

Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No – will be undertaken with each appropriate work stream**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No – PIAs will be conducted as required at an individual project level**

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

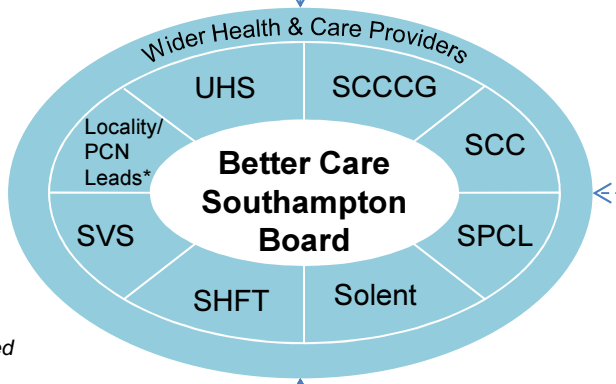
This page is intentionally left blank

Better Care Southampton
working together to make a difference

Strategic Oversight

Health and Wellbeing Board

Joint Commissioning Board



** During Quarter 1 of 2019/20, the relationship/alignment between localities and the emerging PCNs will be reviewed and the governance structure updated to reflect this*

Start Well
- Multiagency Children's Group

Live Well
- Prevention & Earlier Intervention Group
- Long Term Conditions Group
- Mental Health Group
- LD Group

Age Well
- Older Person's Group

Die Well
- End of Life Group

Underpinning Programmes & Enablers
- Strengthening Primary Care
- Making Social Care Work
- A&E Delivery Board
- Estates
- People & Workforce
- Digital
- Comms & Engagement
- Quality
- Finance

Local Delivery Groups
- localities/PCNs*
- Local Solutions Groups

Wider Cross System Working
- Strategic Clinical Networks
- Alliances
- HIOW STP Programmes

This page is intentionally left blank

TERMS OF REFERENCE		
	BETTER CARE SOUTHAMPTON STEERING BOARD	**SUBGROUPS OF THE BOARD (UNDERPINNING PROGRAMMES AND ENABLERS)**
Overarching Role	Providing system wide leadership, setting and driving the programmes of work required to achieve the city's vision and goals as set out in the city's 5 year plan (2019/24) through an integrated city wide system of person centred, strengths based, joined up care and support across health and social care, physical and mental health, primary and secondary care.	Designing and implementing the change required in specific areas (i.e. enabling workstreams and service areas) to deliver the city's vision and goals as set out in the 5 year health and care plan (2019/24)
Purpose	To set strategic direction and oversee the successful development and delivery of integrated, person centred, strengths based services in Southampton through which the Southampton 5 year plan will be delivered. The board is responsible for being the sponsors of Better Care Southampton by: • Overseeing new system wide models of pro-active care that ensure financial sustainability of health and social care services which promote collaboration and integration. • Holding all stakeholders/organisations to account to operate as a single Southampton "system". This will be underpinned through a Partnership Agreement. • Delivering the agreed plans for Better Care in Southampton, mitigating risks and removing blocks to progress. • Ensuring resources within organisations are prioritised and organised in a joined up way to maximise outcomes and that localities/PCNs are resourced and empowered to deliver real change on the ground. • Utilising and encouraging the use of outcome based system wide specifications/contracts etc to incentivise providers to work together. • Holding organisations to account to ensure the continual ongoing engagement of all stakeholders in co-designing, informing and delivering Better Care Southampton plans. • Representing their own organisations whilst prioritising the needs to operate in a collaborative partnership manner for the benefit of Better Care Southampton. • Ensuring that work programmes are aligned across the Local Delivery System and making connections with wider system planning and development (e.g. at a SW system or STP wide level) to ensure achievement of Southampton's Better Care and 5 Year Health and Care Plan.	To design and implement more proactive, joined up and person centred models of care and support which transcend health and social care, physical and mental health, primary/community and secondary care in order to deliver the city's vision and goals as set out in the 5 year health and care plan (2019/24). This includes: • Being responsible to the Better Care Steering Board for delivering change, including the design of and adherence to a project plan and providing a regular highlight report to the Board. • Taking account of developments and information/data/service user feedback across the local system, STP and nationally to inform future service developments. • Ensuring that proposals are evidence based and needs led. • Defining key system wide outcomes which will support the shift towards outcome based specifications/contracts • Maintaining a focus on the benefit for local people. • Ensuring engagement with local citizens, patients, service users and wider community stakeholders.
Activities	• Set the work programme for Better Care Southampton. • Identify, assess and manage risks to the delivery of the programme. • Ensure the programme delivers to agreed parameters and regularly review the vision and operating model. • Maintain a clear focus on achieving better quality outcomes. • Maintain a close understanding of the likely financial benefits, and assess the risk of underperformance robustly and transparently. • Resolve strategic and directional clashes between projects/programmes. • Resolve or escalate any cross-organisation problems that impede progress. • Monitor benefit realisation KPIs. • Provide assurance over the impact and feasibility of implementation. • Communicate the aims, objectives and actions of the work programme across the whole system. • Ensure that local people (adults, children and young people) are at the centre of decision making and that their voices are heard. • Implement an effective evaluation framework.	• Design and implement future models of care and support. • Defining key system wide outcomes which will support the shift towards outcome based specifications/contracts • Consult widely with partners and service users, taking a co-production approach. • Put in place clear project plans with benefit realisation KPIs and performance metrics. • Provide a regular highlight report to the Better Care Steering Board outlining progress, key achievements, benefits/outcomes, risks and mitigation. • Provide a forum which facilitates partner collaboration, shared learning, information sharing, peer support and joint working.
Core Membership	One Representative from each of the key organisations/sectors operating in the Southampton system. Representatives will need to have the ability to commit their organisation financially and operationally to key decisions (this will ***typically be individuals operating at Chief Operating Officer/Professional Lead level***) • Solent NHS Trust • University Hospitals Southampton FT • Southern Health FT	This will be dependent on the focus of the group but as a general rule will include representation from each of the key organisations/sectors operating in the Southampton system (both commissioners and providers of services). • Solent NHS Trust • University Hospitals Southampton FT • Southern Health FT • Southampton City Council

