Public Document Pack

Joint Commissioning Board

Monday, 11th June, 2018
at 9.30 am

PLEASE NOTE TIME OF MEETING

Conference Room - CCG HQ

This meeting is open to the public

Members

Dr Kelsey
June Bridle
John Richards
Councillor Hammond
Councillor Payne
Councillor Shields

Please send apologies to:

Emily Chapman, Board Administrator,

Tel: 02380 296029

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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 officers 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 20181/19

2018	2019
12th April	10th January
14th June	14th February
12th July	14th March
9th August	
13th September	
11th October	
8th November	
13th 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**
Beccy Willis	Information	None

2 APPOINTMENT OF CHAIR AND VICE-CHAIR

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Beccy Willis	Decision	None

3 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**
Chair	Discussion	None

4 PREVIOUS MINUTES/MATTERS ARISING AND ACTION TRACKER (Pages 1 - 6)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chair	Decision	Attached

5 MEMORANDUM OF UNDERSTANDING AND TERMS OF REFERENCE (Pages 7 - 26)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chair	Decision	Attached

6 BETTER CARE PERFORMANCE REPORT - QUARTER 4 (Pages 27 - 98)

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

7 INTEGRATED COMMISSIONING UNIT BUSINESS PLAN (Pages 99 - 144)

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

8 QUALITY UPDATE ON SOCIAL CARE PROVIDERS (Pages 145 - 176)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Carol Alstrom	Discussion	Attached

9 BETTER CARE STEERING BOARD TERMS OF REFERENCE (Pages 177 - 178)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chair	Decision	Attached

10 BETTER CARE STEERING BOARD MINUTES (Pages 179 - 184)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chair	Decision	Attached

Friday, 1 June 2018

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Meeting Minutes

Joint Commissioning Board

The meeting was held on 8th March 2018, 09:30 – 10:30
Conference Room, Oakley Road

	NAME	INITIAL	TITLE	ORG
Present:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	Councillor Simon Letts	Cllr Letts	Leader of the Council	SCC
	June Bridle	JB	Lay Member (Governance)	SCCCG
	Councillor David Shields	Cllr Shields	Health and Sustainable Living	SCC
	Councillor Warwick Payne	Cllr Payne	Adults, Housing and Communities	SCC
In attendance:	Dawn Baxendale	DB	Chief Executive Officer	SCC
	Suki Sitaram	SS	Chief Strategy Officer	SCC
	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG/SCC
	Beccy Willis	BW	Head of Business	SCCCG
	Amanda Luker	AL	Commissioner	SCCCG/SCC
	Carole Binns	CB	Associate Director	SCCCG/SCC
	Matthew Waters	MW	Senior Commissioner	SCCCG/SCC
	Donna Chapman	DC	Associate Director System Redesign	SCCCG/SCC
	Sarah Spooner	SSp	Board Administrator (Minutes)	SCCCG
Apologies:	John Richards	JRichards	Chief Executive Officer	SCCCG
	Mel Creighton	MC	Chief Financial Officer	SCC
	James Rimmer	JRimmer	Chief Financial Officer	SCCCG
	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Sarita Riley	SRil	Service Lead: Legal Services Partnership	SCC

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted	
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 of Interest were declared in relation to the agenda.	
3.	**Previous Minutes/Matters Arising & Action Tracker**	
	The minutes from the previous meeting dated 8th February 2018 were agreed as an accurate reflection of the meeting. **Matters Arising** Item 3 - RSH Future Options – Cllr Letts advised that an MP version of key points will be circulated to Southampton City MP and wider. It was suggested a face to face MPs briefing is held in April. Item 8, Integration Board minutes – SR raised that interviews were unsuccessful in appointment of the Better Care Programme Manager and is currently being re-advertised until the end of March 2018. **Action Tracker** The outstanding actions were reviewed and the action tracker updated.	**Cllr Letts**
4.	**Residential Recovery and Rehabilitation Services**	
	Amanda Luker (AL) and Carole Binns (CB) attended the meeting to present the paper. AL talked through the highlights. The Board supported the proposal of a longer contract period. DB commented that it is important for robust performance measures to be in place. CB responded that this is a bespoke service; however there is benchmarking available from similar services elsewhere. There are also a range of quality measures in place which include looking at the improvement to each individual's functioning. The Board supported the recommendation to proceed with a procurement of a Residential Recovery and Rehabilitation Provision for people with Enduring Mental Health problems. AL and CB left the meeting.	
5.	**Market Development and Care Home Market Shaping**	
	Matthew Waters (MW) attended the meeting to present the Market Development and Care Home Market Shaping paper. DB commended the High Cost Placement team on over performance on expected savings. WP queried whether the intention is to potentially move clients from one home to another. MW assured the Board that is not the intention. The	

	focus is on renegotiation of existing rates and ensuring payment made for services provided. WP queried whether the proposed changes to bands for the Published Rate levels could be discussed with Hampshire County Council to see if they would consider different rates across the county to allow alignment with the Southampton rates. Cllr Letts agreed to explore with politicians on this and SR will liaise with Graham Allen. The Board agreed the need to develop communication with the public to provide information on types of care and the complexity in keeping an individual in a safe environment. Increasing Nursing Home capacity was discussed. There is a need for more nursing home beds for city residents, especially for those with dementia and /or complex behaviours. Impact of availability of workforce was discussed. SR commented that the potential development of Adnac Park could attract skilled clinical nursing staff to the city. Recruitment of care workers will remain a challenge. There is a potential that this may align with the development of the proposed transitional unit on the University Hospital Southampton site and so significantly increase staffing requirements. **Action: MW to clarify timeline so that pressure points are highlighted and plan can be established for workforce capacity depending on how many beds are required.** The Board supported the recommendation for the Council to enter into specific agreements with the identified homes and at the agreed rates. The Board also supported the continued moves to agree rates and access arrangements with homes. The Board noted the anticipated cost savings and supported the actions. The Board supported investment of iBCF monies in additional nursing home capacity. MW left the meeting.	**Cllr Letts SR** **MW**
6.	**Better Care Quarterly Report - Q3**	
	The Board received the Better Care Quarter 3 2017/18 Report. Donna Chapman (DC) attended the meeting to talk through the highlights of the paper. DC highlighted that a reduction in Delayed Transfers Of Care performance has been seen compared to this time last year. An area of focus is Southern Health Foundation Trust (SHFT). It is likely that their data is not being recorded correctly and SHFT are working with Southampton City Council to rectify this.	

	JB queried how it is proposed to support resilience in the voluntary sector. DC responded that the Community Development Offer is being finalised and will be brought to a future Board Briefing. WP queried whether the uptake of Care Technology could be added as a 7th priority for Better Care for the next 3 – 6 months. It was agreed that the Board would monitor the uptake. The Board thanked DC for report.	**DC**
7.	**Performance Report**	
	The Board received the Performance Report. SR talked though the highlights. DC highlighted to the Board that there is a programme of work ongoing around high intensity users; these are individuals who present more than five times in one year to A&E. An update will be provided to the Board. The Board discussed that there is an element of training needed for staff within care homes on how to assist an individual who has fallen without them automatically calling for an ambulance. It was noted that this links with the Enhanced Health in Care Homes work that is already underway. SR commented that iBCF funding has been invested in providing Rise and Recline Mobility Chairs in a number of places within the city to support staff in raising an individual off the floor. SS referred to the high level risk areas and suggested Workforce is an agenda item in 3-6 months time. Cllr Letts supported this suggestion and added that perhaps providers, university and college colleagues are invited to a Seminar on Workforce. SR supported this and highlighted that there is a workforce summit, being supported by Geoff Glover and Solent University, currently being organised. The Board agreed that following the Workforce Summit a discussion will be held at a future Joint Commissioning Board meeting and Denise Edgehill and Geoff Glover are to be invited.	**DC** **SR**

Date of next meeting: Thursday 12th April 2018, 09:30-10:30, Conference Room 3, Civic Centre

Joint Commisioning Board - Action Tracker						
Agenda Number	**Date of meeting**	**Subject**	**Action**	**Lead**	**Deadline**	**Progress**
3	11/01/2018	Matters Arising - RSH Future Options	JRimmer and Peter Horne to informally raise the issue with the Chief Executive Officer of NHS Property Services	JRimmer	Feb-18	08/02/2018 - Ongoing
8	08/02/2018	Integration Board Minutes	SR/SS to look at SCC Integration Board attendance	SR/SS	Mar-18	Complete
3	08/03/2018	RSH Future Options	Cllr Letts to circulate an MP version of key points to Southampton City MPs and wider	Cllr Letts	Apr-18	Unconfirmed
5	08/03/2018	Market Development and Care Home Market Shaping	Cllr Letts to explore with politicians the proposed changes to bands for the published rate levels and whether Hampshire County Council would consider different rates across the county	Cllr Letts	Apr-18	Unconfirmed
	08/03/2018		SR to liaise with Graham Allen	SR	Apr-18	Complete - No further action needed
	08/03/2018		MW to clarify timeline so that pressure points are highlighted and plan can be established for workforce capacity depending on how many beds are required	MW	Apr-18	Complete - Timeline agreed as part of the ICU plan for the year
6	08/03/2018	Better Care Quarterly Report - Q3	DC to add Care Technology as a priority for Better Care	DC	Apr-18	Complete
7	08/03/2018	Performance Report	Update on high intensity users to the Board	DC	Jun-18	On Forward Plan

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DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		Joint Commissioning Board Terms of Reference and Memorandum of Understanding		
DATE OF DECISION:		11th June 2018		
REPORT OF:		Dr Mark Kelsey		
CONTACT DETAILS				
AUTHOR:	**Name:**	Rebecca Willis	Tel:	023 80296002
	E-mail:	beccy.willis@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	023 80296075
	E-mail:	Stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY		
Not Applicable		
BRIEF SUMMARY Southampton City Council and Southampton City CCG have 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 on the progress and outcomes of the integrated commissioning function.		
RECOMMENDATIONS:		
	(i)	Joint Commissioning Board are asked to review and sign off the Terms of Reference
	(ii)	The Board are asked to review and agree the Memorandum of Agreement
REASONS FOR REPORT RECOMMENDATIONS		
1.	To ensure the Governance process is in place for the Joint Commissioning Board that follows the constitutional arrangements of both the Council and Clinical Commissioning group	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not Applicable	
DETAIL (Including consultation carried out)		
3.	Nationally there is an expectation that full integration of health and social care will be implemented by 2020. Southampton is ideally placed to increase the pace and depth of integrated commissioning, with its asset of co-terminosity between health and local government; its track record of delivering benefits through integration, its existing integrated commissioning functions and good working relationships. As a consequence a shared ambition for change has been agreed between SCC Cabinet and the Clinical Commissioning Group (CCG) Governing Body: 'Commissioning together for health and wellbeing will allow us 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'.
4.	In July 2017 Southampton City Council and Southampton City Clinical Commissioning group both gave formal approval for the establishment of Joint Commissioning Board with delegated powers to make joint decisions on behalf of the Council and CCG on certain agreed functions related to health and care. it was agreed by Full Council and the CCG Governing Body that the scope of the integrated commissioning arrangements will broadly mirror those areas of health and care commissioning covered by the Better Care Fund S75 plus other existing partnership agreements/shared funding arrangements.
5.	Full Council agreed to delegate authority to undertake joint commissioning functions that are non-executive functions within agreed budgets to individual members of the Board (Officers and Members as appropriate) acting at Board meetings within the procedures set out in the terms of reference. CCG Governing body delegated authority to the nominated members on the Joint Commissioning board.
6.	The Terms of Reference for the Board were approved at this time by both organisations. Terms of Reference require reviewing at the start of the year.
7.	As part of the process in developing the Joint Commissioning approach a number of joint sessions were held between the Cabinet and CCG Governing body members. This active discussion between clinicians and politicians led to a number of agreed values, principles and behaviours. These have been outlined in a Memorandum of Understanding, attached as Appendix 2 this requires reviewing.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	The scope of the integrated commissioning arrangements is limited to agreed elements of health and care commissioning. A large majority are already included in the well-established Better Care Fund Section 75 agreement between the council and the CCG. It will also include other existing partnership agreements and shared funding arrangements. As a consequence the Joint Commissioning Board are responsible for a budget of of at least £105M. The services included within this budget will form part of the budget process for both organisations and still be required to contribute to the efficiency and savings programmes. The remit of the Joint Commissioning Board will be to recommend savings to contribute to these programmes. The Joint Commissioning Board will be responsible for delivering agreed savings, many of which will be inter related across social care and health.
Property/Other	
9.	Not Applicable
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	Children and Families Act 2014 – emphasises that a local authority in England and its partner commissioning bodies must make arrangements ("joint commissioning arrangements") about the education, health and care

	provision to be secured .
11.	Care Act 2014 establishes requirement for integration of care and health by 2020
12.	NHS Five Year Forward View 2014 which outlines the future direction for the NHS which requires new partnerships in how care is delivered breaking down barriers between health and social care with more integrated approaches and with patients having far greater control over their own care
Other Legal Implications:	
13.	It is the responsibility of the Board to: • assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes • monitor financial contributions of the Council and the CCG and make recommendations regarding future financial contributions • receive and sign off all Better Care Fund performance reports for approval and submission to NHS England • provide the Council/Cabinet and CCG Governing Body with an annual review of the S75 Better Care Partnership Agreement arrangements.
CONFLICT OF INTEREST IMPLICATIOINS	
14.	None
RISK MANAGEMENT IMPLICATIONS	
15.	None
POLICY FRAMEWORK IMPLICATIONS	
16.	In line with both Constitutions

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Terms of Reference
2.	Memorandum of Understanding

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**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact	**No**

Assessment (PIA) to be carried out.		
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	

Memorandum of Understanding between

Southampton City Council and

Southampton City Clinical Commissioning Group

Introduction

There is an emerging consensus about the opportunity to improve outcomes through a unified approach to health and care planning and funding (commissioning). Southampton is ideally placed to increase the pace and depth of integrated commissioning, with its great asset of co-terminosity between health and local government; its track record of delivery and good working relationships.

There are a range of strategic challenges for the council and health in Southampton especially delivering better outcomes for all residents (not just the most vulnerable) with significantly less resources, the consequences of reducing demand and managing future demands through prevention and early intervention. There is also a need to promote change in behaviours, increase individual independence and community resilience so that contacting the statutory service is the last resort.

Purpose

Both parties have therefore articulated 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'

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 delivery a single view of the city's needs and how we can best meet them
  - 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

Benefits

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

Challenges

There were many challenges that were identified during the planning and implementation of the Joint Commissioning Board these include:

- Changing demography and population profile: Increasing needs and complexity
- Reducing resources to meet increasing demand
- Demand driven by the wider determinants of health and illness.
- Continuing inequality and increasing deprivation.
- Increasing social care needs
- Complex decision-making for integrated services – two governance routes with different timescales and requirements.
- A national and local shift towards commissioning for outcomes – one system, one city, one budget.
- Ensuring that commissioning arrangements align with, and can drive, provider integration.
- Ensuring alignment with wider strategic change across the NHS, Local Authority and wider public services – including Hampshire and Isle of Wight Sustainability and Transformation Plan, SCC Transformation Programme, potential devolution to Solent.

Opportunities

- Southampton City Council and Southampton City CCG have the same boundaries and shared objectives to improve the outcomes for the citizens of Southampton
- Delivering better outcomes through cost effective and seamless services.
- Substantial relationship with a track record of delivering benefits through integration. The ICU has been key to demonstrating that integration leads to reduced costs as well as improved outcomes.
- Clusters – emerging infrastructure for integrated services.
- National policy provides a ‘window of opportunity’ for radical change – focus on integration and devolution.

Principles and Values

The key principles that will underpin partnership working between the two parties include:

- Engagement at all levels built on mutual trust that comes from open, honest and constructive dialogue, sharing as much information as possible
- Ability to support each other with difficult decisions
- A strong focus on quality of service provision and outcomes which keep patients and citizens and the needs and views of the local population at the centre of commissioning activities
- A commitment to an aligned approach with providers of health and care.
- Actively involve other clinicians and politicians
- Collaborative working that reflects local variation recognising variability in levels of need, priority and resources
- A commitment to represent each other positively with mutual respect
- Recognition that CCG and SCC staff require a consistent approach to undertake the supporting arrangements effectively; staff will be respected as officers of both organisations.
- Ensure that there is time for ongoing reflection, learning and celebrating successes
- A commitment to achieve outcomes based on evidence

Expectations of each other within the Group

- 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 City of Southampton

- 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 members are at all times acting in the best interests of Southampton 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.

- We will be open to others disagreeing with us, willingly accept feedback that might be uncomfortable, and say when we might be wrong.

- 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.

Governance arrangements and conflict resolution

These are set out in the Joint Commissioning Board Terms of Reference

Review

This Memorandum of Understanding will be reviewed annually or earlier if requested by either party

April 2018

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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.

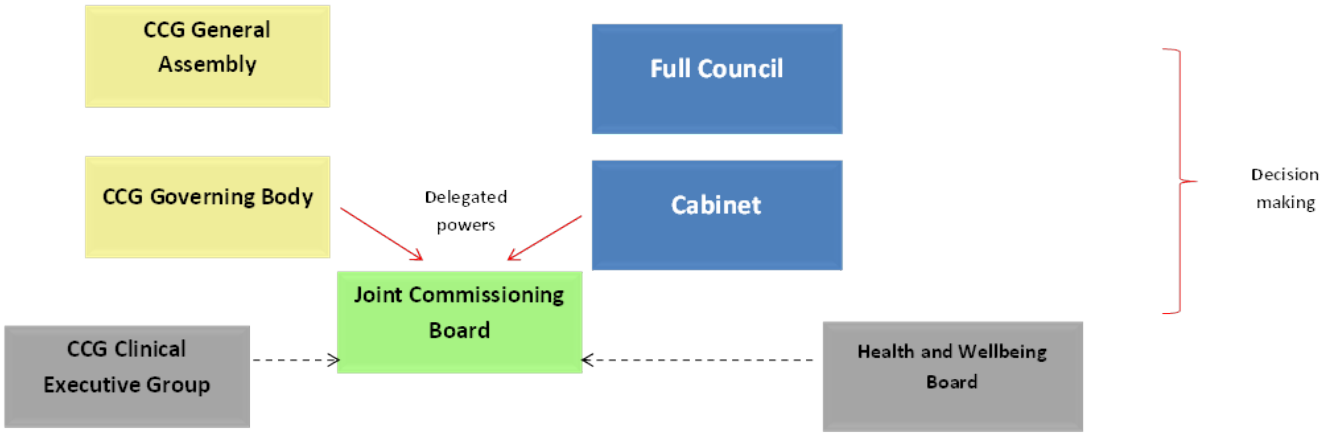
If we are to realise this vision and meet the challenges we face then we will need to

- 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 as defined in Annex A. This includes those areas of health and social care commissioning covered by the Better Care Fund Section 75. (BCF)

1.5. 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.

1.6. It is proposed that the scope of the integrated commissioning arrangements overseen by the new Board will be broadly as described below.

1.7. 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. A list of the schemes included and planned for the Better Care Section 75 Partnership Agreement can be found at Annex A.

- 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.

1.8. 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 scope of the Board will cover joint NHS and City Council services commissioned by the Integrated Commissioning Unit. The scope is outlined in Annex A.

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

2.3. 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.

3.9. 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.

3.10. To set priorities for, and review the performance of, the Integrated Commissioning Unit on behalf of Southampton City Council and Southampton City CCG.

3.11. 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.

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

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

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

4. Better Care Section 75 Partnership Agreement

4.1 With specific reference to the Better Care Section 75 Partnership Agreement, the Joint Commissioning Board:

4.2 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.

4.3 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).

4.4 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.

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

4.6 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.

4.7 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.

4.8 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.

4.9 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.

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

4.11 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.

5.5. 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.

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

5.7. 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.

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.

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.

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.

12.2. The Terms of Reference will be reviewed in March 2018 or sooner at the request of the Chair or Vice Chair.

April 2018

Annex A

Integrated Commissioning – Potential scope

1. Initially, it is proposed that the scope of the integrated commissioning arrangements overseen by the new Board will be broadly mirror those areas of health and social care commissioning covered by the Better Care Fund Section 75.

2. As is currently the case, the assumption is that some of the services in scope will be jointly funded and jointly commissioned under a S75 or S256/76 arrangement (primarily through the Better Care Fund S75 Agreement).

3. However there will 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.

4. 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

<u>Jointly commissioned/funded services</u>

5. 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

6. 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 strategy
   - Community development (definition to be agreed)

Benefits

7. 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

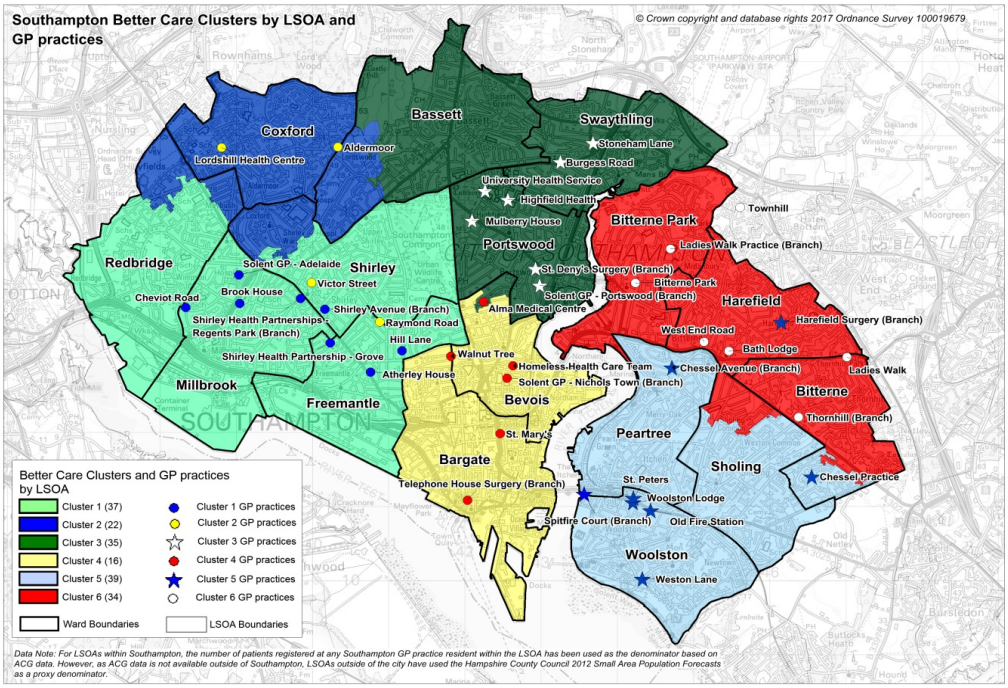
DECISION-MAKER:		**Joint Commissioning Board**		
SUBJECT:		**Better Care Quarter 4 2017/18 Report**		
DATE OF DECISION:		**11 June 2018**		
REPORT OF:		**Stephanie Ramsey**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman**	**Tel:**	**023 80296004**
	E-mail:	**d.chapman1@nhs.net**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296941**
	E-mail:	**Stephanie.Ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
NOT APPLICABLE		
BRIEF SUMMARY		
This report provides an end of year overview of 2017/18 performance against Southampton's Better Care programme and pooled fund. A more detailed report on individual scheme performance can be found at Appendix 1. Detailed data on the performance indicators can be found at Appendix 2. The financial position is attached at Appendix 3. A highlight report is attached at Appendix 4.		
RECOMMENDATIONS:		
	(i)	To note the end of year 2017/18 performance report for Better Care.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Joint Commissioning Board (JCB) is responsible for oversight of the Better Care pooled fund. This responsibility has been delegated to JCB from the Health and Wellbeing Board (HWBB). It is the responsibility of the JCB to assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes, monitor financial contributions of the Council and the CCG and make recommendations regarding future financial contributions and receive and sign off all BCF performance reports prior to onwards presentation to the Health and Wellbeing Board for approval and submission to NHSE.	
2.	It should be noted that this year's Better Care plan is year one of a two year plan. No changes to the schemes are envisaged for 2018/19.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
3.	**NOT APPLICABLE**	
DETAIL (Including consultation carried out)		
4.	**Overview** Southampton's Better Care Plan aims to achieve the following vision: • to put **individuals and families at the centre of their care and support**, meeting needs in a holistic way	

- To provide the **right care and support, in the right place, at the right time**
- To make **optimum use of the health and care resources** available in the community
- 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** to support people to retain and regain their independence

It is a programme of whole system transformational change which is based around 3 key building blocks:

- **Implementing person centred, local, integrated health and social care through the city's six cluster teams** (shown in the map below). This includes harnessing the assets within communities and the power of individuals in improving their own health and wellbeing. It also includes health, social care, housing and voluntary sector teams in each cluster coming together to proactively identify those people most in need in the local area and plan and deliver care and support in a more joined up and personalised way.