TERMS OF REFERENCE		
	BETTER CARE SOUTHAMPTON STEERING BOARD	**SUBGROUPS OF THE BOARD (UNDERPINNING PROGRAMMES AND ENABLERS)**
	• Southampton City Council • Southampton City CCG • Southampton Primary Care Limited (SPCL) • Southampton Voluntary Services **Plus one representative per Locality (PCN representation to be agreed)** **Plus a lay member who will be adequately supported and able to liaise with wider representative groups of public and service users in order to represent the service user voice.** **Plus Better Care Southampton Programme Manager who will be accountable to the Board** Members of the Board will be responsible for communicating information and enacting decisions made at the Board within their host organisation and bringing to the Board's attention any decisions being made in their host organisation or elsewhere which impact on delivery of the Better Care work programme/ delivery of integrated care. Anyone unable to attend the meeting should send a deputy sufficiently briefed and empowered to make decisions. A cumulative attendance record will be held by the Board along with a decisions log.	• Southampton City CCG • Southampton Primary Care Limited (SPCL) • SMS • South Central Ambulance Service (SCAS) • Voluntary Sector • Locality and PCN leads • Service User representation Representatives will need to have the ability to implement/operationalise strategy and plans within their organisations (this will typically be individuals operating at Senior Management/Professional Lead level) Anyone unable to attend the meeting should send a deputy sufficiently briefed and empowered to make decisions. A cumulative attendance record will be held.
Extended Membership	***Once a quarter, the Better Care Southampton Board will be joined by System Chiefs*** ***Three times a year, the Board will hold a wider thematic meeting with extended membership to include:*** • ***South Central Ambulance Services FT*** • ***Hampshire Fire and Rescue*** • ***NHS England Specialised Commissioning and relevant Clinical Alliances*** • ***Care UK*** • ***Hampshire Constabulary*** • ***Schools and Colleges*** • ***Health Watch*** • ***DWP***	Not Applicable.
Declarations of Interest	Members are asked to declare their interests. Each Group will ensure that a register of interests is established as a formal record of declarations of interests and kept up to date. If a conflict of interest is identified, the Group shall determine whether the member should withdraw from the meeting and play no part in the relevant discussion or decision	
Frequency	Monthly	Generally monthly although will be dependent on area of work
Chair	To be nominated by group for 12 month period	To be nominated by each group
Quorum	A minimum of 50% of the Board's core membership including the Chair or proxy nominated by the chair.	A minimum of 50% of the group's core membership including the Chair or proxy nominated by the chair.
Accountable to:	Joint Commissioning Board and Health and Wellbeing Board	Better Care Steering Board
Ground Rules/ Behaviours	We will focus on strategic, evidence-based decision-making and the harnessing of innovative developments to help us shape the best possible future for the SW Hants system. We will act cohesively and try to reach a collective view. In so doing, we will share views openly and be honest about differences. We will constructively challenge each other but ensure we treat each other's views with respect and we will respect and support the role of the Chair. We will trust that Group members are at all times acting in the best interests of the system and of the people who use our services. We will promptly declare our own agendas where these might differ from the Group as a whole. We will always be curious to learn about others' ideas, make best possible use of the experience and expertise within the Group and encourage others' contributions. We will be sensitive to the impact of our own behaviours and will tell others if we have a problem with them – and tell them first. We will be open to others disagreeing with us, willingly accept feedback that might be uncomfortable, and say when we might be wrong.	