- **Joining up Rehab and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams** that in turn link with each of the six clusters.
- **Building capacity** across the system to promote and support people to maintain their independence for as long as possible. This includes promoting self management approaches and supporting the role of carers. It also includes developing the capacity of the voluntary and community sector to meet lower level needs in local communities, as well as investing in the home care sector to enable more people to continue living in their own homes.

At the heart of the Better Care Programme is the focus on **prevention and early intervention**, encouraging local people and the health and care workforce to

promote positive health and wellbeing at every opportunity and to identify problems as early as possible, taking proactive action to address them.

The **Better Care Fund** pools resources from both the CCG and Local Authority to support the delivery of the Better Care Programme. In 2017/18 this totalled just over £109M (£71.5M from the CCG and £37.8M from the Council), making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which is £16.177M, demonstrating its commitment to integrating health and social care at scale.

Southampton's Better Care Fund is made up of the following schemes:

1. Supporting Carers
2. Cluster working
3. Integrated Rehabilitation and Reablement and Hospital Discharge
4. Promoting Care Technology
5. Prevention and Early Intervention
6. Learning Disability Integration
7. Promoting uptake of Direct Payments
8. Transforming Long Term Care
9. Integrated provision for children with SEND
10. Integrated health and social care provision for children with complex behavioural & emotional needs

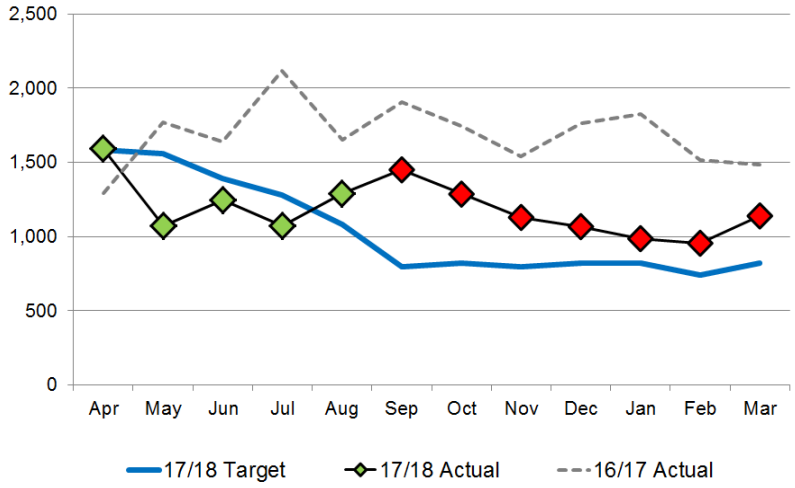
5. **Performance in 2017/18**

The table below provides the Performance against the key Better Care national indicators at 2017/18 year end.

Metrics	End of Year Performance vs. Target	End of Year Performance vs. Previous Year	Commentary
Non elective hospital admissions	Target Achieved (0% variance to target)	Flat (0% change to last year)	▪ It is likely that the following initiatives helped with delivery: 1. **Changes to coding/counting of very short stay NEL admissions** where a patient is admitted into a CDU chair. From August 2017, these are now only counted as an A&E attendance. 2. **Introduction of GP front door streaming in ED**, from October 2017. 3. **Case Management** in primary care and with care homes
DTOC Rate (Marchanapahot)	Target Not Achieved (6.4% vs. 3.9% target)	Better (2.2% lower than last year)	▪ Provider DTOC rates at the end of the year – UHS, 5.9%; Solent, 4.1%; Southern Health: 3.6%. ▪ Strong focus this year on community hospital DTOC as well as acute hospital
Delayed Days	Target Not Achieved (14% higher than target)	Better (29% lower than last year)	
Permanent admissions into residential care	Target Achieved (8% lower than target)	Better (12% lower than last year)	▪ Success in this area is believed to be the result of focus on "home first" principles supported by developments in domiciliary and extra care and discharge to assess schemes focussing on supporting clients to maintain their independence
Injuries due to falls	Slightly Missed Target (7% higher than target)	Slightly Higher than Last Year (3% higher than last year)	▪ Reducing admissions related to falls continues to be a challenge although the numbers are small exaggerating percentage variance ▪ A number of initiatives are in place to reduce falls, some only starting in Quarter 3, e.g. the Fracture Liaison Pathway and the expansion of falls exercise across the city. It is known that, as with many prevention programmes, it can take a while for interventions to embed and have an impact

6. **Performance Headlines**

- **Permanent admissions to residential and nursing homes** have reduced

	significantly compared to 2016/17, exceeding the 2017/18 target. This is believed to be the result of a relentless focus on "home first" principles supported by developments in home care and extra care and discharge to assess schemes focussing on supporting clients to maintain their independence. • **Delayed transfers of care** have reduced significantly compared to 2016/17 (29% reduction of 4913 bed days), albeit not achieving the national 3.5% target (delayed bed days as a % of total available bed capacity). The position for UHS at year end was 5.9% against the 3.5% target. Good progress has been made at the community hospitals with a year end position of 4.1% for Solent and 3.6% for Southern Health. The chart below shows the significant reduction made in 2017/18 compared to 2016/17:  The reduction has been significantly noticeable in delays related to completion of assessment - these reduced by 2308 in 2017/18 compared to 2016/17 (a reduction of 76%). • **Non Elective admissions** remained the same in 2017/18 as in 2016/17, despite a 1.9% increase in population. • **Falls** were 7% above target at year end and 3% higher than in 2016/17. A number of initiatives have been put in place to reduce falls, although some only starting in Quarter 3, e.g. the Fracture Liaison Pathway which commenced 1 October 2017 to identify patients with fragility fracture following attendance in A&E or hospital admission and ensure they are appropriately referred to community support services. It is known that, as with many prevention programmes, it can take a while for interventions to embed and have an impact.
7.	**Key highlights in relation to the Better Care Schemes in 2017/18** Below is a summary of the key developments in 2017/18 against each of the three "building blocks" identified in section 1. • **Implementing person centred, local, integrated health and social care through the city's six cluster teams** o Cluster Development: six clusters are embedding across the city. Cluster leadership has been strengthened with the appointment of dedicated professional leads for each cluster from December 2017. o A Better Care programme manager has also been appointed (starting May 2018) to provide additional support and capacity for cluster

development, the initial task being a stock take of progress made in each cluster towards integrated person centred working with a view to putting in place a development plan for each cluster.

- Local Solutions Groups bringing together voluntary, community, faith organisations and the business sector have now been established in each cluster. The initial focus of the groups will be to map neighbourhood resources to aid signposting to community alternatives. The Itchen to Bridge the Gap group (Cluster 5) has already been established and has completed this mapping exercise (to be uploaded to the Southampton Information Directory (SID)) and developed Dementia Friends with local businesses in the Bitterne area.
- Additional investment from the CCG has been made available to Solent NHS Trust to provide enhanced End of Life support – recruitment of additional palliative care support workers commenced in Quarter 3; the enhanced provision will support more people to die in their place of choice.
- A model of Enhanced Health in Care Homes has been piloted since September 2017 to provide additional support to care homes. This includes a city wide team providing training and development and support with implementation of best practice, e.g. early warning signs tool; and case management and enhanced primary care support delivered respectively by Solent NHS Trust and Southampton Primary Care Ltd focussing on the 15 homes with the highest number of hospital admissions. This model will be evaluated in June 2018 with a view to further roll out across the city.

- **Joining up Rehab and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams**
  - The Integrated Rehabilitation and Reablement and Hospital Discharge service continues to embed and achieve key performance targets (92% of referrals for crisis response responded to within 2 hours, 88% reablement clients achieving their goals).
  - Data from the Urgent Response Team (within the Rehab and Reablement Service) continues to show that the service is reducing long term care needs. In Q3 there were 42 users of rehab and reablement. 40% of these left independent, requiring no further care; of those remaining 23% saw a 13% reduction in their care. This resulted in a saving of 129.5 home care hours a week.
  - The Hospital Discharge Team is now providing a service across the community hospitals as well as the acute hospital in line with the city's ambition to improve hospital discharge across the system as a whole.
  - Discharge to assess is now standardised for pathway 2 (clients requiring additional support, including rehab and reablement) and the numbers of discharges to this pathway are exceeding target levels. A similar model has been piloted for pathway 3 and the results are currently being evaluated.
  - The work undertaken on integrating and strengthening rehab and reablement has also achieved the intended refocus from bed based

reablement to reablement in a person's own home, and, as a result, we have seen a drop in demand for the five reablement beds commissioned from the residential care sector over the last 6 months and have subsequently reduced this to 3 beds for 2018/19.

- **Building capacity** across the system to promote and support people to maintain their independence for as long as possible
    - The Carers in Southampton Service has increased the numbers of carers identified. Between 98% and 100% of carers assessed and awarded a personal budget have taken this as a Direct Payment.
    - There have been a number of developments with the voluntary and community sector which have resulted in new services being procured during 2017/18, including:
        - The Integrated Advice, Information and Guidance service which went live in February 2018
        - The Southampton Living Well Service which went live in April 2018 and will transform the current older person's day services into a more community focussed model.
        - The roll out of Community Navigation across all clusters. A number of different providers are currently delivering this service and work is currently underway with them to develop a more integrated model of provision.
        - Falls exercise classes are now operating in all parts of the city and their impact is currently being evaluated.
        - The new Behaviour Change Service went live 1 April 2017.
    - The additional iBCF funding (which is part of the Better Care pooled fund) has been used to increase capacity within the care market particularly over the winter period. This has included the following developments:
        - The development of extra care; new placements have been made, including individuals moving from nursing care settings to extra care. Significant savings have been achieved following the opening of Erskine Court in 2016/17 - £272K full-year effect. The ICU is working with the care provider to continue to increase complexity levels that can be met within Erskine Court. This includes additional training for staff to meet greater needs, payment for covering call alarms in schemes, activities, and planning for additional capacity overnight to support individuals with night-time care needs. Learning from Erskine Court is being utilised in the development of Potters Court to maximise positive outcomes.
        - Consolidation of increased home care (5,829 additional home care hours purchased for 17/18), promotion of 7 day working and extension of an existing retainer for 6 months to provide additional capacity over the winter to support hospital discharge.
        - Promotion of community based resources as an alternative to social care - temporary resource put in place to update

	Southampton Information Directory (SID) so that people are aware of the services available. ▪ Development of prevention, early intervention and return to home initiatives to help people keep well and maintain their independence thereby reducing future pressure on the care market. Grants for agencies were provided to go live from April 2018 onwards. ▪ Transport options for care workers increased as part of a broader programme supporting care staff through agencies. This includes car parking passes and access to bicycles for key parts of the city
8.	**Key Areas of Focus for 2018/19** In 2018/19 we will continue to deliver against the 6 key priorities identified in the 2017-19 Better Care Plan: • Further expansion of the integration agenda across the full life-course • Continue to strengthen prevention and early intervention • Further shift the balance of care out of hospital and other bed based settings into the community • Development of the community and voluntary sector • Development of new organisational models which better support the delivery of integrated care and support • New contractual and commissioning models which enable and incentivise the new ways of working 2018/19 will specifically focus on the following key developments: **2018/19 Work Programme** Person centred local coordinated care • Strengthen cluster leadership and embed integrated working practices • Embed new strengths based model of adult social care and housing into clusters. • Develop integrated models of care and support, including Frailty model, Learning Disability Services and prevention and early help provision for children and families. • Develop community services to manage greater levels of acuity outside hospital. • Implement the new service model for end of life care Responsive Discharge and Reablement • Embed the three discharge pathways (simple, supported and enhanced), including Discharge to Assess with a particular focus this year on Pathway 3 • 7 day services to support seven day discharge, including improving quality of discharge and relationships with care homes • Develop the role of the clusters in supporting timely discharge. • Roll out of the Enhanced Health in Care Homes model Building Capacity • Embed the new Southampton Living Well Service, Community Navigation and new integrated Information and Advice Service. • Full implementation of online carer support services. • Continue to seek development partner(s) to increase the supply of extra care housing. • Re-procure home care and stimulate growth in the local supply of nursing care for people with complex needs and challenging behaviour. • Procure and implement the care technology strategy in Southampton.
RESOURCE IMPLICATIONS	
Capital/Revenue	

9.	The total value of the pooled fund for 2017/18 is just over £109m. As at 2017/18 year end, overall performance against the pooled fund was a slight (1%) overspend of £1.167m. The main areas of overspend relate to: • the Cluster Scheme where the Council ended the year with a £293k overspend owing to additional spend on locums. This has taken place partly to cover staffing vacancies and also to carry out additional client reviews. (The CCG also ended the year with an overspend of £314k on this scheme; however this was due to planned investment in the Dorset Healthcare contract for the Improving Access to Psychological Therapies (IAPT) Service). • the Learning Disabilities Scheme where there was a year end overspend of £1.285m (£511k for the CCG and £774k for the Council) owing to care packages. These projected overspends were to some extent offset by underspends on other schemes: • Integrated Rehab and Reablement and Hospital Discharge where there was a collective underspend of £609k, mainly related to staff vacancies (that are now being recruited to) and less than anticipated spend on independent home care provision. Financial performance against each Scheme is monitored on a monthly basis by the Better Care Finance and Performance Group. The detailed 2017/18 year end position can be found at Appendix 3.
10.	Within the Better Care pooled fund is also the additional improved BCF (iBCF) social care funding announced in two tranches in 2016/17 and 2017/18. In total this came to £5,585,472 for 2017/18. The first tranche of this funding was invested into existing adult social care teams. The second tranche which equated to £4,981,651 has been invested in a range of developments, as agreed by Cabinet in July 2017, and in line with the grant conditions below: ▪ To meet adult social care needs: 32% ▪ To reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready: 12%. The main areas of investment being in the hospital discharge team and discharge to assess schemes. ▪ To ensure that the local social care provider market is supported: 56%. The main areas of investment being: o Establishment of a £1M capital fund for additional dementia nursing beds – identification of potential schemes that will deliver increased capacity. The initial scheme was no longer possible to agree within the financial year and therefore the funding has been transferred to 2018/19 with negotiations underway. o £900k allocated for additional financial support to the care market (following justification and accounting reviews) enabling providers to meet their legal obligations in full within Southampton, increasing staff pay and provider sustainability. This has included National Minimum Wage impacts and meeting changes to sleep-in payment requirements. o £1.2m allocated to Adult Social Care to support increases in demand and complexity.

Property/Other	
11.	There are no specific property implications arising from the Better Care pooled fund.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
12.	The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006, which requires that in each Local Authority area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2017-19, NHS England set the following conditions: • Agreement of a joint plan between the CCG and Local Authority • NHS contribution to social care is maintained in line with inflation • Agreement to invest in NHS-commissioned out-of-hospital services • Implementation of the High Impact Change Model for Managing Transfers of Care. Southampton is compliant with all four of these conditions. As at the time of writing, no updated guidance has been published for the Better Care fund in 2018/19 and beyond.
Other Legal Implications:	
13.	None
CONFLICT OF INTEREST IMPLICATIOINS	
14.	None
RISK MANAGEMENT IMPLICATIONS	
15.	Risks on specific Better Care Fund Schemes are listed in the templates at Appendix 1. Key risks and issues for the Better Care Programme overall are summarised below: • **Capacity and Capability of leadership within clusters** to embed the new model of person centred integrated working at the pace required - one of the key initial tasks of the Better Care Programme Manager who commenced this month will be to undertake a stocktake of progress within each cluster to identify strengths and weaknesses and work with the Cluster leadership teams to put in place development plans, highlighting any requirements for additional support and resources to the Better Care Steering Board. • **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 • **Resilience in the voluntary sector** and ability to respond to new ways of working - A number of mitigating actions are being taken including: various procurement options being considered to make best use of local market and encourage innovation; support to local agencies also being considered as part of the developments; proactive review of any bidding opportunities.

POLICY FRAMEWORK IMPLICATIONS	
16.	Southampton's Better Care Programme supports the 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 CCG Operating Plan 2017-19, which in turn complement the delivery of the local HIOW STP, NHS 5 Year Forward View, Care Act 2014 and Local System Plan.
17.	Southampton's Better Care Plan also supports the delivery of Southampton's Health and Wellbeing Strategy 2017 - 2025 which sets out the following 4 priorities: • People in Southampton live active, safe and independent lives and manage their own health and wellbeing • Inequalities in health outcomes and access to health and care services 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

KEY DECISION?	**Not Applicable - No decision required**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Better Care Fund Scheme Updates – Year End 2017/18
2.	Better Care Performance Report – Month 12 2017/18
3.	Better Care Finance Schedule – Month 12 2017/18
4.	Better Care Highlight Report – Year End 2017/18

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 - Update only**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No - update only**
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**	

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Appendix 1

Southampton City Better Care Partnership Agreement 2017/18

Quarter 4 and End of Year Performance Report

1. Carers

Host Organisation	Council
Report Author	Kirsten Killander
Reporting Period	Q4 2017-18
Report Date	22.05.18

Overall Financial Performance

Annual value	Total = £1.374m CCG = £1.240m – 90% SCC = £0.134m– 10%
Year-end spend (based on latest financial position – **information provided by Finance**)	Total = £1.341m CCG = £1.208m SCC = £0.133m
Variance	Total = (£33k) CCG (£32k) SCC (£1k)
What are the reasons for Over/Underspends? Underspend negligible	
What actions are being taken to address Over/Underspends? Not applicable	
Are there any opportunities for Savings? None	
Predicted Cost Pressures: None	

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme	• To identify a significant number of Adult and Young Carers and provide them with relevant, accessible and meaningful information and advice. • To provide access for Carers to proportionate assessment and support services in their local communities. • To involve Carers in service planning and development. • To provide Carers with choice and control though personal budgets and direct payments. • To support Carers to remain healthy and maintain their own wellbeing both physically and mentally.	
Provide Evidence of Key Developments/Successes/ Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	The main overall BCF target for this service is improving service user experience; however it will also contribute towards all other targets by supporting adult carers to continue caring. • All adult carers who receive an assessment are also contacted by Carers in Southampton (CiS) to offer support that is relevant to their identified needs: CiS will signpost to other agencies as appropriate. • Assessments are proportionate to carers needs. The majority of assessments are via telephone using the on-line tool. All carers who receive a personal budget have a Support Plan developed through the Assessment Service and include access to community services as appropriate. All young carers are assessed in their home with the appropriate involvement of their parent/s or guardian/s. They are signposted to local activities and enrolled onto the project if they meet the eligibility criteria. • **Direct payments are now being processed in a timely way. This quarter 100% of carers who are assessed through this service and are awarded a personal budget receive a direct payment.** • The support plans show that carers are exercising choice in how they anticipate spending their personal budgets. Young carers' key workers help those that need intensive support to access additional activities in the community with a personal budget of £80 for individual young carers which can be spent over 6 planned sessions.	
Performance Indicators	<u>Indicator</u> • Increase number of adult and young carers identified. • Increase number of adult and young carers provided with assessment and appropriate support plan and accessing direct payments	<u>Progress to Date</u> • Both services have exceeded the number of carers reached. • **For Q4 the following were completed: 64 supported assessments; 12 self-assessments; 21 reviews; and 60 support plans**. All adult carers who have a support plan will have a personal budget attached to it and this quarter **all 60 carers accessed a direct payment**.

		• **I**n the last quarter **211 young carers were supported and 4 young carers received a personal budget**.
Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	Risks • Replacement care, to enable the carer to achieve their aims in their support plan, not being integrated into their personal budget. • Whole Family Approach, particularly where young carers are involved, not embedded in working practice.	Mitigation • Specific member of staff to be placed in CiS Service to ensure this is included. • MoU signed and Task and Finish group established to embed practice into work procedures. • A 'Carers Aware' E-learning course has been developed which promotes a whole family approach. Staff will be encouraged to take the course once it has management approval.

Summary	
Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	Mencap were awarded the new contract: start date of 1st April 2018. No Limits are subcontracted to work with young carers.
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Develop practices within adult social care and children's service's to deliver a whole family approach to children's and adults care. • To develop a mechanism for carers to receive an element of replacement care within their RAS.

2. Clusters

Host	Southampton City CCG
Pooled Budget Manager	Adrian Littlemore, Senior Commissioner ICU
Report Author	Adrian Littlemore, Senior Commissioner ICU
Reporting Period	Qtr 4 2017/18
Report Date	23/5/18

Overall Financial Performance

Annual value	£48,820,000 CCG Budget = £47,436,000 (97%) SCC Budget = £1,384,000 (3%)
Projected year end spend (based on latest financial position – **information provided by Finance**)	£49,427,000 CCG = £47,750,000 SCC = £1,677,000
Variance	607k overspend

Reasons for Over/Underspends:

CCG overspend relates to planed one off payment for IAPT to Dorset Health Care

SCC overspend relates to additional costs incurred by Adult Social Care Review Team- to achieve package revenue savings (Agreed by Paul Juan)

Actions being taken to address Over/Underspends:

- No action required

Opportunities for Savings:

No direct savings envisaged on clusters budget. Focus is on targeting this resource to achieve wider system savings related to reduced emergency admissions, reduced hospital length of stay and reduction in social care residential placements.

Key opportunities:

- Continued redesign of community nursing service to further target those people at highest risk of admission
- Continued development of cluster working - strengthening managerial and clinical leadership

Predicted Cost Pressures:

- None

Overall Delivery

Original Aims and anticipated Outcomes	• A more integrated approach to service delivery to address system wide problems which cannot be tackled by one agency alone

	○ Through focussing spending on system need rather than agency need. ○ Through supporting integrated strategic development, mutual responsibility and joint outcome measurement. ○ Through creating more opportunity for cross skilling of staff. ○ Through bringing together generic and specialist resources in a more integrated way that supports people's needs holistically but at the same time enables the person and/or the professionals involved in the person's care to access specialist resources for input/advice/support on specific conditions. • Fewer unscheduled admissions to hospital ○ Through proactive multiagency risk stratification tools which bring together a breadth of information to identify those people most at risk of deterioration and intervene earlier, maintaining and promoting independence ○ Through better use of case management and shared care planning to better manage people at home ▪ Stronger focus on prevention,: ○ Falls and bone health prevention and management including the development of fracture liaison functions, falls and bone health patient database (built into HHR), development of falls exercise offer within the City ○ Wider Prevention and Early Intervention programme. • Fewer admissions to long term care, eg. residential or nursing homes ○ Through better case management and shared care planning ○ Through a stronger reablement ethos ○ Through more proactive discharge planning, ensuring that people are only in hospital for as long as they clinically need to be and that their independence is promoted • Better service user experience ○ Through supporting people to manage their own health and wellbeing and have a single lead professional who will coordinate their health and social care. ○ Through providing accessible services in a timely streamlined fashion that will seek to help them to be as independent as possible. ○ Through providing consistency and reducing duplication through single processes such as single assessment, lead professionals and shared recording and communication systems. • Improved joint working with local communities and voluntary sector ○ Through development of community navigator role to signpost people to community resources

	○ Through better understanding and knowledge of local area ○ Through working in partnership with local solutions groups
Provide Evidence of Key Developments/Successes / Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	• Cluster leadership with strengthened admin support and identification of clinical and managerial leads. Commissioning leads linked to each cluster in place. Better Care programme manager appointed, and will undertake audit of cluster delivery (risk stratification, case management processes, MDT working and leadership). • Community Nursing Service Specification developed with associated improvement plan. Service improvement plan agreed with timescales for implementation. • Local Solutions Groups bringing together voluntary, community, faith, business sector in each cluster established. Groups currently embryonic and require time to develop role. Admin support to the groups in place. Need to plan how this is delivered from Nov 2018 as funding time-limited for one year. Most groups initially focusing on mapping neighbourhood resources to aid signposting to community resources. Itchen to Bridge the Gap group (Cluster 5) established and completed mapping (to be uploaded to SID), working on implementing Dementia Friends with local businesses. • Adult Social Care restructure completed, greater links with clusters being established. Service moving to a strengths and assets based approach. Systems to support greater use of direct payments are being embedded to ensure DP are the default option for people to organise care. • UHS developing My Plan to enable patient led records/ communication to support self-care, submission for additional funding made for Local Health and Care Record Exemplar (LHCRE) monies. Planning tools to be available on CHIE (formally HHR) when version 3 becomes available (June 18). • Review of Continence and Bowel care pathways. New specification agreed, with Solent. • Fracture Liaison Service commenced to improve identification of patients who are at falls risk and direct them to assessment and services in the community. Work ongoing to improve pathway flow and management. Saints Foundation funded by CCG (plus match funding from Premier League) to develop network of exercise providers and training to expand exercise opportunities. 10 exercise providers now completed postural stability training and able to provide falls prevention exercise. Falls Exercise commissioning review underway (workshop planned for the 21st June 2018). Saints Foundation has also been funded to develop an Escape Pain programme with the exercise provider network to offer exercise to patients who have lower limb rheumatic pain. • Implementation of the GENIE tool through trained volunteers and community wellbeing team, which supports individuals to strengthen their social networks and engage in healthy lifestyles. Part of a CLARHC research project.