TERMS OF REFERENCE		
	BETTER CARE SOUTHAMPTON STEERING BOARD	**SUBGROUPS OF THE BOARD (UNDERPINNING PROGRAMMES AND ENABLERS)**
	We will ask others to repeat something if part of it doesn't ring true. We will take an active part in the meetings and make it a priority to attend. We will ensure meetings have clear and effective processes for agreeing agendas, contribute papers by required deadlines, and ensure follow through and reports back to the Group. We will ensure that our organisational resources are directed appropriately to deliver what has been agreed.	

Last reviewed: 1 April 2019

Next review due:

This page is intentionally left blank

DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		Terms of Reference		
DATE OF DECISION:		20 June 2019		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Beccy Willis	Tel:	023 80296002
	E-mail:	Beccy.willis@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	023 80296941
	E-mail:	Stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
The Joint Commissioning Board Terms of Reference (ToR) have been updated in line with their annual review. They have received a general tidy up, and removal of any duplication.		
RECOMMENDATIONS:		
1.	(i)	Approve the updated Joint Commissioning Board Terms of Reference
REASONS FOR REPORT RECOMMENDATIONS		
2.	The ToR were due for their annual review.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
3.	Not Applicable.	
DETAIL (Including consultation carried out)		
4.	The review has been undertaken in conjunction with Director of Quality and Integration.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	Not applicable.	
Property/Other		
6.	Not applicable.	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
7.	Not applicable.	
Other Legal Implications:		
8.	Not applicable.	
CONFLICT OF INTEREST IMPLICATIOINS		

9.	None
RISK MANAGEMENT IMPLICATIONS	
10.	None
POLICY FRAMEWORK IMPLICATIONS	
11.	Not applicable.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**Not applicable.**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Joint Commissioning Board Terms of Reference

Documents In Members' Rooms

2.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**
Other Background Documents **Other Background documents available for inspection at:**	

Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
3. None	

Terms of Reference for the Joint Commissioning Board

1. Introduction

1.1. Southampton City Council (the Council) and Southampton City Clinical Commissioning Group (CCG) have developed a shared ambition for change *'Integrated Health and Wellbeing Commissioning allows the city to push further and faster towards our aim of completely transforming the delivery of health and care in Southampton, so that it is better integrated, delivered as locally as possible, person centred and with an emphasis on prevention and intervening early to prevent escalation'.* For the purpose of these Terms of Reference, Health and Wellbeing is defined as Health and Care services outlined in the scope Annex A.