Performance Indicators	Being refreshed. • Number of NEL admissions as a proportion of patients identified frail/falls risk on GP systems. % of population identified as frail/falls register. • Numbers/% of patients with a care plan reviewed within past 6 months available on CHIE. • Number of NEL admissions from Nursing Homes and Residential care settings within each Cluster • Rolling average for patients on frail/falls risk who have improved or maintained their level of Functional Fitness score in the past 6 months • Proportion of patients who have received a comprehensive medication review in the past 6 months • Proportion of patients who report as being lonely using Loneliness Scale • Rolling average of domiciliary care usage • Home environment risk assessments completed as a proportion of patients at risk • Rolling average of LOS for NEL admissions for patients on the frail/falls risk register • Rolling average of the number of GP appointments for patients referred for Social Prescribing • Number admissions to residential care services for the patients registered within the Cluster • Rolling average of domiciliary care usage for patients on the at risk register (top 5 % of population) • I statements survey results "qualitative".	
Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	**Risk** • Cluster leadership remains under-developed owing to lack of capacity or capability and clusters do not develop at the pace required to achieve system wide change.	**Mitigating Actions** • Better Care Programme Manager to audit cluster development and put individual cluster development plans in place

Summary

Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	Investment in Cluster Leadership to really embed the key characteristics of person centred integrated care and take direct responsibility for delivering the system wide Better Care targets at a city wide level through a robust programme of work in each cluster
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Cluster leadership development • Developing the new strengths based model of social care, in particular strengthening the social care links with clusters • Confirming and implementing Standard Operating Procedure for clusters (work that Better Care Southampton group is leading on)

3. Integrated Rehabilitation and Reablement and Hospital Discharge

Host Organisation for Scheme	CCG
Report Author	Jamie Schofield
Reporting Period	Q4 2017-18
Report Date	24/05/2018

Overall Financial Performance

Annual value	£16.1m
Projected year end spend (based on latest financial position – **information to be provided by Finance**)	£15.5m
Variance	£609k underspend

What are the reasons for Over/Underspends?

- Underspend relates to staff vacancies within the service and fewer hours than budgeted being commissioning from independent domiciliary care

What actions are being taken to address Over/Underspends?

- Vacancies are being recruited to
- Provision of domiciliary care to support reablement is currently under review to ensure that sufficient care is available in a timely manner.

Are there any opportunities for Savings?

No direct savings envisaged on clusters budget. Focus is on targeting this resource to achieve wider system savings related to reduced emergency admissions, reduced hospital length of stay and reduction in social care residential placements.

There are further schemes currently in development associated with this service which will further support savings across the wider system (by reducing costs of long term care and promoting more timely hospital discharge) including:-

- Discharge to Assess out of the community hospitals designed to support a reduction in delayed transfers of care went live in November and should further support greater patient flow (iBCF funded).
- Discharge to Assess pilot for more complex health and social care clients on Pathway 3 is now operational and should reduce hospital delays caused by complex assessment however there is still much learning required to make this scheme operationally robust (iBCF funded).
- Working with Urgent Response Service to develop:-
    - IV Therapy to reduce hospital admission and length of stay (pilot to begin in July 18)
    - Potential increase in reablement capacity to strengthen reablement, further supporting more people to regain their independence and reducing pressure on social care resources
    - Support for hospital discharge patients with Low Level Health Needs

○ Increased support for managing Falls Assessments, again designed to support more people to maintain their independence and reduce pressure on social care and NHS resources.
Predicted Cost Pressures • None at this stage

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme	• Improve coordination of hospital discharge processes through standardisation of approaches such as "Discharge to Assess", "Trusted Assessment" and "Early Supported Discharge". • Reduce delayed transfers of care • Reduce hospital length of stay • Maintain hospital patient flow • Avoid making decisions about long term care in an acute setting • Ensure assessment and care planning includes a person centred community focussed approach	
Provide Evidence of Key Developments/Successes / Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	• The scheme continues to deliver the bulk of the Pathway 2 out of hospital activity • Lot 5 (SCA) is delivering an **additional level of care averaging between 230 – 250 hours a week (commissioned 240hours).** • Data from the Urgent Response Service presented in quarter 2 (based on Dec 17 – Feb 18 data) reports that **on average 54% of people are independent when leaving the service.** • We are currently looking to reduce the 5 reablement beds to 3. This has been a particularly successful piece of work which over the last 2 years has seen a refocus from 25 reablement beds in Brownhill House to an emphasis on home based care which has resulted in an underuse of 5 reablement beds and consequently a further reduction to 3 beds.	
Performance Indicators (List the performance indicators attributed to this scheme – to be taken from BCF Scheme Specifications – and provide a summary of progress this Quarter)	<u>Indicator</u> • 90% of referrals for crisis response will be responded to within 2 hours of referral • No. of Comprehensive Falls Assessments to be undertaken annually (1500) • Comprehensive Falls Assessments - at least 90% of those who require it being offered rehabilitation/ intervention. • 85% of elderly patients assessed in A&E as not requiring admission to not be admitted.	<u>Progress to Date (Q4)</u> **88% This drop relates to unusual capacity issues within the service and is expected to return to 90+%.** Annual target significantly surpassed - Target (YTD):- **1375 Actual:- 2021** **99%** **98%**

	• 95% of patients needing to access a community bed to do so within 36 hours of being ready to do so. • Inpatient beds to achieve 85% occupancy levels or above. • 95% of clients receiving reablement to have an initial review by rehab/ reablement service within 2 weeks of commencing their reablement package • 70% of agreed reablement goals achieved or partially achieved	88% this was due to a combination of capacity/move on difficulties and a patient needing a single room which wasn't available immediately. **88%** **97%** **89%** when last audited in June17
Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	Risks • The greatest risk is one of flow out of the service which affects the overall capacity. • The scheme is 2 years old however the functions and scope of the service are constantly expanding in an attempt to meet the requirements of ever-increasing demands. There is a risk that processes don't have time to "bed in" before a further change is made to the service which can create hidden risks.	Mitigation • The CPS team prioritise transfer out of the Urgent Response Service (part of Rehab and Reablement Service) • The developing dom care framework will support move on out of this service. • Extra care management support has been put into the service to help with the assessment processes which support decision making, particularly financial, that helps with smoother transfer out of the service. • The service does need to be able to adapt to the demands of an ever changing agenda and reports regularly to a Provider Board and the Community Transformation Board. It is important that both these boards do not allow the service to "stretch" resources beyond a level that allows them to maintain quality and process.

Summary

Describe any proposed Changes/ Recommendations for consideration	None Currently

by Joint Commissioning Board and HWBB	
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Pilot IV Therapy work • Agree future Pathway 3 operational model following D2A Pilot. • Agree development model for increased URS capacity for low level care and increased reablement capacity.

4. Care Technology

Host Organisation for Scheme	Council
Report Author	Sandra Jerrim
Reporting Period	Q4 2017-18
Report Date	25.05.2018

Overall Financial Performance

Annual value	Total = £0.050m CCG = £0 – 0% SCC = £0 – 0% SCC iBCF = £0.050m 100%
Projected year end spend (based on latest financial position – **information to be provided by Finance**)	

Telecare	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	0	0	0
Southampton City Council	50	27	(23)
Total	**50**	**27**	**(23)**

Variance	Underspend of £23k

What are the reasons for Over/Underspends?

- The scheme relates to employment of a project manager to promote the implementation of care technology across social care and health settings. iBCF funding not approved till July 2017. Post not filled until October 2017.

What actions are being taken to address Over/Underspends?

- None - the slippage has been reallocated to other iBCF schemes in 2017/18 and will be used in 2018/19.

Are there any opportunities for Savings?

- None - the scheme itself is aimed at promoting the uptake to care technology to support people's independence, thereby achieving wider system savings.

Predicted Cost Pressures:

- None

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme (To be taken from BCF Scheme Specifications)	• To help maintain the current level of services offered across the Health and Social care system • To support a number of initiatives and developments already identified and moving forward • To aid fledgling developments that are evidenced to show positive benefits but needing focused attention and support • To provide the analysis and benefits tracking necessary to evidence the benefits and performance of the use of care technology. • To continue to support the culture change through training, awareness raising, support and monitoring. • To support the work necessary to secure a new service model. • To provide additional financial resources to support a steady expansion of the service, in particular equipment and installation capacity.
Provide Evidence of Key Developments/Successes/ Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	**Key developments** • Interim post appointed 1 October 2017 to promote uptake of care technology across health and social care settings • Decision from SCC not to proceed with integrated service **Delivery of original aims outcomes** *Maintain the current level of services (health and social care)* • Referral levels have returned to the previously high point of 2016 and maintained at around 70 referrals per month (SCC) since November 2017 and around 25 referrals per month from health. Although this is below the monthly targets originally set, the overall trend in referral numbers continues upwards. *Support existing initiatives and new developments.* • New initiatives are been flagged for consideration and support where relevant. Initiatives that have made slow progress or stalled are now receiving dedicated support from Service Development Officer. *Evidence from analysis and benefits tracking* • Benefits tracking process has been challenging and is now being combined with a piece of work to build a financial model for predicting potential financial benefits. *Procurement of a new service model.* • Workshop to scope service development on SCC side due by end of May 2018. • Consultant engaged to develop service specification for Health. **Support for BCF targets** • Telecare, telehealth equipment and other forms of technology enables improved delivery of care and when fully established, will support the achievement of key targets. • Providing falls equipment to individuals within the health pathway will help reduce admissions relating to falls through appropriate and planned response options. A range of technology helps individuals, usually frail elderly but also

<table>
<tr><td></td><td colspan="2">those with learning disabilities, to maintain independence and therefore reducing permanent admissions to residential and nursing home settings.
• As new areas of care technology are introduced it is envisaged they will assist and help address delays. Initiative may include increased use of technology in the home, support for carers to deliver care or remote monitoring of care post discharge.</td></tr>
<tr><td>Performance Indicators

(List the performance indicators attributed to this scheme – to be taken from BCF Scheme Specifications – and provide a summary of progress this Quarter)</td><td>Indicator

Referrals: 420 per quarter (140 per month) by ASC teams, commencing in Quarter 3 2017/18
<table><tr><td></td><td>Target</td></tr><tr><td>Quarter 3</td><td>420</td></tr><tr><td>Quarter 4</td><td>420</td></tr></table>
Conversion rate from referral to install
• 65%</td><td>Progress to Date

Referrals
<table><tr><td></td><td>Target</td><td>Actual</td></tr><tr><td>Quarter 3</td><td>420</td><td>263
203 (exc health)</td></tr><tr><td>Quarter 4</td><td>420</td><td>288
218 (exc health)</td></tr></table>
Conversion rate
Quarter 3 - 38.42%
Quarter 4 - 62.27%

Financial benefits
Data team (SCC) have reviewed all sources of information and developing reporting process. Data cleansing activity underway.</td></tr>
<tr><td>Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter</td><td>Risks
• ASC unable to achieve 140 referrals per month

• Conversion rate not achieved</td><td>Mitigation
• Regular data is being fed back to frontline teams and there is ongoing communications to promote uptake of care technology. Staff training has taken place and champions for care technology have been identified in frontline services. The numbers of referrals are increasing although acknowledged there is still some way to go to hit original targets set.
• Conversion rate now tracked and reported. Q4 conversion rate now close to target. Referral process reviewed to identify where we are losing customers.</td></tr>
</table>

	• Actual savings are not realised to the level required • Cost avoidance financial benefits are not realised • New service is not secured	• Monitoring reduction in packages of care looking at average costs with and without telecare • Agree average gross /net savings figures for cost avoidance financial benefits. • Support development within both organisations as required by their respective directions of travel.

Summary

Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	With the Council's decision not to progress with an integrated tender, responsibility for Care Technology will be returning to Housing and Adult Social Care as business as usual.
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Agree limits and scope of supporting work for each organisation. • Embed specialised tasks undertaken by Service Development Officer within the continuing City Telecare service. • Facilitate the rescoping of service specification for health technology service. • Develop modelling tool to predict return on investment. • Develop process for evaluating and implementing new initiatives. • Identify savings opportunities across different pathways.

5. Prevention and early intervention

Host Organisation for Scheme (see BCF Scheme Specifications)	SCC
Report Author	Moraig Forrest-Charde
Reporting Period	Q4 2017-18
Report Date	09/05/2018

Overall Financial Performance	
Annual value	Total = £7.469m CCG = £0 – 0% SCC = £7.469m – 100%
Projected year end spend (based on latest financial position – **information to be provided by Finance**)	Total = £7.291m
Variance	Underspend of £178k
What are the reasons for Over/Underspends? Council saving being used to offset adverse variances in Public Health	
What actions are being taken to address Over/Underspends? None	
Are there any opportunities for further Savings? • The Prevention and Early intervention scheme was not identified to deliver savings in 2017/18 but is a system enabler for other savings areas and transformation programmes. Added value will be achieved by improved outcomes, increasing activity within the same envelope and use of the Social Value Act. • 2 of the areas made significant savings in previous financial year (Housing related support and Behaviour Change)	
Predicted Cost Pressures: • None known at this stage	

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme	• To provide good quality, consistent information which enables people to exercise choice, be active in their own care and have control over their lives • To increase community based services such as time banking, peer support and volunteering networks and coproduction.

	• To develop community solutions which reduce the demand on services, and increase the use of local community resources. • To achieve Improvements in key lifestyle indicators both universally and in targeted areas. • To ensure there are appropriate levels of warm and sustainable accommodation for our most vulnerable adults and families. • To increase levels of employment for those furthest from the labour market (by length of unemployment, disability or vulnerability) • To support people to remain healthy and maintain their own wellbeing both physically and mentally	

Provide Evidence of Key Developments/Successes/ Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	• Following a tender there has been a contract award to establish an Integrated Advice, information and Guidance service.
	• A consultation on a future model for community development has been concluded and options for procuring a service are being developed and explored with council representatives.
	• A new Behaviour Change service which encourages people to adopt healthier lifestyles has been fully rolled out.
	• Housing related support services to enable people to access and maintain accommodation and avoid homelessness have been recommissioned and are now being implemented.
	  ○ Phase 1 of the quality review of properties is complete
	  ○ Phase 2 HRS - Hospital discharge & A&E round table discussion completed to inform commissioning intentions for 2019.
	• The Council has awarded a contract to Social Care in Action (SCA) to transform the current older person's day services to a new wellbeing and activity offer. Through a process of coproduction with existing service users, carers and the wider community plans will be developed to implement wellbeing centres offering access to information and advice, support to manage health conditions and access to a range of activities, including access to replacement care.	

Performance Indicators (List the performance indicators attributed to this scheme – to be taken from BCF Scheme Specifications – and provide a summary of progress this Quarter)	<u>Indicator</u> • complete grants review • Behaviour Change - TBC pending outcome of decisions regarding the public health grant • Tender integrated advice service to meet needs of in excess of 22,000 per year.	<u>Progress to Date</u> • Grants review completed • Behaviour Change service retendered and launched • Significant under-performance across contracted PI's. Formal contract process commenced. • Advice, information and Guidance services retender and contract let – service roll out completed in this quarter

	• Review Housing Related Support services Phase 1 • Retender Housing Related Support services Phase 1 • Review Housing Related Support Phase 2 (homelessness and Substance misuse services) • Develop Community Development model and procurement option – no indicators at this time.	• Housing related support review completed, retendered and launched • Quality review of Housing related support properties completed. • Phase 2 HRS - Hospital discharge & A&E round table discussion completed to inform commissioning intentions for 2019. • Service model and procurement options for Community Developed. Final decision re these options expected for Qtr 1 of 2018/19
Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	Risks • Limited funding and lack of consensus for community development model • funding challenges for voluntary sector • capacity within local market to respond to new ways of working • transformational plans may put some vol sector providers at risk • Behaviour Change Service challenged to meet anticipated targets •	Mitigation • ongoing consultation and engagement to develop consensus • scoping work completed to identify funding resource for community development within current grants, contracts, services • soft market engagement being undertaken to generate market interest • Support offered to providers as part of each commissioning or redesign process • Commissioners working/supporting SCA through the SIP process •

Summary

Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	None
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Implementation and oversight of integrated Advice, Information and Guidance contract and where required related subcontracts • Living well service undertaking engagement with users/staff on future model and wider consultation in Qtr 2

	• Engage within SCC regarding the options for community development model and identify potential funding streams and funding requirements • Community Navigation network forming with a view of exploring consortium options • Community Navigation Specification to be developed for possible procurement in Qtr 3 • Community/local solutions embedding • Phase 2 HRS - Task & finish group established. Report to be submitted February 2018

6. Learning Disability Integration

Host Organisation	CCG
Report Author	Tania Emery
Reporting Period	Q4 2017-18
Report Date	23.05.2018

Overall Financial Performance

Annual value	Total = £26.182M CCG = £9.858M SCC = £16.324M
Projected year end spend (based on latest financial position – **information to be provided by Finance**)	*Total = £27.467M* *CCG = £ 10.369M* *SCC = £17.098M*
Variance	Overspend of £1.285M
What are the reasons for Over/Underspends? Movement in client packages and cost pressures listed below	
What actions are being taken to address Over/Underspends? Detailed action plans in place – overseen by LD oversight group with senior manager representation SCC and CCG are responsible for managing own non pooled fund within budget and are accountable for own underspends and overspends Overspends and underspends on the existing S75 Learning Disabilities (LBHU) pooled fund will be managed in accordance with that agreement.	
Are there any opportunities for Savings? Savings plan in place – overseen by LD oversight group. Areas of focus are: • Complex Housing developments to accommodate people locally • High Cost Placements reviews • Joint reviews with CHC where individuals are joint funded • Joint reviews of individuals living in the same placements to enable sharing of staff and other cost where possible • Life Skills support to enable individuals to move into employment or volunteering • Support Package reviews targeted at high cost packages not reviewed in the last year • Implementation of the strengths based approach	

Predicted Cost Pressures: • New clients transitioning from children's services • Ordinary residence transfers • Increasing complexity of client needs • Aging demographic of carers • Legacy of traditional model not being outcomes focussed and enabling of life skills development • Emergency/urgent placements often made at very high cost residential homes • Transfers from inpatient mental health hospital to community provision under the Transforming Care Programme • Increases in package costs due to individual client needs and uplifts in rates to meet pressures of national living wage, pensions and increase to sleep in rates following clarification of the law • Delay in employing of additional posts funded by iBCF – positions hopefully to be filled by July 2018

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme	• Integrated health and social care team for clients with Learning Disability across SCC, CCG and Southern health Foundation Trust (SHFT) • Support Transforming Care agenda • Improved service user outcomes including increases in placement stability and meaningful daytime occupation • Simplified and more responsive services for clients, carers and wider stakeholders • Improved cost efficiencies by developing shared assessment, business process and infrastructure • Reduction in cost of packages of care
Provide Evidence of Key Developments/Successes/ Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	**Key developments** • Externally facilitated programme to facilitate culture change and increase integrated working completed May 17. • Information sharing arrangements drafted and comments from legal being obtained prior to sign-off. • Integrated service lead – specification and host organisation identified. Recruitment commenced on Service manager post. • Interim integrated service lead appointed January 2018 pending permanent recruitment of integrated service lead. • Mapping of total LD population completed with a view to understanding overlap of work and opportunities for efficiencies across the integrated LD team. • Engagement with service users and carers in development of model. • Standard operating procedure (SOP): advanced draft agreed and signed off, shadow running alongside organisational policies • Team managers implementing lessons from strengths based training within LD team – focus on prioritising individuals. Set targets - team/ individual monitoring to be set up for increasing referrals for connected care/Direct Payments/extra care housing/employment or volunteering and routinely monitored as part of performance review. • List of all LD clients with individual details of the complex housing and High Cost Placements savings projects involved and a record of savings made per client as and when they occur.

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- Development of Market Position Statement to encourage improved community provision for individuals with LD with a focus on supported living/ life skills and support into employment.

Delivery of original aims outcomes

•*Integrated health and social care team for clients with Learning Disability across SCC, CCG and Southern health Foundation Trust (SHFT)*

Development work undertaken by the teams. Joint sessions with team leaders from SCC, SHFT and CCG teams ongoing to progress integrated working, including development of policies and procedures. Interviews planned for integrated team manager

•*Support Transforming Care agenda*

- Clients moved from out of area placements
- Risk register established to improve integrated working with the aim of preventing admission to hospital and facilitating discharge from hospital for individuals with LD and/or autism

•*Improved service user outcomes including increases in placement stability and meaningful daytime occupation*

- Increases in reviews undertaken

•*Simplified and more responsive services for clients, carers and wider stakeholders*

- Client involvement in developing the new model. Improved communication across teams with one list of clients and actions. Information Governance agreements being finalised

•*Improved cost efficiencies by developing shared assessment, business process and infrastructure*

•*Reduction in cost of packages of care*

- There have been reductions in packages but this has been more from services working alongside each other currently rather than functioning as fully integrated team.

Support for BCF targets

Reducing permanent admissions into residential homes

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<tr><td>Performance Indicators

(List the performance indicators attributed to this scheme – to be taken from BCF Scheme Specifications – and provide a summary of progress this Quarter)</td><td>Indicator

90% clients have review within target period

Reduction in placement costs</td><td>Progress to Date

CCG clients on target, SCC clients at approx. 78%

Placement costs have been reduced for a number of clients – through improved reviews and the High Cost placement team</td></tr>
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Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	Risks • Failure to recruit permanent integrated service manager • Receptiveness to change for all stakeholders and overreliance on traditional models • Social work capacity to achieve transformation required alongside business as usual pressures • Sustainability of provider market	Mitigation • Interim options explored – and suitable person identified and appointed until end July 2018 • External development training for LD teams. Involvement of users and carers in transformation • Additional review capacity from iBCF investment • Leadership development in home care and care homes, quality support • Development of Market Position Statement

Summary

Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	• Options for co-location being investigated. At present the most viable option is a two site co-location.
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Information sharing arrangements: agreed, signed off by project board and clearly communicated to teams. • Management structure/operational policies: Shared management structure agreed, signed off and implemented • Alignment of reviews with High Cost placement team and newly established review team with wider LD team and agreement on how work will be prioritised • Development of shared policies and procedures and Management structure • Agreement on joint trajectories for assessments, reviews and savings • Business case being developed for costs associated with ensuring both buildings are fit for purpose for the work of the integrated team specifically around IT considerations, office space and client accessibility. • Consideration being given to the integrated team staffing structure to ensure efficiency of the team and most efficient use of resources

7. Direct Payment Scheme

Host Organisation	Southampton City Council
Report Author	Louise Ryan
Reporting Period	Q4 2017-18
Report Date	May 2018

Overall Financial Performance

Annual value	Total = £350,000 SCC iBCF = 100%
Projected year end spend	£192k
Variance	Underspend of £158k
What are the reasons for Over/Underspends? iBCF allocations approved at July Council. Therefore recruitment did not start until later in the year and further delayed due to Consultation on Phase 3 Adult Service Reorganisation within Southampton City Council, although the fixed term posts of social worker and independence advisor have now been advertised with interviews planned for 15 and 18 June. It has also taken time to source suitable locum social workers with appropriate experience and skills to work on this project.	
What actions are being taken to address Over/Underspends? Slippage has been reallocated to other iBCF schemes in year.	
Are there any opportunities for Savings? N/A	
Predicted Cost Pressures: • No cost pressures predicted	

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme	• To increase Southampton City Council's current direct payments position of 19.6% (377 people) to a target of 39% (750 people) by April 2020. • To increase the number of people starting a Direct Payment to 25 a month • To introduce the use of the ALL Pay card and connected bank account • To develop the use of the online platform • To assist with the implementation of the new model Southampton Living Well and support people to take up direct payments for part of this service

Provide Evidence of Key Developments/Successes/ Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	Steam-lined and improved process for Direct Payments designed through a series of workshops with staff and service users during the year and implemented improve the customer experience and set up of direct payments. Changes have been made within the associated financial assessment process and billing process which affects the processing of the direct payment, reducing delays to the customer. Current proportion of ASC service users taking a DP is now at 20.28% - above the original baseline position but short of the target. Uptake by carers has been a particular strength with 87.50% carers taking their personal budget as a DP.	
Performance Indicators (List the performance indicators attributed to this scheme – to be taken from BCF Scheme Specifications – and provide a summary of progress this Quarter)	<u>Indicator</u> • To increase the number of people starting a Direct Payment to 25 a month • Service users accepting a direct payment have been set up with the All Pay card and connected account. • The online digital platform	<u>Progress to Date</u> We have not achieved this increase in number yet. This has been in place since the process began in June and is working well. 13 fully complete with a further 9 about to be completed. This pilot has closed as it was not viable to continue.
Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	Risks • Increased delayed transfers of care – This has been an issue in the Urgent Response Service when people are trying to source care. • Residents not wanting to accept direct payments resulting in failure to hit target • Market forces - There is little market for PAs at present and needs further development. Care agencies are charging DP customers higher rates for care and this is a significant barrier.	Mitigation • Placement service and Social workers actively assisting the client to commission care and support. • Linking with the design of the older person's offer (Southampton Living Well Service) to ensure strong focus on direct payments. • Reviewing existing service users and discussing with them transfer to the All Pay card and connect bank account. • This needs further work with ICU and how care providers may be able to work in a different way to support people who want to use direct payments.