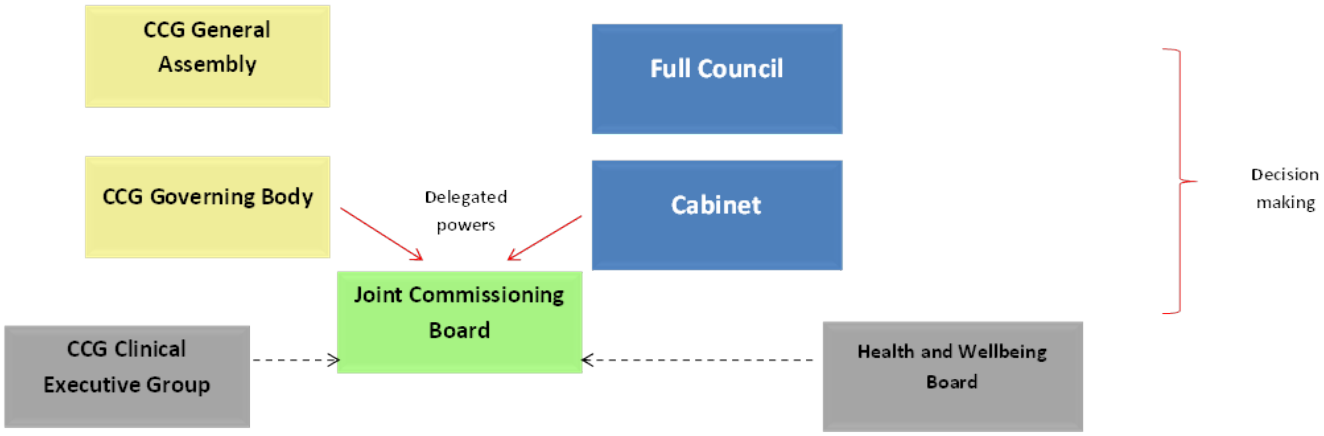
If we are to realise this vision and meet the challenges we face then we will need to

- Act as one for the city by
  - developing and delivering a single view of the city's needs and how we can ensure they are best met
  - aligning and allocating our collective resources to achieve prioritised outcomes
  - working for the whole population
- Support people to become more independent and do things for themselves by changing the relationship between citizens and services
- Be innovative and have an appetite for risk to make the change
- Make the most of new opportunities and powers
- Build on our existing good work
- Ensure that the system is financially sustainable and flexible enough to meet current and future challenges.

1.2. There are a number of benefits from integrated commissioning that have been grouped under three broad headings

1. **Using integrated commissioning to drive provider integration and service innovation**. It is through these innovations that integrated commissioning has the greatest potential to benefit citizens and patients.
2. **Improving the efficiency of commissioned services**. This includes both streamlining process and reducing duplication and variation. This is particularly relevant for services/providers working across both commissioning organisations.
3. **Increasing the effectiveness of commissioning – across the whole of the commissioning cycle.** Combining the knowledge, expertise and importantly authority and leaderships of both organisation (clinical and democratic) has the potential to significantly increase the effectiveness of commissioning across the City.

1.3. The Council and CCG have therefore established a Joint Commissioning Board 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 hereafter will be referred to as the Board



1.4. The Board will act as the single health and wellbeing commissioning body for the City of Southampton and a single point for decision makers. The Board will convene and exercise their functions following consensus / consultation with each other on those functions in scope. This includes those areas of health and social care commissioning covered by the Better Care Fund Section 75. (BCF)

The CCG Governing Body and SCC Cabinet may grant delegated authority (with any appropriate caveats) 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. It is therefore the individual member or officer who has the delegated authority to make a decision rather than the Joint Commissioning Board itself.

- 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.

1.5. Evidence based commissioning will be key to achieving our vision and the Board will be informed and driven by needs assessment, market analysis, user experiences, consultation and engagement.

2. Scope

2.1 The Board will have oversight of all schemes established under the Better Care Section 75 and other remaining Partnership Agreements which in some cases may have their own specific Partnership Board, under the NHS Health Act 2006 flexibilities, and Local Government Act 1972 (s.113). This will include shadow monitoring of schemes under development and scrutinising their suitability for future inclusion in the BCF Partnership Agreement or other Partnership Agreements. An example of schemes to be included is to be found in Annex A

2.2 There are also be services in scope for which the commissioning responsibility/ decision making remains solely with the CCG or City Council but the funding is aligned to deliver a jointly agreed

strategy. Examples can be found in Annex A

2.3 Beyond this, there could be areas of shared commissioning where the Council and CCG will want to discuss and share information about relevant commissioning intentions, budget and spend. The Board could also consider bids that are of joint interest. These 3 categories are described below:

- Jointly commissioned/funded services
- Single agency commissioning aligned under a jointly agreed strategy
- Other areas relevant for the achievement of the outcomes

2.4 The scope of the Board will cover joint NHS and City Council services commissioned by the Integrated Commissioning Unit.

2.5 The Board may, where appropriate, develop a wider range of services subject to final approval of the CCG Governing Body and Council

2.6 Subject to the agreement of the CCG Governing Body and the Council, the Board membership may be amended to include any other partner who jointly commissions with the City Council or Southampton City Clinical Commissioning Group and other agency representatives may be co-opted as necessary.

3 Role and Objectives

3.1 To agree shared commissioning priorities for the Council and CCG based on where a partnership approach will improve outcomes and promote greater efficiencies.

3.2 To approve and monitor the development and implementation of the Integrated Commissioning Plan to ensure it meets agreed priorities, objectives, savings and performance targets and aligns commissioning arrangements with partners' financial and business planning cycles.

3.3 To ensure that all commissioning decisions are made in line with the principles set out in the Integrated Commissioning plan.

3.4 To monitor the financial plans and financial performance of the integrated commissioning function, including forecasts for the year.

3.5 To ensure compliance with any specific reporting requirements associated with the formal pooled fund described in the Section 75 agreement.

3.6 To ensure compliance with rules and restrictions associated with any other blocks of funding, including specific grant funding.

3.7 To ensure management response to risks identified and the assurances against them regarding the integrated commissioning function.

3.8 To agree, subject to the financial decision making limits of the council and the CCG, all financial planning commitments across areas of integrated commissioning responsibility for pooled or non-pooled budgetary provision.

To receive and consider reports on service development, budget monitoring, audit and inspection reports in relation to those services which are the subject of formal partnership arrangements.

3.9 To seek assurance on the quality and safety of commissioned services in relation to key performance indicators and standards. Where performance is outside of expected threshold to receive exception reports.

3.10 To provide system leadership and direction to the staff of the integrated commissioning function.

3.11 To promote quality and identify how the health and wellbeing strategic intentions and priorities of partners will be supported and enabled through integrated commissioning.

3.12 To maintain oversight of the Section 113 arrangements between the two organisations.

4 Better Care Section 75 Partnership Agreement

4.1 Shall oversee and review the schemes established under the Better Care S75 Partnership Agreement, ensuring adherence to the relevant legislation and protocols in the development of Partnership Agreements have been followed.

4.2 Shall receive, review and approve Business Cases for new pooled fund schemes to be established under the Better Care Section 75 Partnership Agreement (with reference to the respective Schemes of Delegation).

4.3 Shall receive and review quarterly reports on each Better Care pooled fund scheme on the exercise of the partnership arrangements. These reports shall include details of:

- Annual forward financial plans setting out the projected annual spend
- Review of the operation of each scheme covering:
  - evaluation of performance against agreed performance measures targets and priorities and future targets and priorities;
  - quality of service delivery and how the arrangements benefit and meet the needs of client groups;
  - any service changes proposed;
  - any shared learning and opportunities for joint training;
  - assurance that monitoring and evaluation processes take account of statutory guidance and policy directives pertaining to quality standards, best value and audit arrangements of the Council and the CCG.

4.4 Shall ensure the Services provided under each scheme are meeting the needs of the service users and their carers.

4.5 Shall ensure that commissioning decisions are the result of the wide ranging consultation and discussion with the key people involved in all aspects of the function of delivering joined up health and social care.