Summary

Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Continue to increase numbers of services users accepting a direct payment. • Continue to increase use of ALL pay card and connected account with new and existing service users. • Work with ICU to explore how market can be developed further to support and encourage choice for people wanting to use a DP. Potential development of broker models. • Work with ICU to explore how new AIG service could support people with DPs. • Ongoing work with ICU on Older Person's offer to promote uptake of DPs through design of new Southampton Living Well Service • Research and development of a PA model

8. Transforming Long Term Care

Host Organisation	Southampton City Council
Report Author	Matthew Waters
Reporting Period	Q4 2017-18
Report Date	14th May 2018

Overall Financial Performance

Annual value	Total = £3.6 Million SCC iBCF= £3.60 Million
Projected year end spend	Total = £2.6M
Variance	Underspend of £1M
What are the reasons for Over/Underspends? £1million allocated for long-term arrangement with nursing home for capital spend and reduced cost bed spaces. Arrangement being carried over into 2018/19. Range of other options for the resource also being considered, to manage any risks to the Council. Legal advice has suggested providing resource as a loan with a repayment schedule and link to the land/building value.	
What actions are being taken to address Over/Underspends? Spend plan agreed. Money carried over to 2018/19.	
Are there any opportunities for Savings? The aim has been to deliver against agreed savings targets. For example, developing the care service within extra care settings is enabling individuals with higher needs to enter this setting, increasing savings opportunities, and contributing to savings targets for adult social care services. This model is feeding into plans for the next Home Care tender process.	
Predicted Cost Pressures: • None.	

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme	• Increased nursing home beds for people with dementia and complex needs. Original plan to contract with a new development will not be delivered in this financial year. Contingency plans being developed and considering other options for increasing access and capacity. This includes working with other providers to support physical changes to deliver new capacity for the city. • Extra care – Significant savings achieved following the opening of Erskine Court in 2016/17 - £272K full-year effect. New placements have been made, including individuals moved from nursing care settings to extra care. Care provider to continue to increase complexity levels that can be met within Erskine Court. This includes additional training for staff to meet greater needs, payment for covering call alarms in schemes, activities, and planning for additional capacity overnight to support individuals with night-time care needs. Learning from the Court is being utilised in the development of Potters Court to maximise positive outcomes. • Stability within the care market – Managed requests for increases in prices from residential homes, home care and day care providers, as a direct result of increases in National Minimum Wage, and of changes to regulations governing

	sleep-ins. Provided significant resources to care homes and domiciliary care providers to ensure basic costs of provision are met. • Timely discharge. Support to the D2A programme to deliver care places within a range of settings including nursing care, residential care and home care. Arrangements in place and working from November 2017 for six months (initial pilot). Shifting arrangements to increase nursing home capacity for the scheme, and reduce residential care requirement. • Increased home care capacity and responsiveness - Consolidation of increased domiciliary care, promotion of 7 day working and extension of retainer for 6 months to 31.3.18. Additional home care support over the winter period. • Promotion of community based resources as an alternative to social care - temporary resource put in place to update SID so that people are aware of the services available and set up of local solutions groups in each of the 6 clusters to map and bring together community resources and identify additional community solutions. • Development of prevention, early intervention and return to home initiatives to help people keep well and maintain their independence thereby reducing future pressure on the care market. Grants for agencies provided. Requests evaluated and grants agreed with activities from April 2018 onwards. • Reviews to ensure that social care resources are being used appropriately and to identify alternative more cost effective solutions - additional temporary resource to undertake care management reviews in targeted areas (under 8 hour packages, older person day care and domiciliary care) as part of an ongoing programme to manage care delivery	
Provide Evidence of Key Developments/Successes / Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	• First clients with planned overnight care needs admitted to Erskine Court extra care scheme, reducing the requirement for nursing home care. This has resulted in four individuals moving from nursing homes to extra care. Currently working with the provider to increase the capacity of the care delivered in the future, to maximise this use, and to ensure lessons are learnt for future extra care schemes. • Care market requirements for additional financial support provided (following justification and accounting reviews) enabling providers to meet their legal obligations in full within Southampton, increasing staff pay and provider sustainability. This has included National Minimum Wage impacts and meeting changes to sleep-in payment requirements. • Transport options for care workers increased as part of broader programme supporting care staff through agencies. This includes car parking passes and access to bicycles for key parts of the city.	
Performance Indicators	<u>Indicator</u> • Increase market capacity	<u>Progress to Date</u> • 5,829 additional domiciliary care hours purchased for 17/18 to support Discharge to Assess Schemes and 7 day working. • Car parking passes provided to two providers to enable access better access in specific parts of the city – pilot currently, with a view to better integration following the next home care tender process. • Agreeing access arrangements with a number of homes to secure placements at a rate below current

	• Support market sustainability • Support financial pressures to Council • Earlier discharge/ reduction in delayed transfers of care • Prevention of care home and hospital admissions	average costs – this is ongoing and will impact in the year 2018/19. It is being developed as part of the programme to support and improve care homes. • Additional investment made to support increased costs in market, e.g. National Minimum Wage and sleep-in costs • £1m allocated to ASC to support financial pressures • Two new D2A schemes (covering community hospitals and the more complex clients on Discharge Pathway 3) went live in November. • A number of schemes being mobilised to develop prevention and early intervention and community alternatives that direct people away from statutory care and support where appropriate, including community solutions groups in each cluster, updating SID, new grants programme to support discharges and to keep people safe and well in the community.
Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	Risks • Late agreement to all scheme details, requiring spend on several areas to be loaded to the end of the financial year. • Funding for nursing home capital is outside usual scope of agreements.	Mitigation • Advance planning in place to meet requirements of spend details. • Engagement of Council solicitors and seeking external advice to ensure no breach of rules. However, the originally planned scheme is no longer viable in this financial year due to safeguarding issues at the home, resulting from staffing and management concerns. Resource has been transferred into 2018/19 budget.

Summary

Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Capital fund for additional dementia nursing beds – identification of potential schemes that will deliver increased capacity. Initial scheme no longer possible to agree within the financial year. Alternatives were considered, and the funding was transferred to 2018/19.

	• Continued discussions with providers on enabling access to nursing home places at rates below average cost being achieved currently. This work is progressing currently, and is extended to included residential care homes who are willing to reconsider the complexity of care delivered, which will help to prevent individuals moving into nursing care from residential homes, and to prevent hospitalisation. • Resource to support care provider in extra care settings to deliver care to support 24-hour delivery – Funds identified and provider continuing to provide additional training for staff and equipment required to support clients. • Awaiting provider feedback on providing responses to call alarm system in extra care settings – this will feed into the next home care tender. • Grants programme managed, to provide long-term community support to individuals returning from hospital, provide education and physical activities and to prevent loneliness. Decisions made and grants awarded for work to commence in April 2018. • TimeBank resources being utilised to provide more support to individuals returning from hospital, and to support those at risk of hospitalisation. Part of a nationwide TimeBank programme. • Discussions with the market regarding longer-term support for people with more complex needs continuing, with dedicated staff in place. • Capital Assets team member employed to identify potential sites in the city that could be suitable for extra care, nursing home and supported living schemes for the future. Initial report due in June 2018, with next steps including refining options and design options from that date. • Continued work on potential developments of extra care in the city on already identified sites. • Mobilised additional domiciliary care capacity and responsiveness through extension of retainer and 7 day working pilots during winter period. • Set up of local solutions groups.

9. Children - SEND Integrated Health and Social Care Provision

Host Organisation	Budgets not pooled - Joint Oversight of Scheme
Report Author	Donna Chapman
Reporting Period	Q4 2017-18
Report Date	28 May 2018

Overall Financial Performance

Annual value	Total = £919k SCC = £398k CCG = £521k (NB. Overheads are included in this figure unlike the SCC figure where they are accounted for centrally)
Projected year end spend	Total = £1.102m SCC = £581k CCG = £521k
Variance	Overspend of £183k on SCC budget
What are the reasons for Over/Underspends? SCC- Staffing costs - temps are being employed at a higher cost to cover vacancies. The overspend is being funded from £106.9k transferred from the Children Services central agency fund and the balance offset by savings from elsewhere within the portfolio.	
What actions are being taken to address Over/Underspends? Seeking to recruit permanently to vacancies.	
Are there any opportunities for Savings? None	
Predicted Cost Pressures: • Current Overspend will continue until posts permanently in place	

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme	• To provide an integrated health and social care service offer enabling children, young people and their families to have one point of contact for their health and social care needs; • To identify and intervene early to promote positive outcomes for children/young people and families, embedding early support programme approaches; • To improve support to families through coordinated care planning that anticipates changing needs, integrated approaches with clear pathways, and through designing services around the needs of children, young people and their families, delivered in their localities and schools.

	• To provide targeted time limited programmes of support through specified care pathways, including support for continence, sleep problems, behaviour, parenting, self help and independent skills, sensory problems and feeding/weight management. • To operate a single recording/information sharing policy, a single set of policies and procedures. • To offer a coordinated response to statutory responsibilities. • To proactively plan for transition, identifying post-16 options at an early stage.
Provide Evidence of Key Developments/Successes/ Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	• A review of the core offer has been undertaken and clear pathways have been developed for: o continence o sleep o weight management o self help and independent living skills o challenging behaviour o communication o parenting skills • Revised criteria scoped that will widen service to include children with severe physical and sensory (visual/hearing) impairments who do not have Learning Disabilities (criteria til now has only included children with severe learning disabilities). The new criteria were consulted on between November 2017 and February 2018 as part of a wider consultation concerning disabled children's eligibility criteria and future model of short breaks. There was general support for the new eligibility criteria which was subsequently agreed by Cabinet and Council in March 2018. The new criteria for the Jigsaw Service correspond to the "complex" level of the eligibility framework and are being implemented from April 2018. • A revised service specification for the Jigsaw Service has now been agreed between the CCG, Council Children's Services and Solent NHS Trust. As part of this a development plan for the service in 2018/19 has also been agreed, key priorities including: • Provision of advice, support and training to Tier 1/2 workers and locality teams to enable them to make their services more accessible for disabled children and young people – including supervision and training for Tier 1/2 staff identified to be part of lead professional network o Contribution to ongoing development of Personal budgets o Use of Positive Behavioural Support as an intervention with children, young people and their families. o Mental Health Pathway to be developed. o Psychology Pathway to be developed o Transitional Pathway to be developed with reference to development of city wide transition policy. o Changes to Short Break Offer to be implemented o Development of statutory social care delivery plan for all Children in Need open within the Jigsaw service.

	○ Database of all Young People with SEND approaching transition to Adult Services to be developed and maintained. ○ Local Offer to be updated and maintained.	
Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	Risks • Risk that extension of criteria may in future put additional pressure on service •	Mitigation • Numbers to be carefully monitored

Summary

Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	None.
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• Implementation of the Service Development Plan and the following key areas: ○ Contribution to ongoing development of Personal budgets ○ Use of Positive Behavioural Support as an intervention with children, young people and their families. ○ Mental Health Pathway to be developed. ○ Psychology Pathway to be developed ○ Transitional Pathway to be developed with reference to development of city wide transition policy. ○ Changes to Short Break Offer to be implemented ○ Development of statutory social care delivery plan for all Children in Need open within the Jigsaw service. ○ Database of all Young People with SEND approaching transition to Adult Services to be developed and maintained. ○ Local Offer to be updated and maintained.

10. Building resilience service (integrated health and social care provision for children with complex behavioural & emotional needs)

Host Organisation	Budgets not pooled - Joint Oversight of Scheme
Report Author	Phil Lovegrove
Reporting Period	Q4 2017-18
Report Date	May 2018

Overall Financial Performance

Annual value (see summary list of 17/18 BCF Schemes)	Total = £1,070,680 CCG = £659,280 – 61.5 % SCC = £411,400 – 38.5%
Projected year end spend (based on latest financial position – **information to be provided by Finance**)	Total = £940k CCG = £659k SCC = £281k
Variance	£130k underspend on Council budget. At the end of each financial year a validation meeting occurs and an equitable 50/50 split of the finances is agreed. It should be noted that the above finances for the CCG include overheads and premises and the SCC figures do not and so accounts for some of the variance.
What are the reasons for Over/Underspends? Staffing vacancies	
What actions are being taken to address Over/Underspends? Posts are being recruited to	
Are there any opportunities for Savings? The BRS service is commissioned in order to address the complex behaviour and mental health needs of mainly Looked After children for the City. As such the majority of the funding allocated to the service is dedicated to staffing needed to deliver the service. The scope for savings is therefore limited unless the capacity of the service is reduced.	
Predicted Cost Pressures: • None known at this stage	

Overall Delivery

Original Aims and anticipated Outcomes for this Scheme	**Aims** • To provide an intensive, locally based systemic assessment service for those children, young people and their families in Southampton whose multiple difficulties place them outside of the local Tier 3 mainstream services, or where the organisations agree that the aggregated need is such that the young person should fit within the criteria of the service. • To work with the existing child or young person's personal and professional network to support the management of the case within mainstream services. • To provide a therapeutic response which will be individually tailored to the identified needs of the child or young person, their families and the professionals already involved in their care to allow for their needs to be managed in mainstream services. • To ensure the delivery of the service is evidence based and underpinned by robust outcome measures. **Objectives** The BRS will: • Provide a tailored assessment for each child, young person and family referred where appropriate, building on existing assessments. • Identify and where appropriate provide intervention programmes in response to each child's, young person's and family's assessment. • Support re-integration into education provision and/or maintain school placements. • Offer consultation, support, training and supervision to families and professionals as part of an agreed intervention package or as an agreed stand-alone service. • Work in partnership with Tier 3 and 4 providers to ensure that the provision of high cost placements or family support arrangements that are jointly funded by SCC and Southampton City CCG is based on sound assessment of need, is quality assured and is regularly reviewed to ensure that it is working towards positive outcomes for the child/young person and the ultimate aim of returning them to their family, local carer or least restrictive environment. • Promote inter-agency working to provide an integrated response to the needs of children, young people and their families. **Outcomes** The service will deliver the following high level outcomes: • improved emotional, mental and physical wellbeing outcomes for each individual child or young person referred • maintenance or return of child/young person to their family/local carer/local community with the support of mainstream services • reduction in out of area placements and/or hospital admissions • improved school attendance or reintegration into education • Improved placement stability for children looked after

Provide Evidence of Key Developments/Successes/ Achievements this Quarter of how this Scheme has delivered its original aims and outcomes and how it supports overall BCF targets (i.e. reducing hospital and care home admissions, improving timely discharge, improving service user experience, reducing falls, reducing hospital readmissions)	• A total of 31 referrals received this month (compared to 31 from Q1-Q3) • Allocations are happening through the Internal management process and the process has been recently updated and amended making the process more streamlined since the Clinical lead took up post.	
Performance Indicators (List the performance indicators attributed to this scheme – to be taken from BCF Scheme Specifications – and provide a summary of progress this Quarter)	<u>Indicator</u> • Proportion of time spent on clinical activity (Target 75%) • % of children/ young people using service that have a child-focussed intervention plan in place with clear goals (Target 100%) • % of service users with an outcomes focussed assessment tool (such as SDQ, CGAS or HONOSCA) undertaken prior to assessment and after closure (Target - 100%) • % of children/young people rating the service they receive as good or excellent (80%) • % of cases showing improvement in outcome/score (80%)	<u>Progress to Date (Most recent report received – Q3 17/18)</u> • Average 70.3% - An improvement on but there was still a delay in the reporting Q4, meaning that staff may have under reported • 100% in Q1 • 83% average (5 of 6) - Of the 9 cases closed, five had initial and closing CGAS scores. In one case, the clinician had neglected to assess opening and closing scores before leaving the service, which was an oversight. In the remaining 3 cases initial and closing CGAS scores were not taken and they would not have been applicable to case/intervention offered. • Annual data • 60% - Of the 5 closed cases where scores were recorded, 3 showed a distinct improvement upon closure.

Provide a Summary of Risks and Issues & Mitigating actions specific to this Scheme this Quarter	Risks • Over the past 6-9 months the BRS has been experiencing a shortage of staff, due to the natural career progression of key team members and as well as maternity leave and sickness. • Feedback from stakeholders has raised concern that they are not able to access immediate BRS intervention when they have crisis that social workers are managing. As a result and further to the previous agreement made in 2017, the LAC teams have requested a permanent BRS member of staff from health to be placed in their teams managing mental health issues or concerns as they arise.	Mitigation • Service has currently recruited to number of vacant posts. Any future vacant posts will be recruited to. • It is planned that a member of BRS will be based in LAC teams undertaking BRS work and offering ongoing consultation each day, this is being drawn up and planned via a rota. It has been requested that SCC Managers feed in to the commissioning review to raise the request and identify their outstanding unmet need.

Summary

Describe any proposed Changes/ Recommendations for consideration by Joint Commissioning Board and HWBB	A commissioning review is currently being scoped. This review include recommendations for the future commissioning of this service
Outline the Priorities for this scheme for the forthcoming period (i.e next 3-6 months)	• To finalise commissioning review of the service and embed recommendations • Consolidate staff team following SCC Transformation. • Continue to recruit to vacant posts

Date received by Joint Commissioning Board	
Date signed off by Joint Commissioning Board	
Date received by Health & Wellbeing Board	
Date signed off by Health & Wellbeing Board	

NHS Southampton City Clinical Commissioning Group

SOUTHAMPTON CITY COUNCIL

Southampton City

Better Care Performance Report

End of Year Report, Month 12 2017/18
(April 17 – March 18)

Clare Young – PMO Manager, Southampton City CCG

2017/18 End of Year Performance Summary

Month 12 (Apr 17 – Mar 18)

Green	≤0% difference	On Track
Amber	>0% and <10% difference	Slightly Off Track
Red	≥10% difference	Off Track

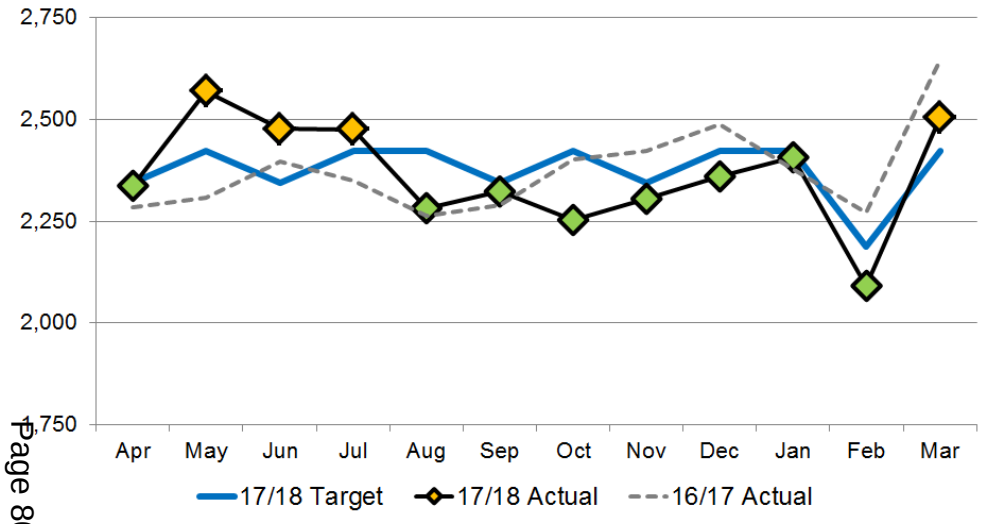
Metrics	End of Year Performance vs. Target	End of Year Performance vs. Previous Year	Commentary
 Non elective hospital admissions	Target Achieved (0% variance to target)	Flat (0% change to last year)	• NEL admissions **delivered** against the end of year target. • It is likely that the following initiatives helped with delivery: 1. **Changes to coding/counting of very short stay NEL admissions** where a patient is admitted into a CDU chair. From August 2017, these are now only counted as an A&E attendance. 2. **Introduction of GP front door streaming in ED**, from October 2017. • A&E attendances continue to be a challenge for older people; 6% higher than last year.
 DTOC Rate (March snapshot)	Target Not Achieved (5.4% vs. 3.9% target)	Better (2.2% lower than last year)	• As at March 2018, the target DTOC rate of 3.9% has **not been achieved**, and is at 5.4%. This has worsened slightly compared to the previous month (February) which had a DTOC rate of 5.0%. • Provider DTOC rates at the end of the year – UHS, 5.9%; Solent, 4.1%; Southern Health: 3.6%. • On a positive note, DTOC performance compared to the previous year was significantly better, with delayed days 29% lower.
Delayed Days	Target Not Achieved (14% higher than target)	Better (29% lower than last year)	
 Permanent admissions into residential care	Target Achieved (6% lower than target)	Better (12% lower than last year)	• Permanent admissions **delivered** against the end of year target and were 12% lower than the previous year.
 Injuries due to falls	Slightly Missed Target (7% higher than target)	Slightly Higher than Last Year (3% higher than last year)	• Injuries due to falls finished the year **7% higher than target** (68 more admissions than the plan). • The final month of the year (March 2018) was the second highest month for admissions for injuries due to falls

Non Elective Hospital Admissions

All Ages

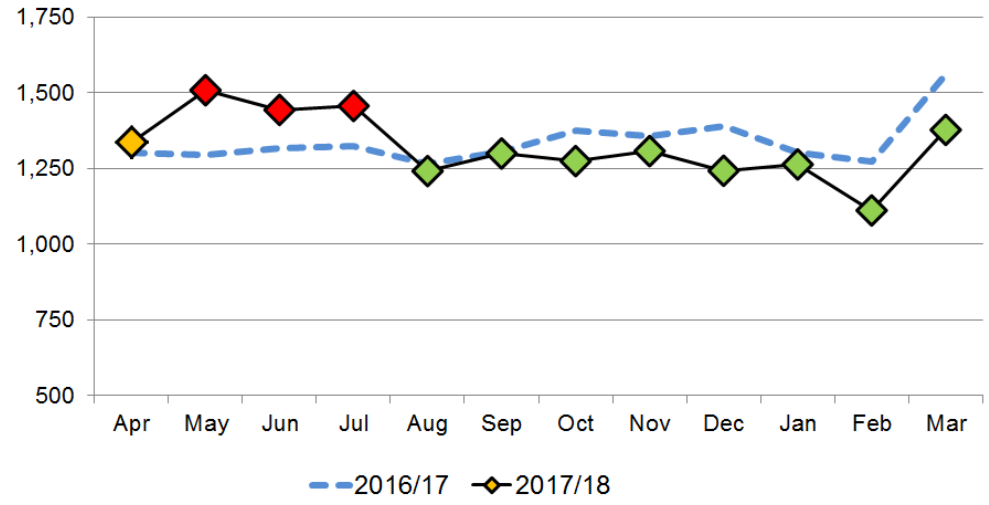
NEL Admissions (all providers)