4.6 Shall encourage and ensure that service providers work collaboratively with service users, other providers and commissioners and that it is promoted through positive design of payment packages and risk and benefit share arrangements into commissioning contracts.

4.7 Shall ensure that commissioners listen to service users and providers and respond supportively to ideas to make services more effective for the user and more responsive to needs.

4.8 Shall assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes and act upon these at the earliest opportunity and monitor their impact throughout the delivery of the services. This shall include consideration of proposed changes to the services and funding and how these may impact on each organisation.

4.9 Shall monitor financial contributions of the Council and the CCG and make recommendations regarding future financial contributions.

4.10 Shall provide the Council and CCG with an annual review report and forward plan of the S75 Better Care Partnership Agreement arrangements, incorporating financial and activity performance, risks, benefits and evidence of improvements for service users.

5 Risk Sharing principles

5.1 The pooled budget arrangements will be managed in such a way as to avoid destabilising either organisation, the detailed arrangements for managing the pooled funds are detailed in the Section 75 Pooled Fund Agreement and its scheme specifications.

5.2 Each organisation will retain responsibility for dealing with any deficit it has at the start of the pooled budget arrangement, for the avoidance of doubt this includes a situation where commitments against the pooled fund are greater than or are likely to be greater than the budget set.

5.3 Each organisation will strive to achieve a balanced budget within the pooled budget.

5.4 The statutory requirements of each organisation must be maintained.

The pooled budget (in line with the Section 75 agreement) will contain a mechanism for dealing with significant changes to the funding or statutory responsibilities of either organisation that effect the areas in scope of the pooled budget arrangement.

5.5 Both organisations will provide robust management information in line with their responsibilities in the Section 75.

Both organisations will ensure the early identification of potential in year under or over spends and for remedial actions to be put into place.

6 Governance and Reporting

6.1 The Board will be accountable to the Council's Cabinet and / or Council as appropriate and the CCG Governing Body. It will work in partnership with the Health and Wellbeing Board and the CCG Clinical Executive Group.

6.2 The Board will need to demonstrate contribution to the Health and Wellbeing Strategy outcomes

6.3 The Board will need to be informed by the Joint Strategic Needs Assessment, needs assessments, market analysis and feedback from consultation and engagement with residents and patients.

6.4 The Board will meet monthly and be minuted. Meetings in public will normally be bi monthly with a seminar in the intervening months. Additional meetings of the Committee may be held on an exceptional basis at the request of the Chair.

6.5 At least one meeting each quarter will be dedicated to reviewing the performance of the Better Care S75 Partnership Agreement, undertaking those responsibilities as set out in Section 4.

6.6 The Board shall be entitled to call a meeting, at any time, outside of the agreed meetings schedule, for any purpose, subject to compliance with any statutory requirements in relation to decision making under the Local Government Acts and CCG Constitution.

6.7 All minutes and papers from the Board will be reported to the CCG Governing Body and made available to Council's Cabinet.

6.8 Agendas will be jointly agreed in line with the Forward Plan and will need to be circulated at least 5 working days in advance of the meeting. All new agenda items are subject to agreement of the Chair or Vice Chair. Where a decision of the Council (Member or Officer) is required at a Board meeting then the requirements of the Local Government Act 2000 and Access to Information regulations must be adhered to (publication of notice of key decisions 28 days in advance, publication of reports 5 clear working days in advance, formal decision Notice signed by decision maker and Proper Officer (Democratic Services must attend for this purpose for these items). Decisions that are 'key decisions' within the meaning of the Local Government Act 2000 are subject to the Council's 'call-in' procedures and cannot be implemented until the time for call-in has expired or the matter has been dealt with in accordance with Overview & Scrutiny Procedure Rules.

6.9 The agendas, minutes, decision notices and briefing papers of the meetings of this Board are subject to the provisions of the Freedom of Information Act 2000, the Environmental Information Regulations and the Data Protection Act 1998. If the Chair concludes that specific issues are exempt from publication and should not be made available under the terms of the Freedom of Information Act, a Part 2 meeting of the Board shall be convened to consider them.

6.10 Part 2 meetings have to be notified 28 days in advance of the meeting and reasons for excluding the public included on the report / agenda item or the decision cannot be taken. There are limited urgency provisions but these require prior consent from the chair of the Health Overview and Scrutiny Panel.

6.11 Meetings of the Board shall be advertised in advance on the calendar of meetings of the CCG Governing Body and Council and shall, unless notice of consideration of an excluded item has been given, shall be open to the public to attend from April 2018.

6.12 The Chair will invite questions or statements by members of the public on matters pertaining to that agenda at the beginning of the meeting.

6.13 Administrative support for the Board will be a shared responsibility although agenda publication etc. will be undertaken by both the Council and the CCG to meet both

organisational requirements.

6.14 The Health and Wellbeing Board have delegated responsibility for Better Care to the Board and the Board will be accountable to the Health and Wellbeing Board for this element.

6.15 The Board will receive the minutes from the Better Care Southampton Steering Board

7 Membership

7.1 The council's representation on the Joint Commissioning Board will be 3 Cabinet Members made through executive appointments. and the CCG have nominated 3 members from the CCG Governing Body. Both organisations have agreed to send deputies in any absences. .

7.2 Other attendees

- Key senior managers from the Council and the CCG as required.
- The relevant commissioning lead for each of the pooled budgets under the S75 Better Care Partnership Agreement will attend as appropriate the quarterly meetings to present the performance report for the S75 Partnership Agreement.

7.3 The Chair will be a politician from the council or a member from the CCG Governing Body who will rotate on an agreed basis. The Vice Chair of the Board will be from the alternate partner organisation.

8 Quorum, Decision Making and Voting

8.1 The Board will require consensus prior to any delegated decisions being taken; consensus will be demonstrated by a show of hands. It is important that given the nature of the decisions, securing the support of both partners will be critical to the success of this Board. The Board will be quorate if there are at least 4 members in attendance with a minimum of 2 from each organisation.

8.2 In those circumstances where consensus cannot be reached, the matter will be deferred for further consideration by the parties and will be reconsidered after discussions between the Chair and respective partner lead.

8.3 Schemes of Delegation to City Council Members and Council Officers shall be amended to reflect that decisions should not be taken under delegation and should stand either deferred to a future meeting or referred back to the parent body where a consensus of those present do not support the decision proposed. The Chair of the Board shall consult those present before deferring the decision or directing that it be referred back to each partner organisation.

8.4 Legally, it is not possible to have a mechanism that requires individual decision makers to exercise their decision making function in accordance with the will of a majority or quorum of a Board. Any individual decision maker must consider any decision on its merits as a whole in accordance with established decision making principles. The process for seeking the support of the Board prior to exercising any delegation meets a requirement in the Scheme of Delegation to limit the power to exercise that delegation to situations only where the support of the Board is demonstrated. For both the CCG and SCC the delegated authorisation limit is up to £500k

8.5 Functions outside the decision making scope of the Board, but related to health and social care

will be discussed for information only at the Board, with the considerations and any recommendations of the Board formally minuted. Items will then be referred to the relevant decision maker (e.g. CCG Governing Body, Council).

9 Dispute Resolution

9.1 If disputes relating to the Better Care Section 75 Partnership Agreement arise then the Dispute Resolution process within that will be followed. Otherwise any matter of dispute will be referred for further discussion by the Leader of the Council and Chair of the CCG before referring back to the Board for further consideration. It is recognised that as the desire is to reach agreement on any matter by consensus that if this is not reached that matter may not move forward. There will be no formal and binding external arbitration procedure.

10 Scrutiny

10.1 Decisions of members of the Joint Commissioning Board will be subject to formal scrutiny normally undertaken by the Health Overview and Scrutiny Panel, on behalf of the Council and Call in. Health scrutiny is a fundamental way by which democratically elected councillors are able to voice the views of their constituents, and hold NHS bodies and health service providers to account. In Southampton the Health Overview and Scrutiny Panel undertakes the scrutiny of health and adult social care. The Panel meets every 2 months. However, there may be some major decisions may be considered by the council's Overview and Scrutiny Management Committee.