0% variance to target | 0% change to last year



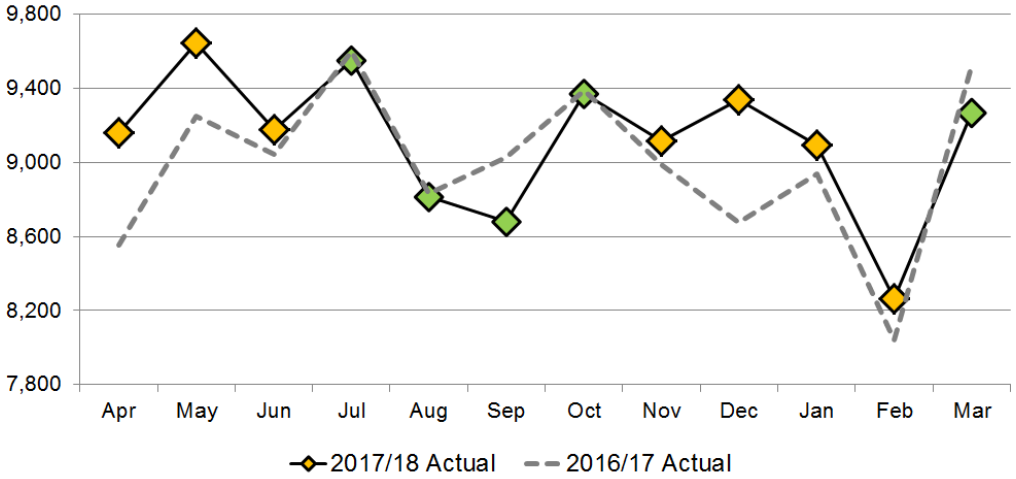
NEL Short Stay Admissions (<24hr) (UHS only)

1% lower than last year



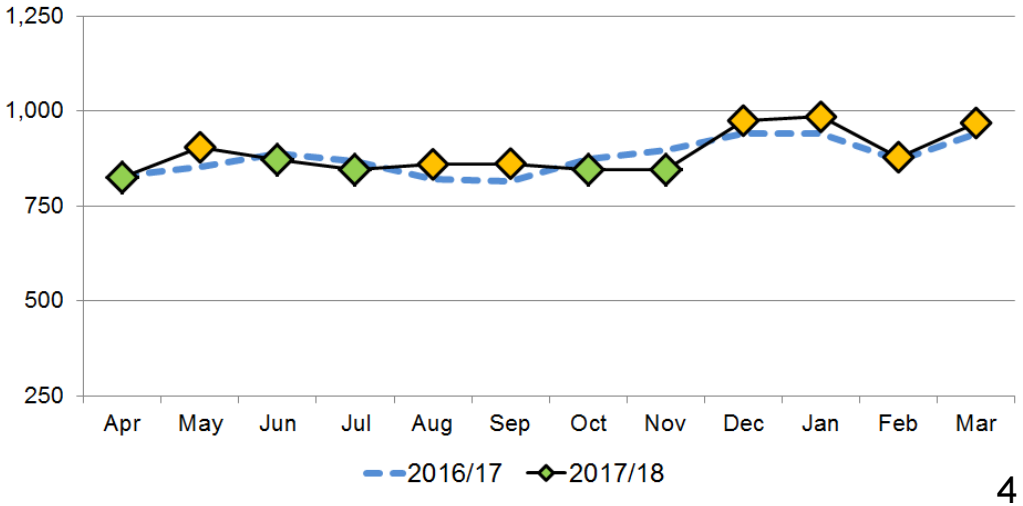
A&E Attendances (Types 1, 2 and 3 – all providers)

2% higher than last year



NEL Long Stay Admissions (>24hr) (UHS only)

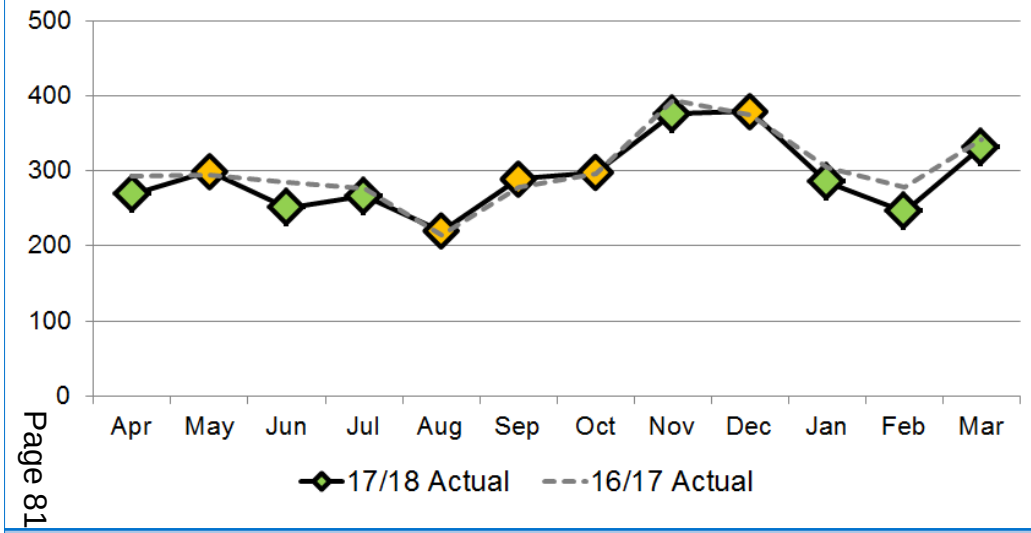
1% higher than last year



Children (0-17yrs)

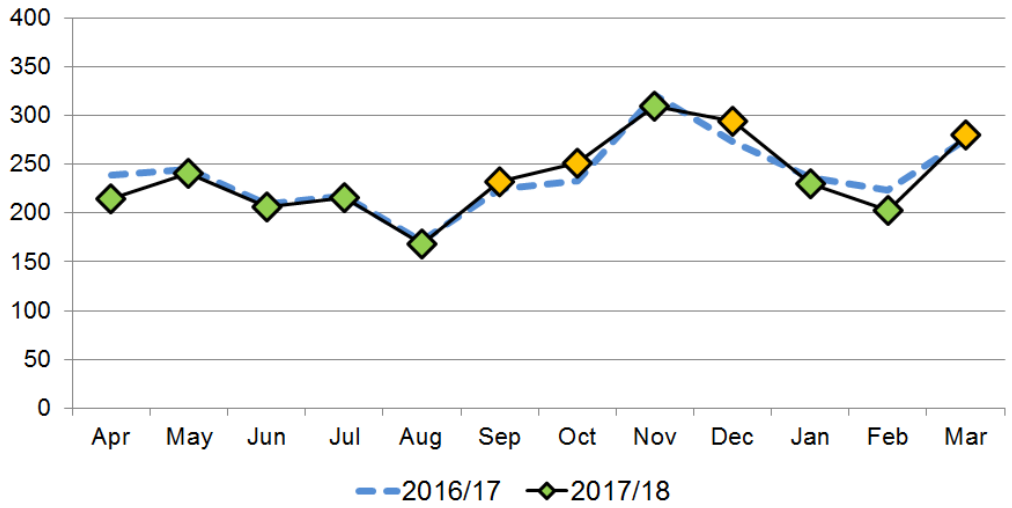
NEL Admissions (all providers)

3% lower than last year



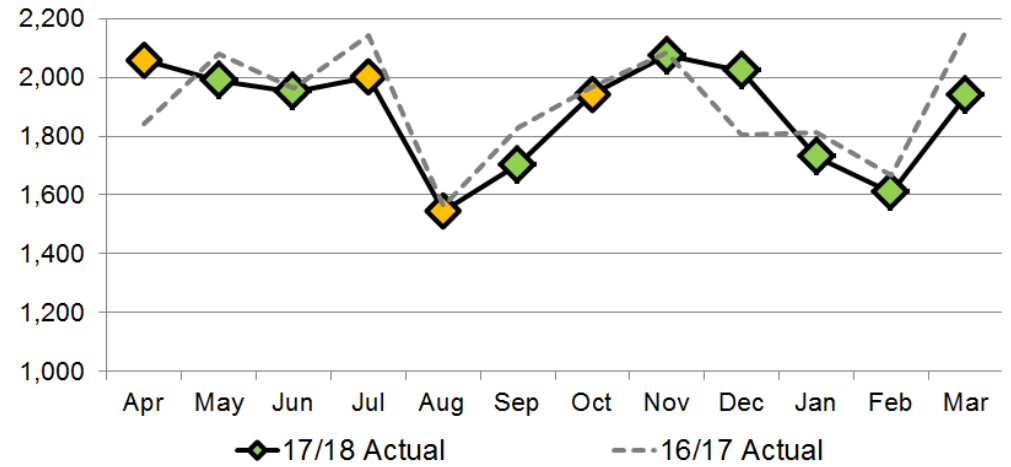
NEL Short Stay Admissions (<24hr) (UHS only)

1% lower than last year



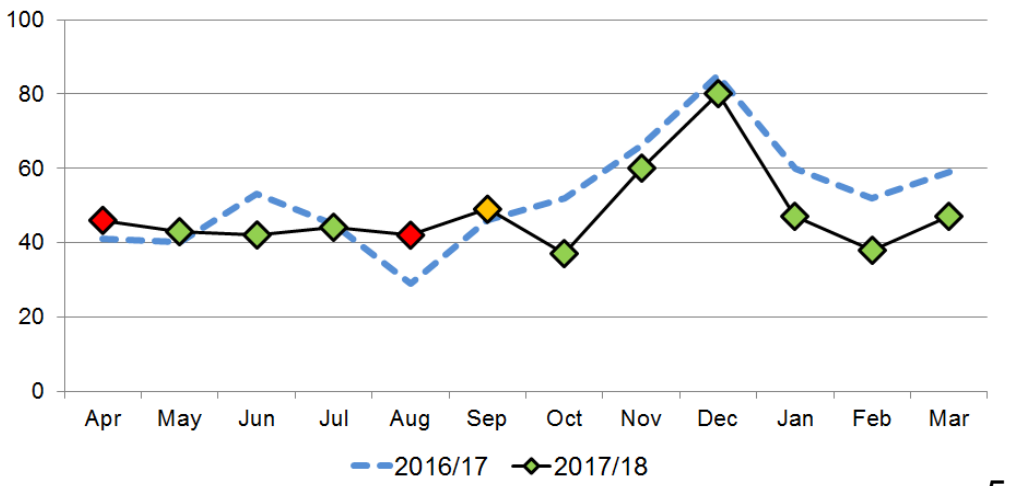
A&E Attendances (Types 1, 2 and 3 – all providers)

2% lower than last year



NEL Long Stay Admissions (>24hr) (UHS only)

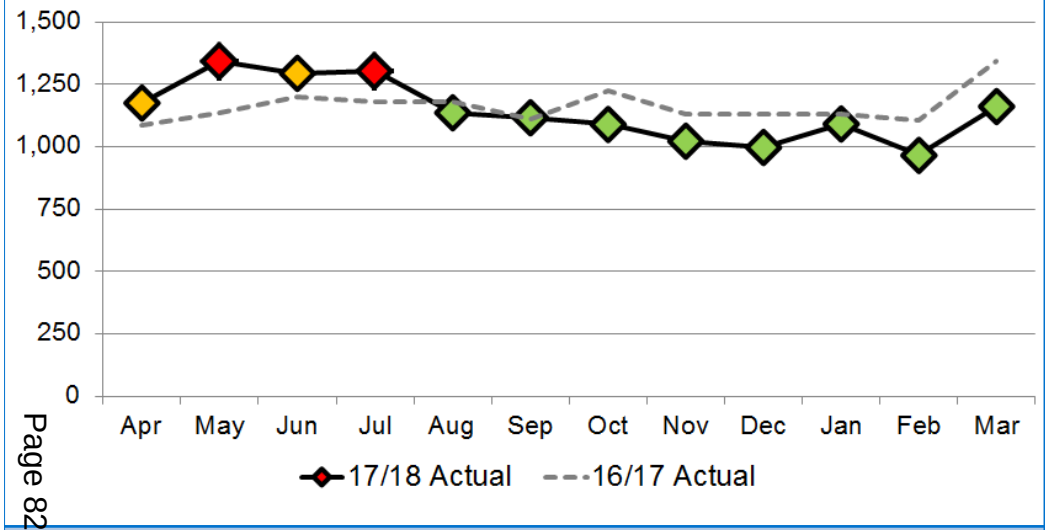
8% lower than last year



Working Age Adults (18-64yrs)

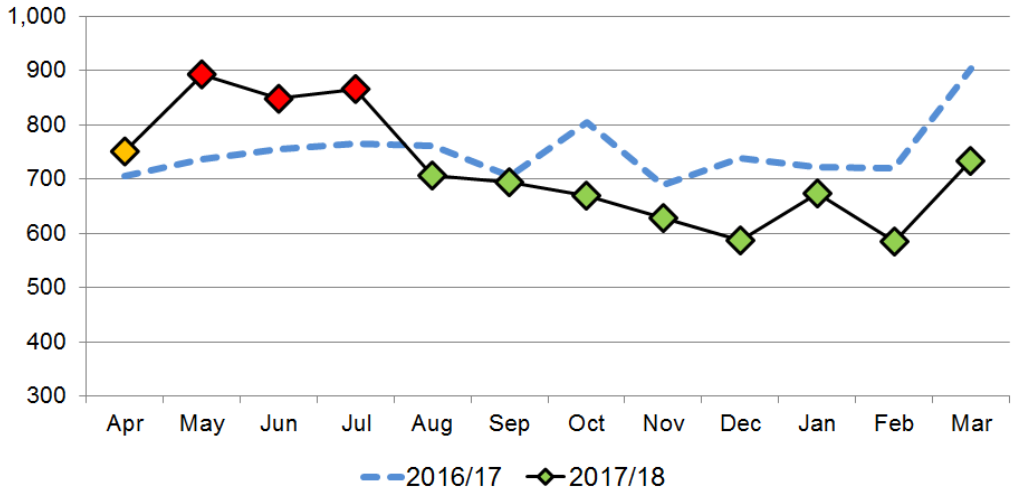
NEL Admissions (all providers)

2% lower than last year



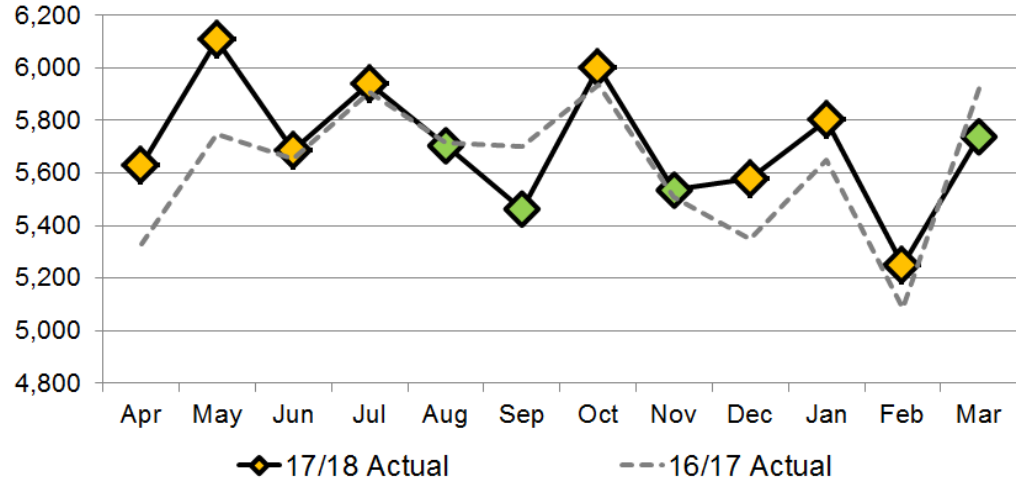
NEL Short Stay Admissions (<24hr) (UHS only)

4% lower than last year



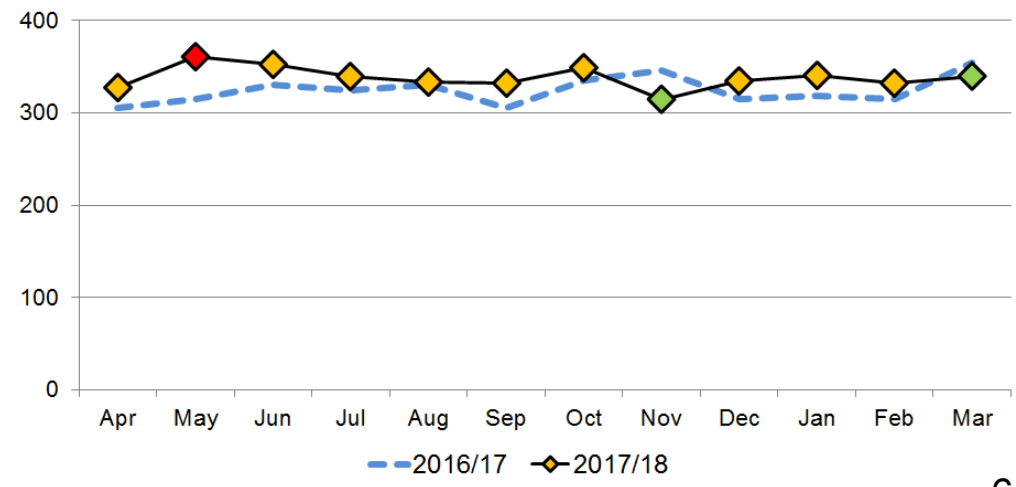
A&E Attendances (Types 1, 2 and 3 – all providers)

1% higher than last year



NEL Long Stay Admissions (>24hr) (UHS only)

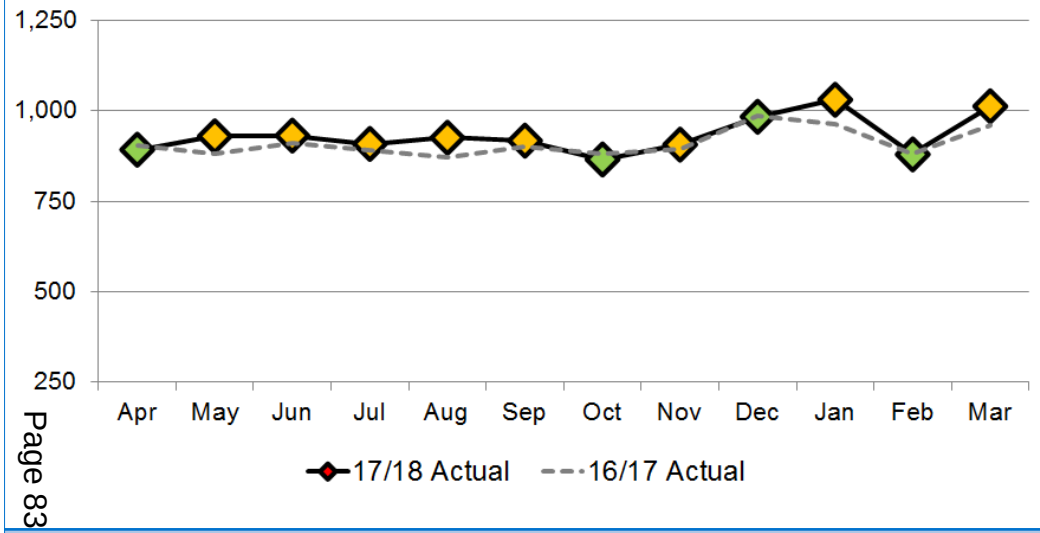
4% higher than last year



Older People (65yrs+)

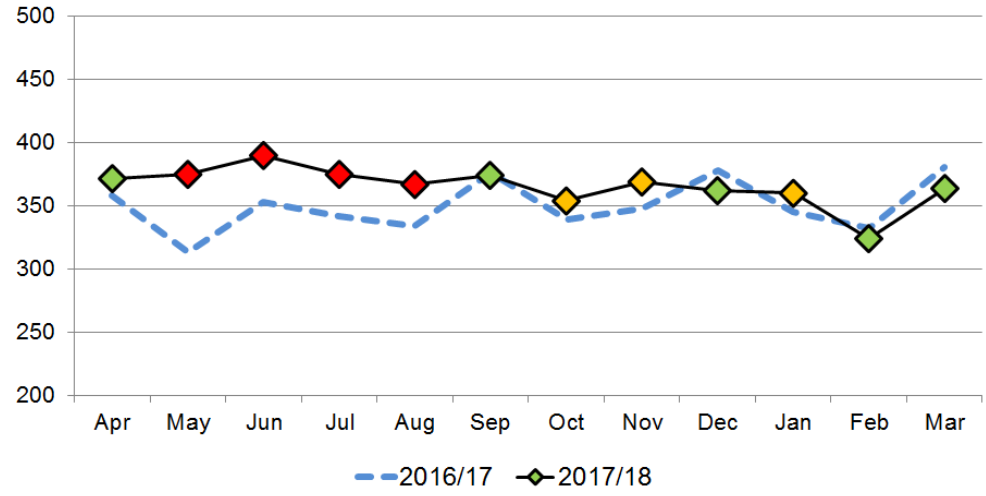
NEL Admissions (all providers)

2% higher than last year



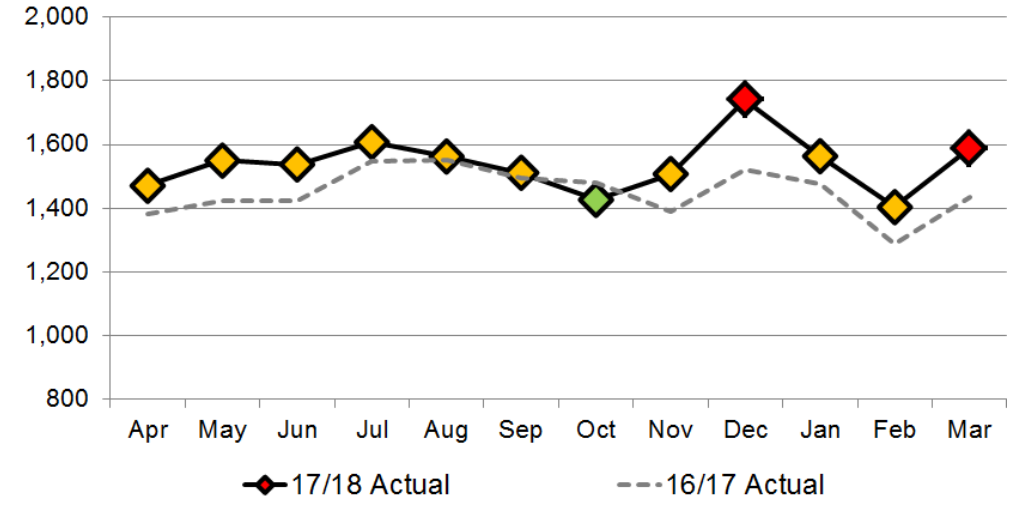
NEL Short Stay Admissions (<24hr) (UHS only)

4% higher than last year



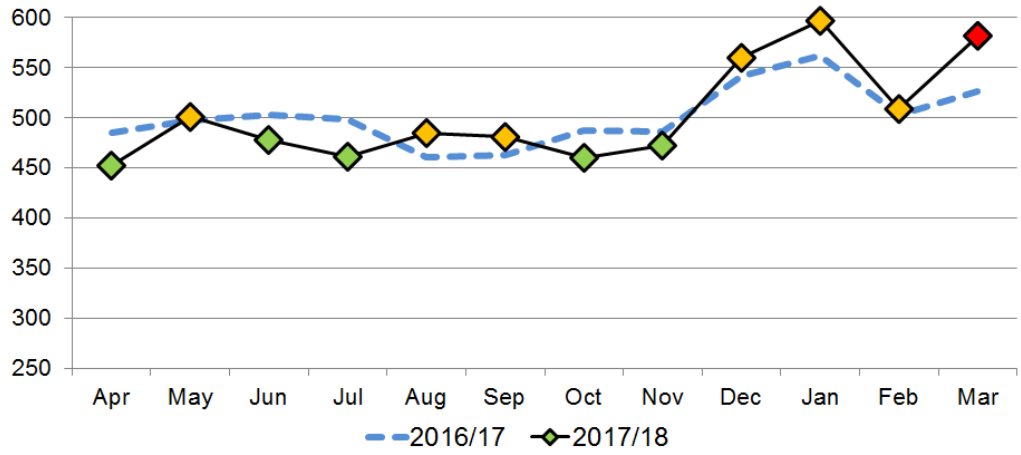
A&E Attendances (Types 1, 2 and 3 – all providers)

6% higher than last year



NEL Long Stay Admissions (>24hr) (UHS only)

0% difference to last year



NEL Admissions – Top 15 Primary Diagnoses (YTD at Month 12)

Children (0-17yrs)

Primary Diagnosis	Activity	Cost
Viral infection	605	£420,537
Acute bronchitis	321	£441,680
Other upper respiratory infections	290	£157,461
Intestinal infection	166	£111,669
Acute and chronic tonsillitis	137	£203,594
Abdominal pain	134	£89,513
Other perinatal conditions	103	£95,503
Asthma	98	£79,687
Epilepsy; convulsions	90	£92,249
Poisoning by other medications and drugs	69	£45,108
Skin and subcutaneous tissue infections	65	£66,731
Superficial injury; contusion	65	£47,455
Other male genital disorders	48	£49,348
Hemolytic jaundice and perinatal jaundice	46	£44,011
Otitis media and related conditions	46	£30,720

Older People (65yrs+)

Primary Diagnosis	Activity	Cost
Pneumonia	801	£3,185,982
Chronic obstructive pulmonary disease and bronchiectasis	524	£1,337,174
Other connective tissue disease	518	£1,071,246
Nonspecific chest pain	509	£360,623
Superficial injury; contusion	396	£418,165
Septicemia (except in labor)	356	£1,600,492
Urinary tract infections	341	£1,283,868
Acute cerebrovascular disease	292	£1,705,345
Fracture of neck of femur (hip)	288	£1,889,108
Congestive heart failure; nonhypertensive	259	£1,139,792
Open wounds of head; neck; and trunk	249	£240,992
Cardiac dysrhythmias	227	£483,979
Syncope	215	£304,470
Other non-traumatic joint disorders	210	£345,491
Abdominal pain	191	£134,363

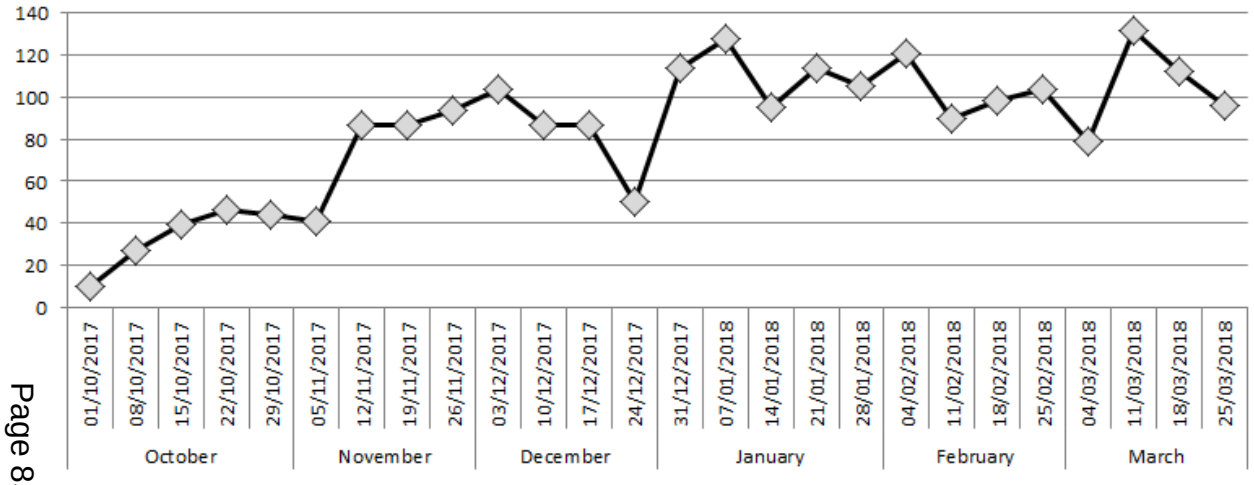
Working Age Adults (18-64yrs)

Primary Diagnosis	Activity	Cost
Nonspecific chest pain	1260	£659,242
Abdominal pain	1041	£763,326
Headache; including migraine	396	£290,074
Skin and subcutaneous tissue infections	381	£586,389
Poisoning by psychotropic agents	374	£224,517
Poisoning by other medications and drugs	351	£193,907
Superficial injury; contusion	307	£179,231
Other connective tissue disease	288	£280,316
Biliary tract disease	263	£495,644
Back pain	260	£191,996
Pneumonia	257	£691,505
Asthma	225	£299,651
Intestinal infection	218	£290,783
Chronic obstructive pulmonary disease and bronchiectasis	199	£372,951
Syncope	188	£132,412

GP Streaming in UHS ED (went live October 2017)

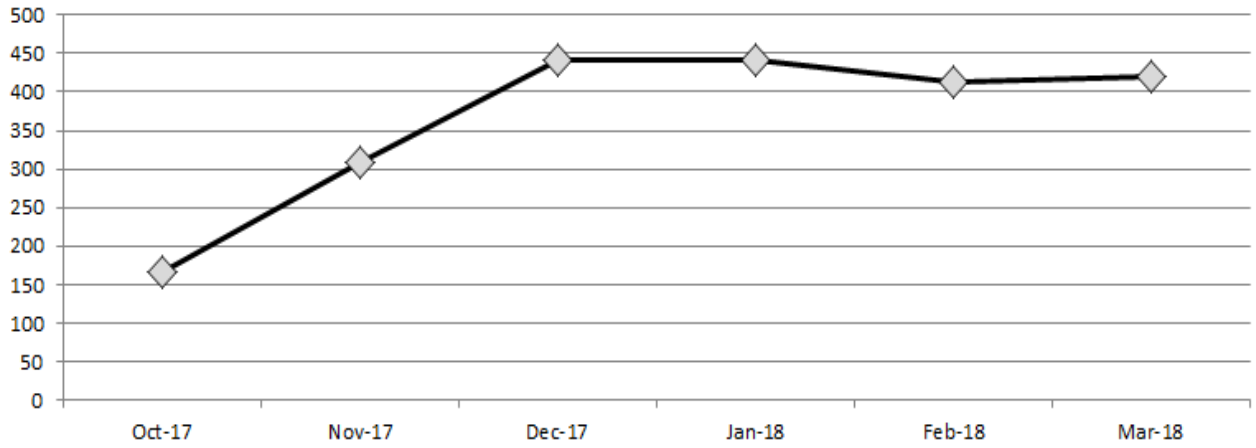
Number of patients being streamed to GP in ED

By week



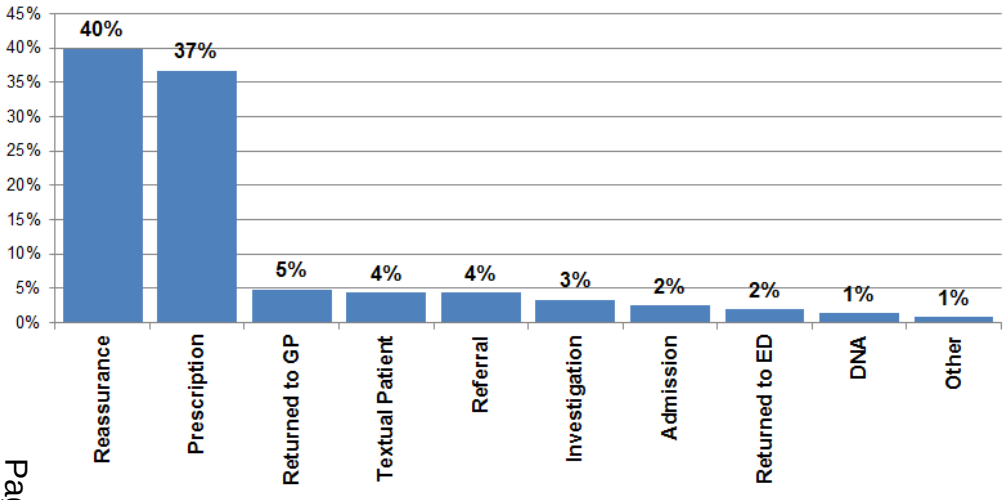
The numbers of patients being streamed to the primary care team in ED has been gradually increasing since launch in October 2017.

By month



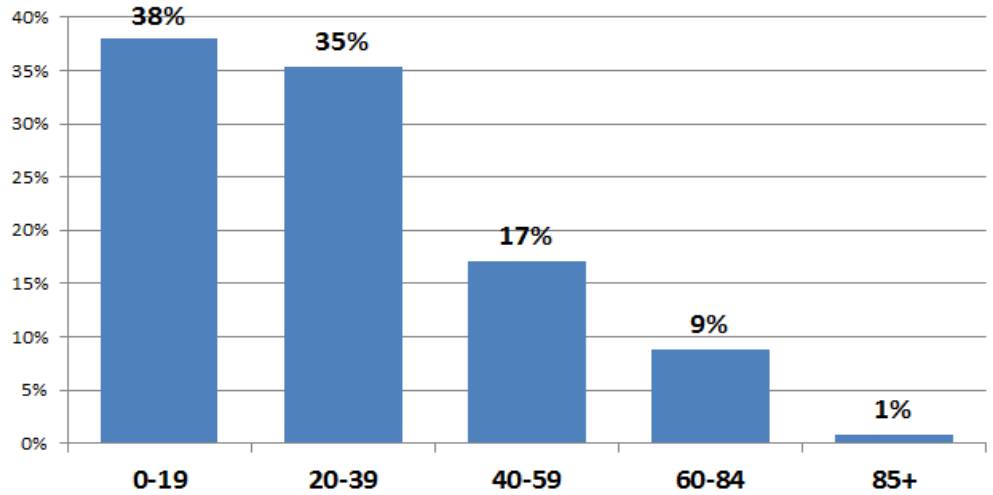
GP Streaming in UHS ED (went live October 2017)

Outcome of appointment with GP



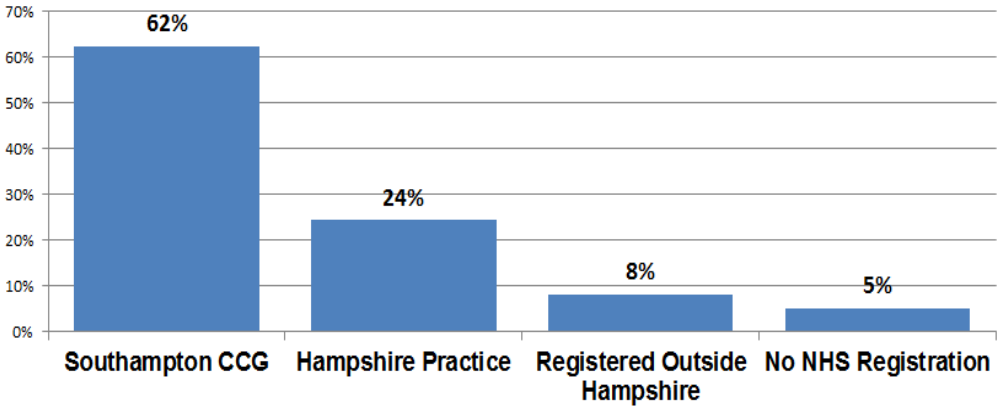
The majority of patients were either given reassurance or a prescription. Only 2% of patients were returned to ED.

Ages of patients being streamed

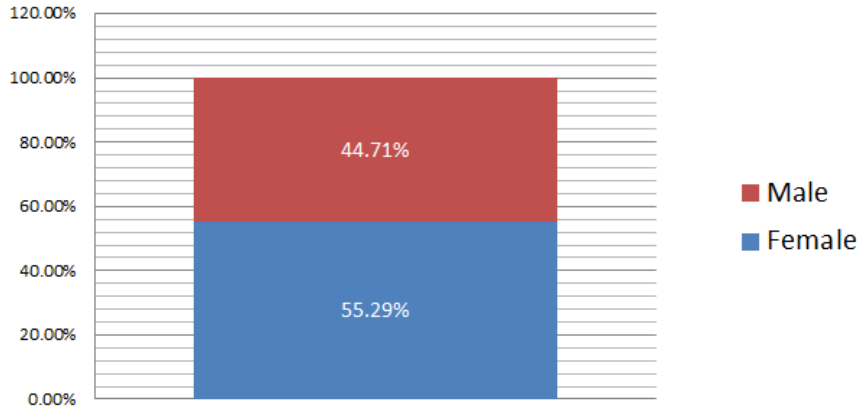


The majority of patients streamed were children and young people, and the younger working age population.

CCG usage of GP Streaming at UHS



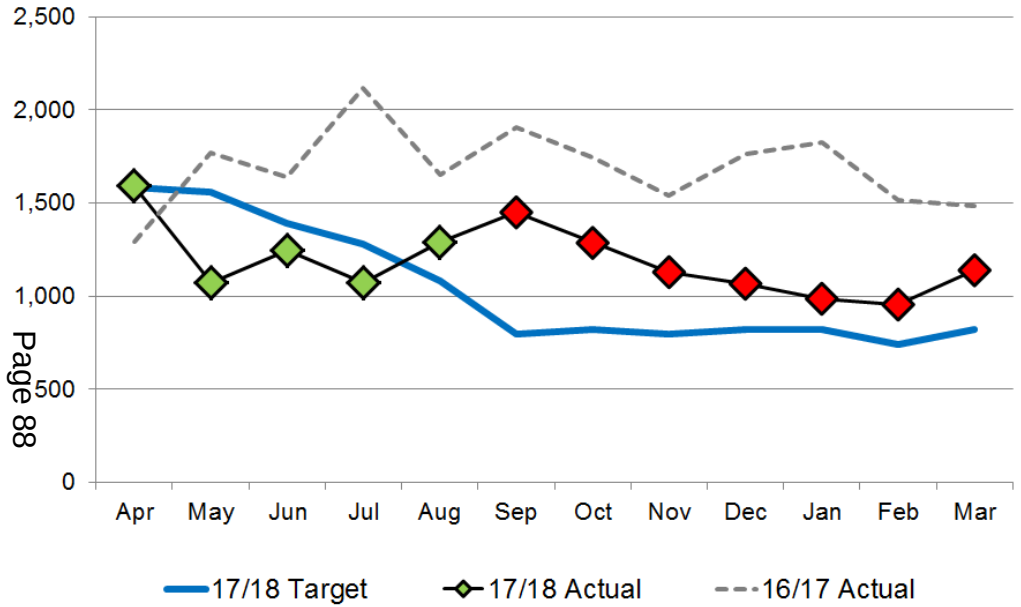
Gender of patients being streamed



Delayed Transfers of Care (18yrs+)

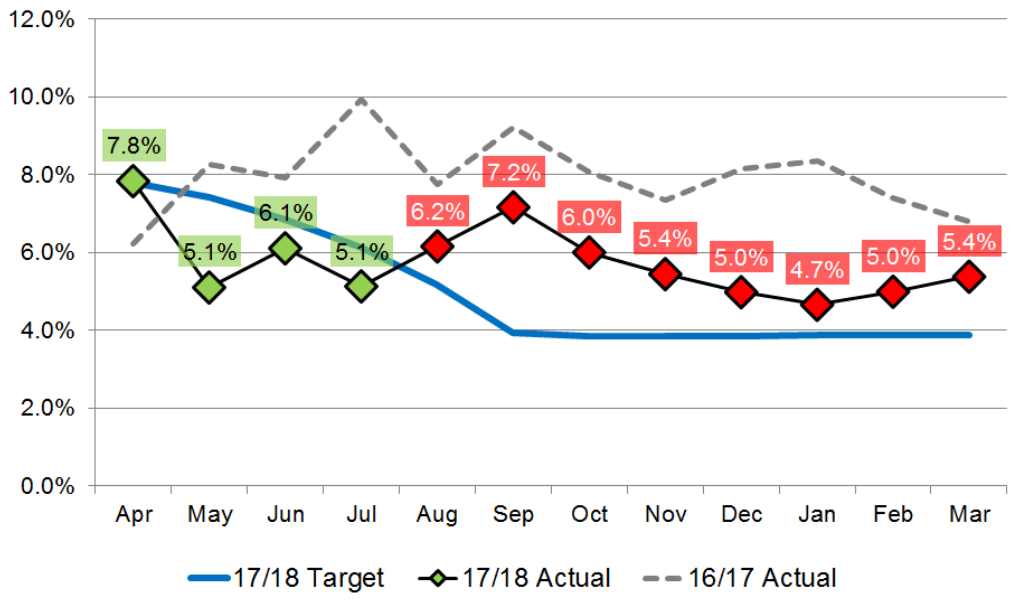
Delayed Transfers of Care (DTOC)

Delayed Days	YTD Target	YTD Actual
	12,518	14,282



(Delayed days, 18yrs+, Total - UHS, Solent, Southern Health)

DTOC Rate	February Target	March Actual
	3.9%	5.4%

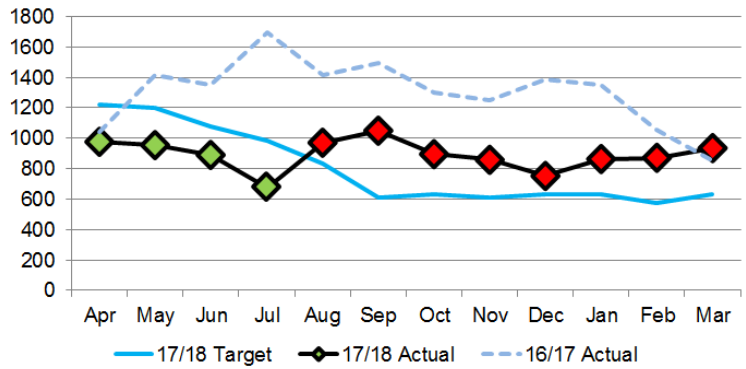


(DTOC rate, 18yrs+, Total - UHS, Solent, Southern Health)

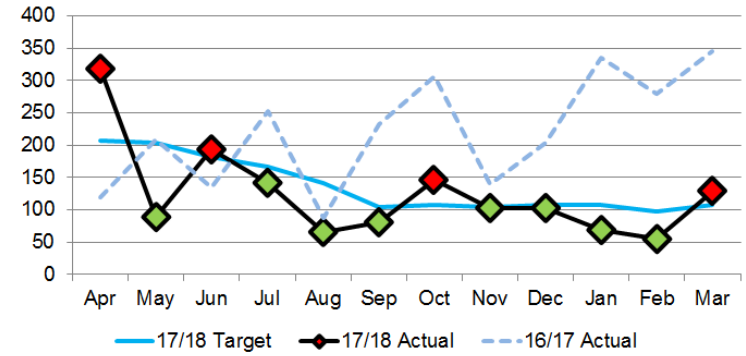
Delayed Transfers of Care (DTOC)

Delayed Days by Provider

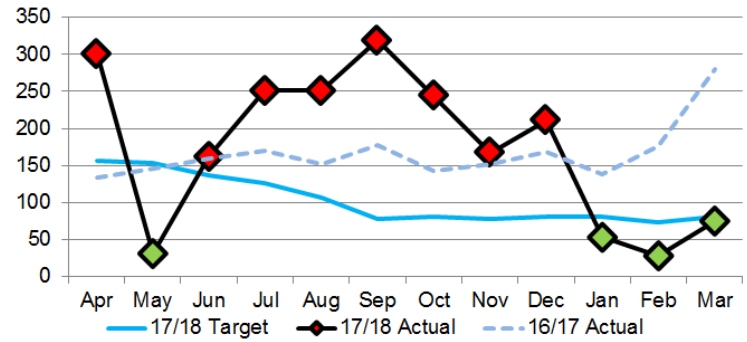
UHS



Solent



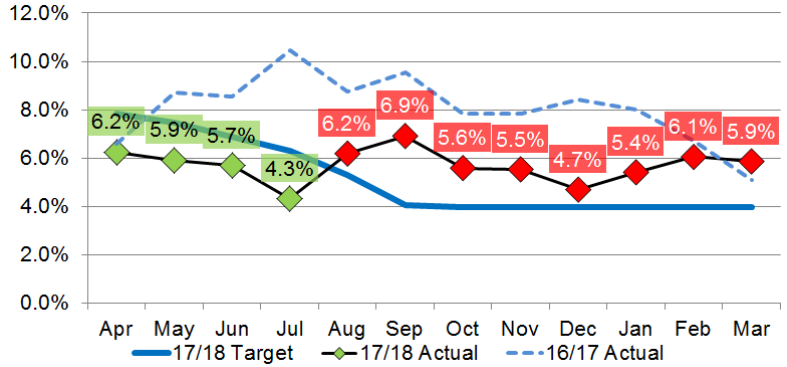
Southern Health



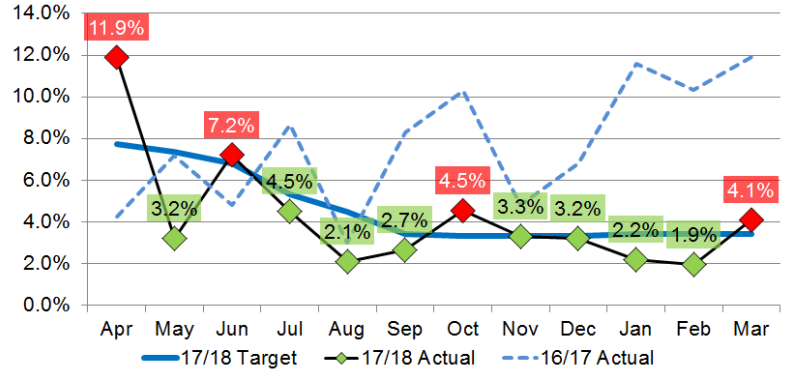
(Delayed days, 18yrs+, UHS, Solent, Southern Health)

DTOC Rate by Provider

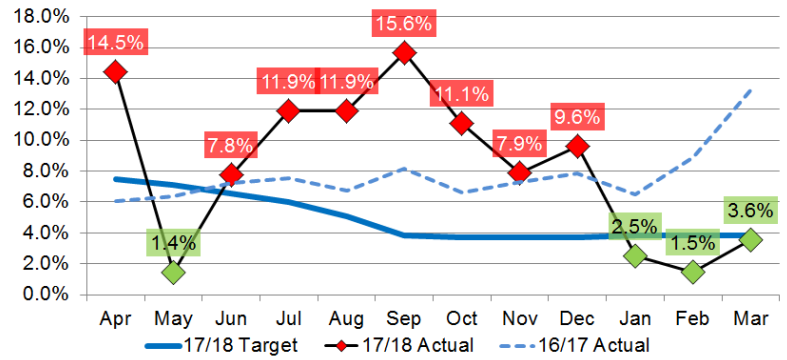
UHS



Solent



Southern Health

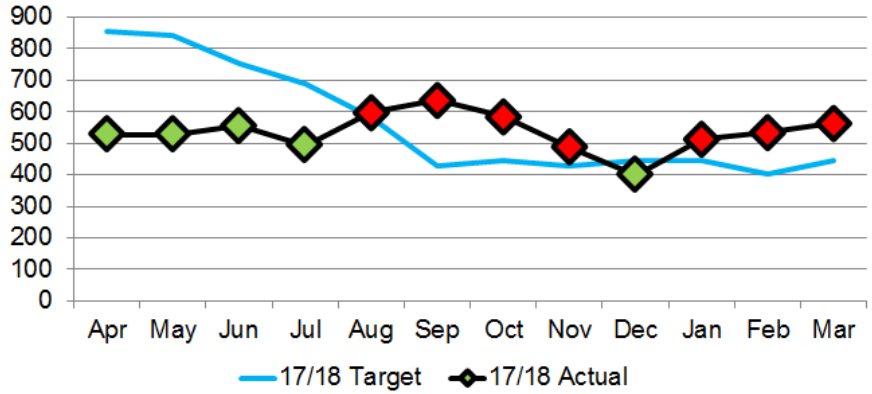


(DTOC rate, 18yrs+, UHS, Solent, Southern Health)