11 Conflict of Interests

11.1 The Board will be bound by the Standing Orders/Standing Financial instructions and Codes of Conduct of both parent bodies. Declaration of interests will need to be declared annually and at each meeting of the Board in line with the agenda. Depending on the topic under discussion and the nature of the conflict of interest appropriate action will be taken and recorded in the minutes

12 Variation

12.1 The parent bodies may agree from time to time to modify, extend or restrict the remit of the Board.

The Terms of Reference will be reviewed annually

- May 2019

Annex A

Integrated Commissioning – Examples of potential scope

Jointly commissioned/funded services

1. These will be services currently in scope for the 2017/19 Better Care Fund S75 agreement. In addition, the scope will include other existing partnership agreements/shared funding arrangements:
   - Integrated Services within the established 6 Better Care Clusters: Community health services for adults (Community Nursing, Continence, Podiatry, Community Wellbeing Services, Community specialist services for people with long term conditions, case management, Palliative Care, community navigation, Community Adult Mental Health Services and IAPT (Improving access to psychological therapies) , Adult Long Term Social Care Teams)
   - Support Services for Carers
   - Integrated rehabilitation, reablement and discharge services (including the Hospital Discharge Team, Discharge to Assess, residential reablement and extra care, Falls Assessments)
   - Care Technology
   - Prevention and Early Intervention services – Behaviour Change, Older Person's Offer, Information, Advice and Guidance
   - Integrated Learning Disabilities provision (placements)
   - Direct Payments Support services
   - Transformation of Long Term Care provision (Adult Social Care additional/improved BCF funding to support transformation of Extra Care and conversion of a Residential Unit to Nursing Care as well as stabilising the Domiciliary Care and Care Home market)
   - Joint Equipment Service, Wheelchair Service, Orthotics and Disabled Facilities Grant
   - Integrated services for children with complex health needs (specifically Building Resilience Service and SEND integrated health and social care team).

Single agency commissioning aligned under a jointly agreed strategy

2. This would mean that commissioning responsibility/ decision making remains solely with the CCG or City Council but the funding is aligned to deliver a jointly agreed strategy. This could include:
   - Long Term Care provision (including domiciliary care, nursing and residential CHC and social care packages) – aligned to Better Care strategy
   - 0-19 prevention and Early Help, CAMHS, Community midwifery – aligned to 0-19 prevention and early help strategy/CAMHS Transformation
   - Sexual health (integrated level 3 service, voluntary and primary care prevention services, termination of pregnancies, vasectomies) – aligned to Sexual Health and Reproductive Strategy
   - Substance Misuse Services – aligned to Substance Misuse Strategy
   - Respite and Short Breaks – aligned to Replacement Care Strategy, services for children, e.g. Edge of care, Family Drugs and Alcohol Court, Looked After Children, Safeguarding – aligned to children's s t r a t e g y
   - Community development (definition to be agreed)

Benefits

3. The scope will increase the ability of both organisations to:
   - Realise a shared vision – e.g. a shared focus on prevention and early intervention and community solutions to promote independence & a shared commitment to realise it
   - Share risks and benefits associated with implementation of the shared vision, enabling us to do the "right thing" without unfairly disadvantaging or advantaging one organisation
   - Commission against a single agreed set of common outcomes and priorities – making best use of resources
   - Share needs data and good practice evidence – leading to more intelligent commissioning
   - Develop more innovative solutions to meet people's needs in the round (as opposed to commissioning in silos for people's "health" versus "social" needs – leading to improved outcomes for people
   - Bring together health, public health and social care resources and strip out duplication – leading to savings and efficiencies
   - Commission a more joined up health and care system, developing together whole pathways from prevention to care - fewer gaps
   - Enable providers to develop more innovative integrated pathways and organisational models – leading to less fragmentation
   - Shape and develop primary medical care as part of the integrated health and social care system
   - Better understand and manage demand through greater influence over assessment and review processes