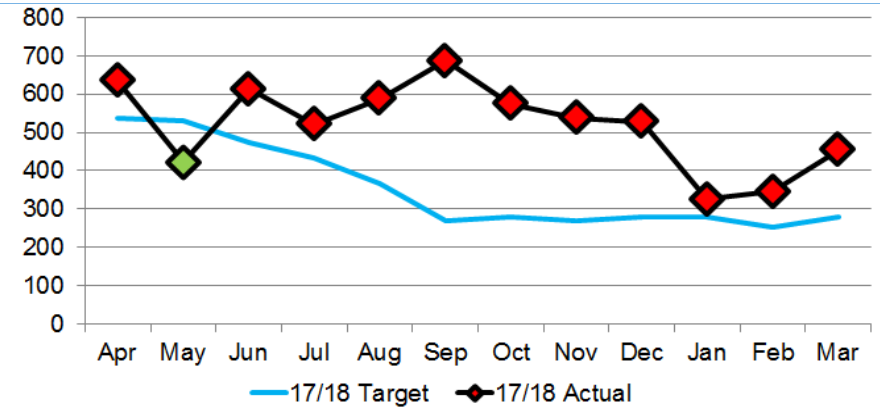
Delayed Transfers of Care (DTOC)

Delayed Days by Responsible Organisation

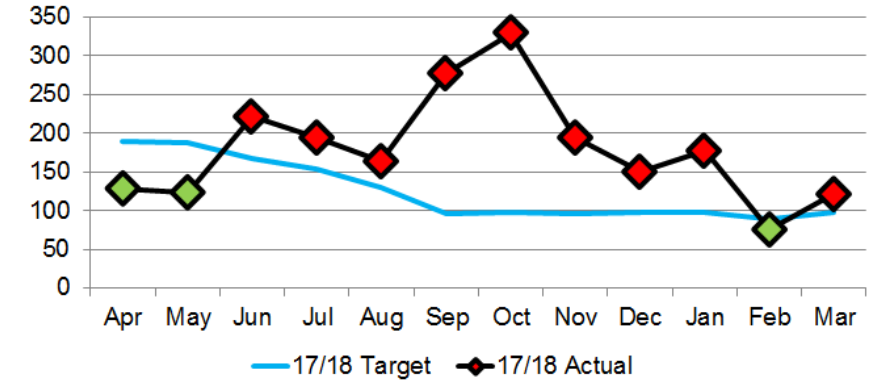
NHS



Social Care



Joint

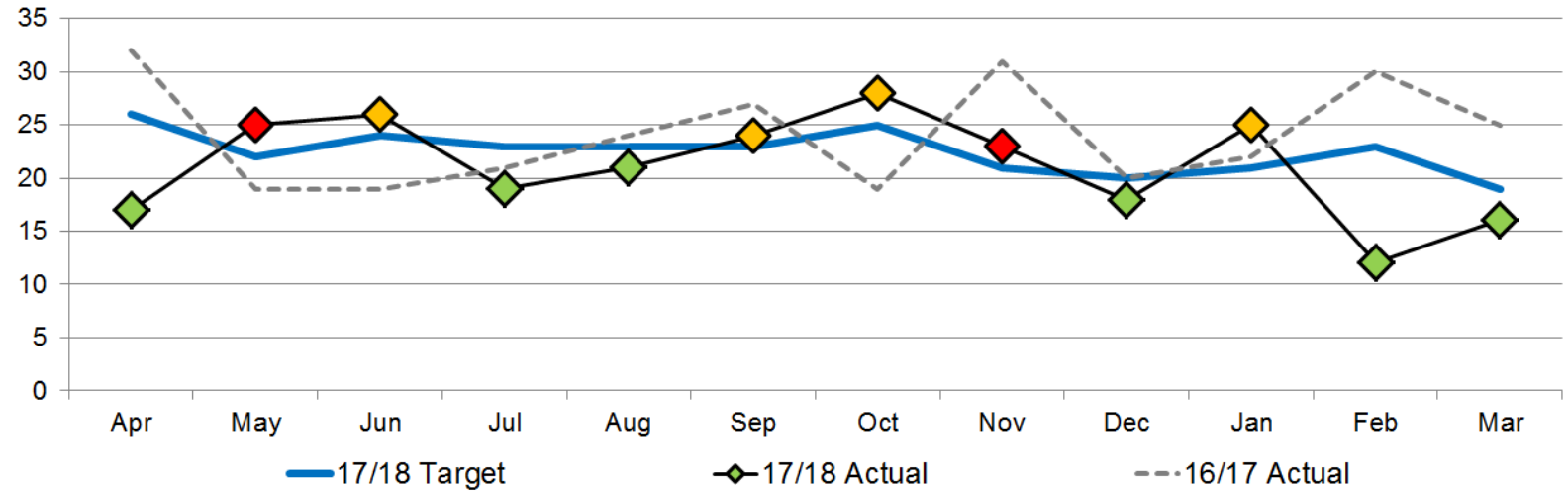


Permanent Admissions into Residential Care (65yrs+)

Injuries due to Falls (65yrs+)

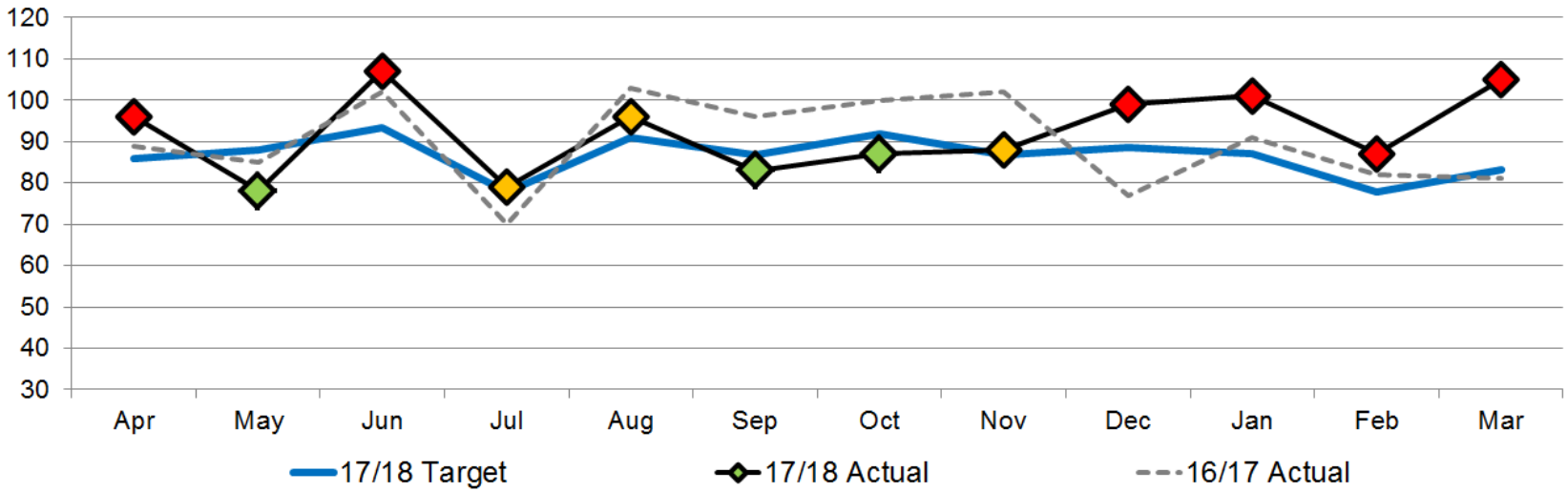
Permanent admissions into residential care (65yrs+)

6% lower than target	12% lower than last year



Injuries due to falls (65yrs+)

7% higher than target	3% higher than last year



Population Growth

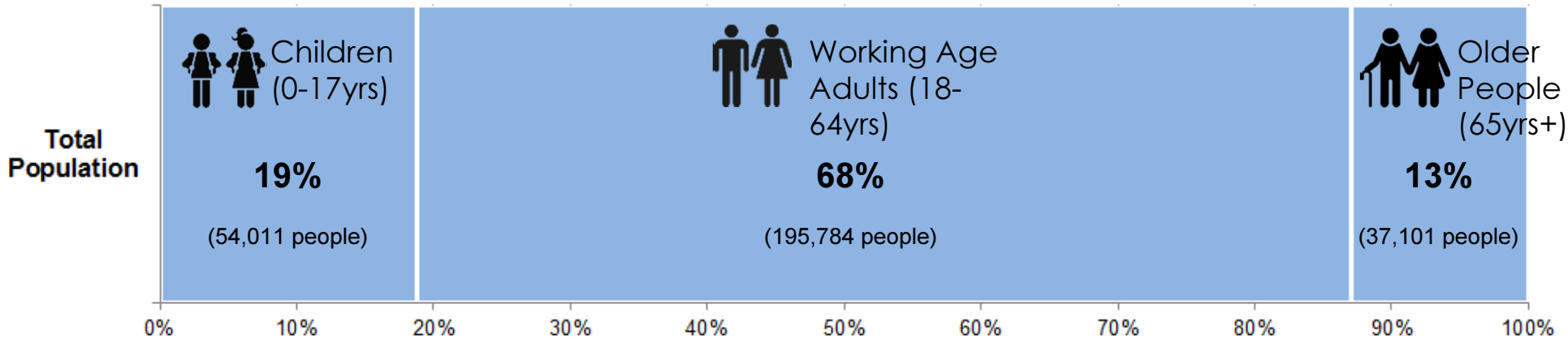
Population Growth

January 2018 vs. January 2017 (CCG GP registered population)

Age Group	January 2017 Population Snapshot	January 2018 Population Snapshot	Increase	% Increase
Children (0-17yrs)	53,461	54,011	**550**	**+1.0%**
Working Age Adults (18-64yrs)	192,170	195,784	**3,614**	**+1.9%**
Older People (65yrs+)	36,761	37,101	**340**	**+0.9%**
Total	282,392	286,896	**4,504**	**+1.6%**

Population Proportions

January 2018 Snapshot (Total CCG GP registered population)



Appendix 3

BCF Finance Report 2017/18 -Month 12

Carers	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	1,240	1,208	(32)
Southampton City Council	134	133	(1)
Total	**1,374**	**1,341**	**(33)**

Commentary:

Previous report

draft outturn

Commentary:

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
1,240	1,208	(32)
134	133	(1)
1,374	**1,341**	**(33)**

0

Clusters	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	47,436	47,750	314
Southampton City Council	1,384	1,677	293
Total	**48,820**	**49,427**	**607**

Commentary:

Commentary:

CCG - Underspends anticipated on HOTs, Insulin Pumps and Orthotics. SCC - An Overspend has been forecasted due to additional spend on locums and the review team. This has taken place partly to cover staffing vacancies and also to carry out additional client reviews

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
47,436	47,750	314
1,384	1,677	293
48,820	**49,427**	**607**

0

Rehab & Reablement	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	11,087	10,900	(187)
Southampton City Council	5,011	4,590	(421)
Total	**16,098**	**15,490**	**(609)**

Commentary:

Commentary:

SCC - Underspend forecasted as less is to be spent on Private Providers & vacant staff posts will remain vacant until year end.

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
11,087	10,900	(187)
5,011	4,605	(406)
16,098	**15,505**	**(593)**

15

Capital	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	0	0	0
Southampton City Council	1,882	1,882	(0)
Total	**1,882**	**1,882**	**(0)**

Commentary:

Commentary:

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
0		0
1,882	1,882	(0)
1,882	**1,882**	**(0)**

0

JES	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	748	748	0
Southampton City Council	757	757	0
Total	**1,505**	**1,505**	**0**

Commentary:

Commentary:

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
748	748	0
757	757	0
1,505	**1,505**	**0**

0

Telecare	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	0	0	0
Southampton City Council	50	27	(23)
Total	**50**	**27**	**(23)**

Commentary:

Commentary:

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
0	0	0
50	27	(23)
50	**27**	**(23)**

0

Direct Payments	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	0	0	0
Southampton City Council	350	192	(158)
Total	**350**	**192**	**(158)**

Commentary:

Commentary:

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
0	0	0
350	192	(158)
350	**192**	**(158)**

0

Long Term Care	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	0	0	0
Southampton City Council	3,600	3,822	222
Total	**3,600**	**3,822**	**222**

Commentary:

Commentary:

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
0	0	0
3,600	3,822	222
3,600	**3,822**	**222**

0

LD Packages	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	9,858	10,369	511
Southampton City Council	16,324	17,098	774
Total	**26,182**	**27,467**	**1,285**

Commentary:

Commentary:

SCC - Movement in client packages. LBHU Pooled fund is anticipated to underspend.

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
9,858	10,369	511
16,324	17,098	774
26,182	**27,467**	**1,285**

0

Prevention & Early Intervention	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	0	0	0
Southampton City Council	7,469	7,291	(178)
Total	**7,469**	**7,291**	**(178)**

Commentary:

Commentary:

SCC - Saving used to offset adverse variances in Public Health

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
0	0	0
7,469	7,291	(178)
7,469	**7,291**	**(178)**

0

SEND/Iigsaw	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	521	521	0
Southampton City Council	398	581	183
Total	**919**	**1,102**	**183**

Commentary:

Commentary:

SCC- Staffing costs - temps are being employed at a higher cost to cover vacancies. The overspend is being funded from £106.9k transferred from the Children Services central agency fund and the balance offset by savings from elsewhere within the portfolio.

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
521	521	0
398	581	183
919	**1,102**	**183**

0

BRS	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	659	659	0
Southampton City Council	411	281	(130)
Total	**1,070**	**940**	**(130)**

Commentary:

Commentary:

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
659	659	0
411	281	(130)
1,070	**940**	**(130)**

0

Total	Outturn		
	Budget	Actual	Variance
	£'000	£'000	£'000
NHS Southampton City CCG	71,549	72,155	606
Southampton City Council	37,770	38,332	562
Total	**109,319**	**110,486**	**1,167**

Commentary:

Commentary:

Outturn		
Budget	Actual	Variance
£'000	£'000	£'000
71,549	72,155	606
37,770	38,347	577
109,319	**110,502**	**1,183**

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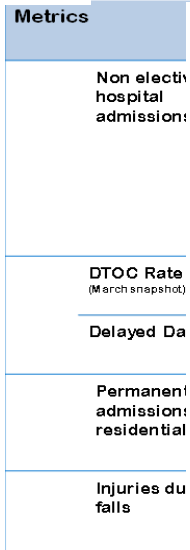
Performance Report – 2017/18 Year End Highlight Report

Key Achievements:



- **Permanent admissions to care homes** lower than target and 12% lower than last year
- **Delayed Discharges** significantly better than last year (29% reduction)
- No increase in **unplanned hospital admissions** , despite 1.6% increase in population
- Integrated **Rehab/ Reablement** reducing long term packages of care - 40% reablement clients leave the service independent, requiring no further care; of those remaining 23% saw a 13% reduction in their care - Saving of 129.5 care hours a week
- Significant savings achieved since opening of **Erskine Court** - £286K full-year effect
- Dedicated professional leads in place for each of the 6 **clusters** and city wide Programme Manager appointed to accelerate implementation of person centred integrated care across all clusters.
- **Enhanced Health in Care Home** model pilot started in September 2017 - for evaluation June 2018
- **Discharge to assess now standardised for pathway 2** across both acute and community hospitals.
- Procurement of a range of prevention and early intervention services: new Integrated Advice, Information and Guidance service, new Southampton Living Well Service

Key Risks and Issues:

- Capacity of care market to meet increasing needs and support additional schemes
- Resilience in the voluntary sector

Year End Financial Position

Overall position:	£1.167m forecast overspend 1% (£109.3m budget)

Priorities for 2018/19:

2018/19 Work Programme

Person centred local coordinated care	• Strengthen cluster leadership and embed integrated working practices • Embed new strengths based model of adult social care and housing into clusters. • Develop integrated models of care and support, including Frailty model, Learning Disability Services and prevention and early help provision for children and families. • Develop community services to manage greater levels of acuity outside hospital. • Implement the new service model for end of life care
Responsive Discharge and Reablement	• Embed the three discharge pathways (simple, supported and enhanced), including Discharge to Assess with a particular focus this year on Pathway 3 • 7 day services to support seven day discharge, including improving quality of discharge and relationships with care homes • Develop the role of the clusters in supporting timely discharge. • Roll out of the Enhanced Health in Care Homes model
Building Capacity	• Embed the new Southampton Living Well Service, Community Navigation and new integrated Information and Advice Service. • Full implementation of online carer support services. • Continue to seek development partner(s) to increase the supply of extra care housing. • Re-procure home care and stimulate growth in the local supply of nursing care for people with complex needs and challenging behaviour. • Procure and implement the care technology strategy in Southampton.

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DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		Integrated Commissioning Plan 2018/19-2020/21		
DATE OF DECISION:		11Th June 2018		
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 80
	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 2018/19-2020/21.
The workstreams identified are to achieve increased integration, improved prevention and earlier intervention, 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 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.
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 Southampton City Local Delivery System Plan 2017-19. 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 by 2020/21. There are a number of workstreams supporting each priority. These are summarised on page 8 of the Appendix 1. 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.	Progress in 2017/18 was very positive and a review of the year will be provided in a separate report and elements are also included in the Better Care Q4 summary. Actions and outcomes have included: • increase in supported living for individuals with learning disabilities to move from residential care, or back into the city • completion of engagement and redesign of Home Care ready to proceed to tender for new framework. This incorporates a more strengths based and reablement approach to help people remain as independent as possible and supports other savings projects • remodelling of substance misuse services and achievement of savings • development of new services for Community Navigation, • reprocurement of Behaviour Change services, developing a collaborative model aligning voluntary and statutory sector services, • recommissioning of Carers service ,including high take up (over 98%) of direct payments of carers involved in the service • significant improvement in number of providers rated as good in the city across health and social care following intensive programme led by ICU quality team. Southampton identified by CQC as most improved in Region for care homes being rated as good following reinspection. • mental health transformation – led to significant changes including development of Crisis lounge at Antelope House; IAPT meeting national targets and commencing national roll out to extend to Long term conditions ; investment in CAMHS services to improve waiting times • leading implementation of Crisis Care Concordat across Hampshire, reducing presentation of people with Mental health conditions to police stations and Emergency departments • retender of services for Housing Related Services (HRS) resulted in new services going live July 17. This improved access arrangements and maintained number of beds for people who are homeless, including rough sleepers, as well as achieving savings • one of the elements of the HRS tender was successfully expanding range of options for care leavers. As a result the council is now exceeding the target for care leavers in suitable accommodation • high cost team have reassessed placements to ensure high quality, cost effective packages and have achieved savings on adult social care packages over £850 per week • achievement of successful bid of £600k pan Hampshire increasing capacity in refugees for those experiencing Domestic violence • Southampton Living Well service established - older person's day services changing into community wellbeing centres with an extended

	range of community activities. • Integrated 0-19 service model went live April 2018 with a streamlined single assessment and approach to working with families • ICU led Independent Fostering framework procurement for 16 local authorities; new rate negotiated which led to savings. Improved negotiations with providers as single conversation with the consortium
RESOURCE IMPLICATIONS	
Capital/Revenue	
12.	The total value of the pooled fund for Better Care is just over £109m. In 2017/18 this was split £71.5M from the CCG and £37.8M For the Council this includes elements of the ICU budget as well as adult, children's and public health budgets. The ICU council budget for 2018/19 is £17,762,200 which comprises contracts and staffing costs. In the CCG the elements specifically related to the ICU work, not including prescribing costs is over £103M. 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. • 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

	• Resilience in the voluntary sector and ability to respond to new ways of working - a number of mitigating actions are being taken including: various procurement options being considered to make best use of local market and encourage innovation; support to local agencies also being considered as part of the developments; proactive review of any bidding opportunities.
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 Local Delivery System Plan 2017-19

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Integrated Commissioning Plan 2018/19-2020/21

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**
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	

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Integrated Commissioning Plan

2018/19 – 2020/21

Agenda Item 7

Appendix 1

NHS
Southampton City
Clinical Commissioning Group

SOUTHAMPTON
CITY COUNCIL

Our Vision & Strategic Priorities

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

NHS Southampton City CCG

Better Care Southampton

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

Mental Health

Improve the quality, capacity and accessibility of mental health services whilst joining up care with other local community services

Primary Care

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

Cancer & Pathways Transformation

Increase earlier detection and treatment of cancer to improve survival, and transform clinical pathways to improve patient outcomes and deliver care closer to home in the community

Urgent & Emergency Care

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

Integrated Commissioning Unit (ICU)

Southampton City Council

People in Southampton live safe, healthy, independent lives

Children and young people get a good start in life

Southampton has strong and sustainable economic growth

Southampton is an attractive modern city, where people are proud to live and work

Our Priorities & Objectives

Integration

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

Prevention & Earlier Intervention

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

Safe & High Quality Services

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

Managing & Developing the Market

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

Integration

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

Our objectives

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

What will success look like by 2020/21?

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

Prevention & Earlier Intervention

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

Our objectives

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

What will success look like by 2020/21?

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

Safe & High Quality Services

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

Our objectives

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

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

What will success look like by 2020/21?

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

Managing & Developing the Market

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

Our objectives

We will continuously review our commissioning arrangements to ensure:

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

We will design our commissioning intentions in a manner that:

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

What will success look like by 2020/21?

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

Our plan on a page for 2018/19

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

**The targets for these KPIs are set nationally*

Our Commissioning Principles

OUTCOMES DRIVEN

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

EVIDENCE BASED

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

INTEGRATION

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

ENGAGEMENT

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

PREVENTION & TACKLING HEALTH INEQUALITIES

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

QUALITY & VALUE FOR MONEY

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

FAIRNESS

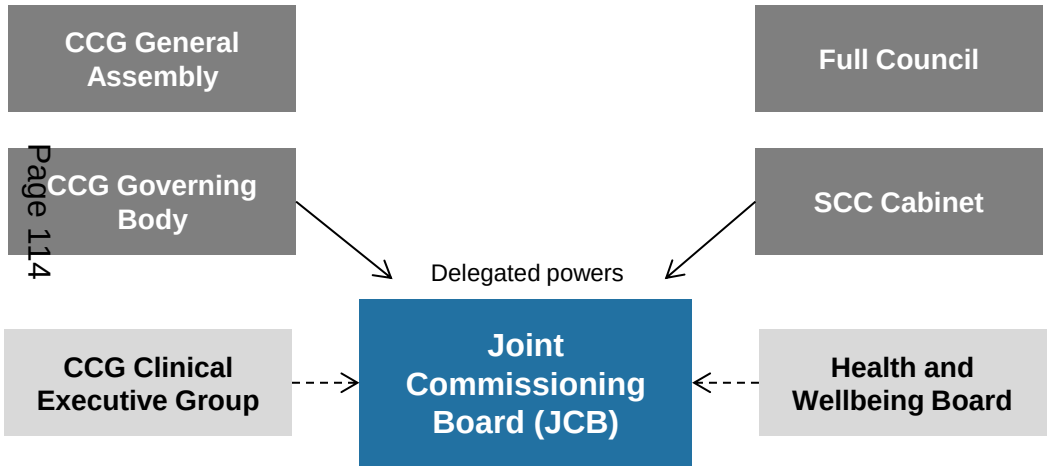
The commissioning process will ensure that the same approach (e.g. service specification and performance monitoring) is applied to all commissioned activity to ensure fairness and that no delivery vehicle is given or gain unfair advantage.

PARTNERSHIP WORKING

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

Our Governance Structure

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



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

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

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

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

Integration

Integration

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

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

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

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Project	Description		2018/19 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 Apr	May	Jun	Outcomes
4. Adult mental health (AMH)	Implement Mental Health Matters (MHM) and Five Year Forward View (FYFV) for Mental Health to improve local services and meet national targets.	*Long term conditions*	Increase access to Improving Access to Psychological Therapies (IAPT) service including a focus on long term conditions															• 17.5% of people with common mental health conditions accessing IAPT. • 60% of people with SMI receiving physical health checks. • 53% of people experiencing a first episode of psychosis will be treated within 2 weeks of referral. • Maintain 50% recovery rates for IAPT. • 25% increase in number of people accessing IPS services.
			◆ Agree long term condition pilot areas															
						◆ Begin recruitment and finalise expansion model and costings												
						Deliver increased access to services including long term conditions												
		Navigation service	Pilot Adult Mental Health navigation service												Implement city wide navigation services to include MH and Dementia navigation			
		Peer support	Coproduce peer support strategy				Produce options papers and formal sign off			Procurement of Peer Support service					Implementation			
		Autism support	◆ Finalise procurement documents for Autism Support Service															
			Procurement				◆ Procurement ratification											
							Provider mobilisation			◆ Contract commence								
		Developmental disorders	Work with current ADHD and autism diagnosis providers to develop future service				Sign off new pathways and mobilisation			◆ Implement revised pathways								
			Continue to develop coherent developmental disorders pathway for children and young people and adults with ADHD, autism and Asperger's.															
		Primary care	Design primary care Mental Health services			◆ Implementation of enhanced MH primary care models												
		Personality disorders	Personality Disorder pathways development				Mobilisation of new model			◆ Implementation of enhanced Personality Disorder pathway								
		0-25 transition service						Develop 0-25 years transition service for mental health.										
		Suicide strategy	Continue implementation of a suicide prevention strategy.															

Integration

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Project	Description		2018/19 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 Apr	May	Jun	Outcomes
5. Child and Adolescent Mental Health Services (CAMHS) transform-ation	Implement CAMHS Transformation plan to improve local services and meet national targets.	*Continue to develop an early intervention mental health team with increased investment*	Review of impact of current CAMHS team			New posts in place												• ≥95% routine CAMHS referrals receive contact within 16 weeks. • ≥95% urgent CAMHS referrals offered an appointment to be seen within 1 week. • 95% of children and young people with an eating disorder receiving treatment within 4 weeks (routine) • Co-production network in place. • Improved service user experience. • Improve recording of the mental health services dataset (MHSDS) to ensure National CAMHS Access target is met.
								Sign off CAMHS service specification, including performance and monitoring										
		Young people's counselling service	Mobilise new Young People's Counselling Service						New service in place									
		Community CAMHS grants	Review community CAMHS Grants			Agree 18/19 spending plan												
		Eating disorders				Community Eating disorder service: review current service provision against agreed staffing establishment and national standards												
		Improve recording of the mental health services dataset (MHSDS)	Set up Task & Finish Group															
			Solent to report a proxy indicator monthly to provide assurance of access rates															
			Report activity from other Solent services (non CAMHS) that provide evidence based mental health interventions					Work with non-NHS Providers to develop systems to report to MHSDS										
		Crisis pathway		Review crisis pathway, linking with HIOW STP														
		CAMHS liaison nurse in ED	Review impact of CAMHS Liaison Nurse in ED with West Hampshire			Implement recommendations from CAMHS Liaison Nurse in ED review												
		Building strength & resilience	Review Building Strength & Resilience Service (BRS)			Recommendations agreed from BRS review		Implementation of BRS review recommendations										
		Personal health budgets	Explore PHBs in CAMHS															

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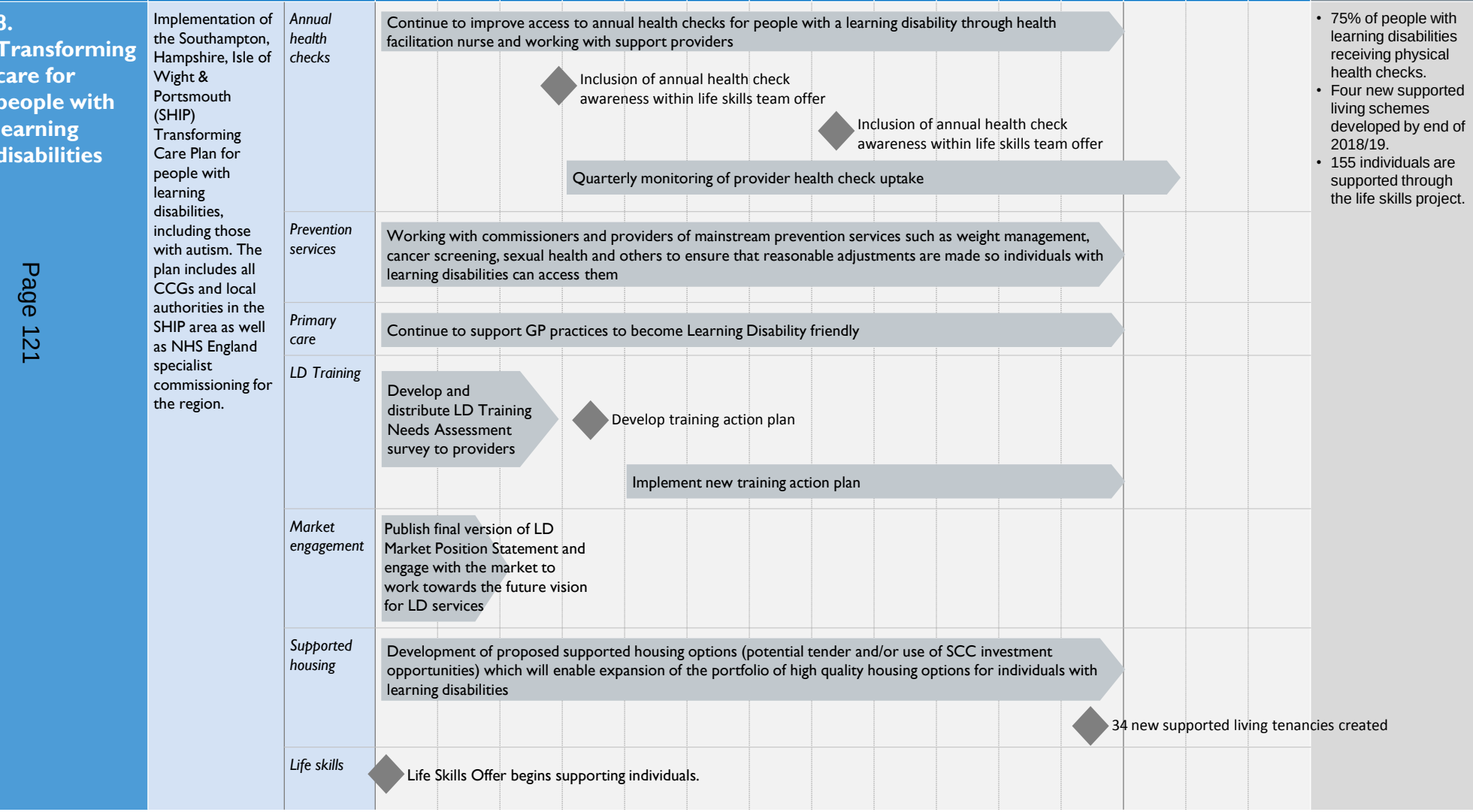
Project	Description		2018/19 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 Apr	May	Jun	Outcomes
6. Crisis care	Implement crisis care concordat to ensure an end to end pathway is in place across the Hampshire & Isle of Wight footprint, which addresses current issues, such as use of Police cells for those in crisis, pressure on ED, delays in accessing crisis care and poor service user experience	*Crisis resolution*	Continue to develop crisis resolution and home treatment teams to be effective and properly resourced delivering best practice standards as described in the CORE fidelity criteria															• Meet CORE fidelity for crisis resolution home treatment team. • Crisis lounge open 24/7. • 24/7 telephone support available. • Meet CORE 24 psychiatric liaison standard.
			Develop community mental health teams to be able to respond flexibly to first signs of crisis following evidence of best practice															
		Crisis Lounge	Continue to recruit to Crisis Lounge to achieve 24/7 access			Evaluate Crisis Lounge outcomes												
		NHS 111 24/7 Mental Health support		◆ 24/7 111 mental health telephone support paper to STP/CCGs for sign off														
					Recruitments to 24/7 MH 111 pilot			◆ Implementation of pilot										
		Core Mental Health liaison services 24 hours a day, 7 days a week	Final recruitment to CORE 24 psychiatric liaison in UHS			◆ 24/7 CORE 24 implementation												
			Review CORE 24 model and review all mental health and substance misuse support in UHS			Develop and agree options appraisal for integration of MH and SM support within UHS												
7. LD Integration	Creation of an integrated health and social care team to support people with learning disabilities in Southampton, putting the individual at the centre	*Comms & engagement*	Ongoing engagement, consultation and communications with stakeholders															• Integrated health and social care team for LD across SCC, CCG and SHFT. • Improved service user outcomes including increases in placement stability and meaningful daytime occupation. • Simplified and more responsive services for clients, carers and wider stakeholders . • Improved cost efficiencies by developing shared assessment, business process and infrastructure. • Reduction in cost of packages of care.
			◆ Comms plan developed															
		Review of clients		◆ Client mapping exercise complete														
					◆ Work plan to review clients agreed													
									Embedding new working practices to ensure clients are reviewed meeting local and national standards									
		IT		◆ IT options paper														
					◆ Decision made on IT and admin support													
		Recruitment					◆ Integrated Service Manager appointed											

Integration

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



Integration

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

Project	Description		2018/19 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 Apr	May	Jun	Outcomes
9. Developing the older person's offer	Implementation of the older person's offer, promoting independence, health and wellbeing.	*Living well service*	Review application of personal budgets for Living Well Service															• Improved sense of wellbeing, physical and mental stimulation and reduced feelings of loneliness. • Improved access to advice services and support. • Increased early identification and prevention. • Reduction in residential home permanent admissions, by promoting independence. • Fewer unnecessary hospital admission/ readmission and reduction in XBDs.
			Agree mobilisation plan for Living Well Service															
						Identify potential sites for Wellbeing Centres												
						Establish DP/3rd party budget arrangements												
									Reach agreement on Oak Lodge and Brook Centre leases									
									Agree transport criteria									
			Work with SCA to develop future model by cluster			Public consultation on new Living Well model changes			Support implementation of Living Well changes									
		Meals on wheels	Review future options for Meals on Wheels service			Agreed way forward for Meals on Wheels recommendations												
							Implementation of Meals on Wheels recommendations											
		Nutrition and hydration strategy			Development of strategy to meet nutrition and hydration needs of older people													

Integration

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

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

Integration

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

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

Integration

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

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

Integration

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

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

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

Prevention & Earlier Intervention

Prevention & Earlier Intervention

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

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

Prevention & Earlier Intervention

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

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

Prevention & Earlier Intervention

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

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

Prevention & Earlier Intervention

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

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

Prevention & Earlier Intervention

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

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

Safe & high quality services

Safe & high quality services

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

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

Safe & high quality services

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

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

Safe & high quality services

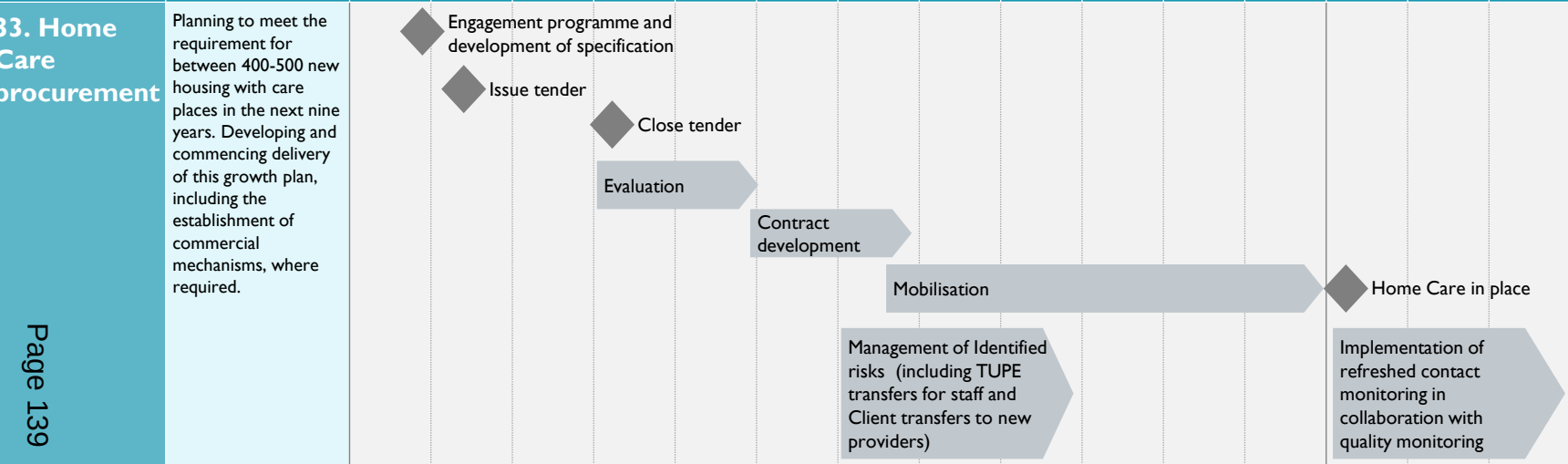
Ensure that people are provided with a safe, high quality, positive experience of care in all providers

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

Managing & developing the market

Managing & developing the market

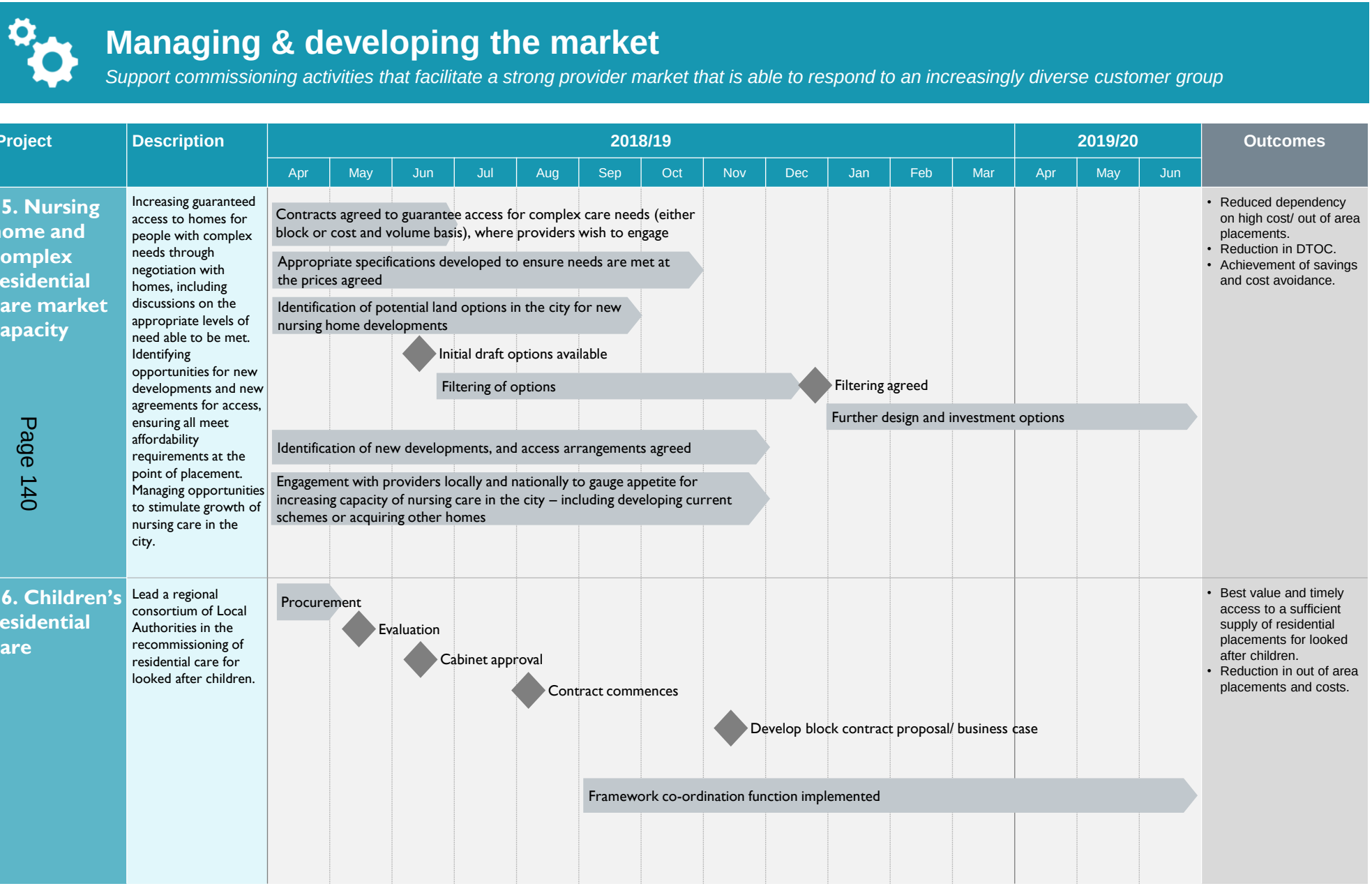
Support commissioning activities that facilitate a strong provider market that is able to respond to an increasingly diverse customer group



Project	Description	Outcomes
33. Home Care procurement	Planning to meet the requirement for between 400-500 new housing with care places in the next nine years. Developing and commencing delivery of this growth plan, including the establishment of commercial mechanisms, where required.	• Increase in Homecare capacity in the city. • 75% of care delivered by Framework providers. • Reduction in DTOC attributable to waits for Homecare package. • Seek alternative way in delivering care to reduce the reliance upon short calls (15mins) particularly outside of housing with care environments. • Reduction in time taken from referral being received by CPS to start of care package. • All framework providers working towards meeting ethical care charter standards.
34. Housing with care	Develop and commence delivery of growth plan for local extra care housing, including establishment of commercial mechanisms for attracting investment and/ or land and reducing risk where required.	• Increased extra care capacity. • Reduced admissions to nursing homes. • Delayed onset of care and support needs. • Lower incidence of falls. • Less health service utilisation. • Reduced social isolation.

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

Managing & developing the market

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

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

Abbreviations & Acronyms Glossary

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

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DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Quality Update including Provider Failure and Provider Exit Guidance**		
DATE OF DECISION:		**11th June 2018**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Carol Alstrom	Tel:	023 80296956
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STATEMENT OF CONFIDENTIALITY		
Not applicable		
BRIEF SUMMARY		
This paper provides an update on quality in social care services in Southampton and is seeking the support of the Joint Commissioning Board for the ongoing use of the Provider Failure and Provider Exit Procedure. This procedure has been developed in line with nationally recognised guidance to support this type of event, and involves both health and social care teams to respond, particularly in the case of a large provider e.g. a care home with nursing or a home care provider who provides home care to a large number of health and social care funded service users.		
RECOMMENDATIONS:		
	(i)	Note the quality report
	(ii)	Endorse the Provider Failure and Provider Exit Procedure
REASONS FOR REPORT RECOMMENDATIONS		
1.	The quality report is an update for Joint Commissioning Board on quality concerns and good practice in the City and is intended as an information only item to provide assurance to the Board	
2.	The Provider Failure and Provider Exit Procedure has been developed by the Integrated Commissioning Unit Quality Team following national best practice and local experience of provider failure or exit. This means that the procedure has been tested to ensure it is applicable to care homes and home care providers, for both provider failure (a situation where the quality or business provided breaks down) and provider exit (a situation where a decision has been made for a provider to exit the local market)	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
3	The Council and CCG could have continued without a clear procedure for provider failure and provider exit however this was rejected as it places both organisations at risk of not being able to appropriately manage this type of situation. This would then potentially put service users at risk	
4	By not having a clear provider failure and provider exit procedure the Council would not be fulfilling its safeguarding responsibilities	

DETAIL (Including consultation carried out)	
5	**Quality Report** This short update provides an overview of the current good practice and challenges for quality of services that are commissioned by the Integrated Commissioning Unit (ICU) between Southampton City Council and NHS Southampton City Clinical Commissioning Group
6	**Good Practice** Currently across Southampton social care providers in the care home market are considered overall to be providing good care. Earlier this year the Care Quality Commission identified Southampton as having the highest increase in ratings of good upon re-inspection (↑190%). A small number of providers continue to be monitored by the ICU Quality Team to ensure that care standards are meeting the Care Quality Commission and locally expected requirements. These providers are subject to regular monitoring visits and intelligence review with early intervention when concerns are identified.
7	Home care providers in Southampton are slightly more challenged and a number of these providers have been subject to large scale safeguarding investigations in recent months. This has resulted in some services being suspended from taking new clients for short periods of time to allow providers to correct problems with their services. Additional support has been provided by the Quality Team and other ICU Commissioners to ensure these services meet local and national quality standards.
8	Over the last 6 months the Quality Team has been working with Adult Social Care operational teams within the Council to ensure the internal care homes and home care services provided are also meeting these requirements. Good progress has been made and it is now felt that the two care homes, shared lives scheme and rapid response service are meeting the requirements. Further work is being undertaken to support these services in developing outstanding aspects of service provision and care.
9	The services provided by health and social care providers as part of the Better Care fund are considered to be meeting the quality requirements. There is ongoing quality monitoring in place for all the health led contracts and this is being developed further for those led by social care. During the early part of 2018 there has been a focus on ensuring all contracts awarded via the ICU have clear requirements relating to safeguarding adults and children. Further work planned for 2018 includes ensuring commissioning managers with responsibility for monitoring contracts have a broader understanding of quality assurance and how to support providers who may be weak in this area.
10	The Provider Failure and Provider Exit procedure has been developed by the Integrated Commissioning Unit Quality Team with involvement from Commissioning Managers, Provider Relationships, and Adult Social Care Safeguarding experts. Input has also been sought from emergency planning,

	communications, finance and legal services.
RESOURCE IMPLICATIONS	
Capital/Revenue	
11	There are no specific resource implications of this paper. The provider failure and provider exit procedure requires Council and CCG staff to undertake additional roles similar to those of managing a significant incident or emergency planning type situation.
Property/Other	
12	None noted
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
13	The Council has a statutory power and responsibility to safeguard individuals receiving services within the Southampton City boundary
Other Legal Implications:	
14	None noted
CONFLICT OF INTEREST IMPLICATIOINS	
15	No conflicts of interest are noted
RISK MANAGEMENT IMPLICATIONS	
16	The Council has a responsibility as a commissioner of services to ensure the quality of those services meets and acceptable standard. In addition the Council has a statutory responsibility under the Care Act to ensure mechanisms are in place to safeguard adults, who may be vulnerable, and are receiving care within the City boundary.
17	**Areas of Concern** The main areas of concern for quality of services in Southampton at this time relate to the ability of all providers to recruit and retain appropriately trained staff. This applies across all sectors with particular concern in home care services, nursing homes recruiting registered nurses, and some health practitioners including general practitioners (GPs), some specialist areas of practice including mental health and learning disability nurses. Over the last 12 months Southampton has had a small number of social care providers, both care homes and home care services, leave the market either by choice or following failure of services. In light of this and in line with national best practice a provider failure and provider exit procedure has been developed and is presented to the Joint Commissioning Board for endorsement. It is a joint procedure between Southampton City Council and NHS Southampton City CCG, reflecting the work of the ICU and the national move to closer working between health and social care. The document is attached to support endorsement.
POLICY FRAMEWORK IMPLICATIONS	

18	The proposals contained within this report are in accordance with the Councils Policy Framework plans

KEY DECISION?	**Yes/No N/A**
WARDS/COMMUNITIES AFFECTED:	
SUPPORTING DOCUMENTATION	
Appendices	
1.	Provider Failure and Provider Exit Procedures

Documents In Members' Rooms

1.	Not applicable
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.	Not applicable	

PROVIDER FAILURE AND PROVIDER EXIT PROCEDURE

Guidance for Southampton City Council and NHS Southampton City CCG Staff

June 2018

Subject and version number of document:	Provider Failure Procedure V03 This procedure identifies actions to be taken in the event of actual or prospective failure / exit of one or more providers of care which appears likely to occur in circumstances where the Provider may not be able to plan and implement an orderly and structured run-down of their services.
Owner of this document:	Associate Director of Quality, Integrated Commissioning Unit
Operative date (first created):	11th June 2018
This document applies to:	Care Home and Home care providers within Southampton City boundaries Southampton City Council NHS Southampton City CCG
Policy Implications:	Guidance for Internal Use Policy to be shared with staff who may be involved with this process
Consultation Process	Integrated Commissioning Unit Adult Social Care
Approved by:	Joint Commissioning Board
Date approved:	11th June 2018
Next review date:	June 2020

INDEX

1. Introduction

1.1 This document has been produced with support and guidance of officers from Southampton City Council (SCC) and NHS Southampton City Clinical Commissioning Group (CCG) and is underpinned by the 4LSAB Multi Agency Adult Safeguarding Policy and Procedures 2nd Edition December 2016. The procedures are also based on guidance by ADASS (the Association of Directors of Adult Social Services) for dealing with provider failure and supports the implementation of the Care Act (2014).

1.2. Failures and exits of care providers from the local market are comparatively rare events and present particular challenges in that City Council and NHS intervention would be required immediately, and the assessment and transfer of residents to alternative care providers may need to take place within a very short time frame.

1.3. The impact of the changes to provision upon service users and their relatives and carers should be managed in the best 'person-centred' way possible by working to the framework set out in this document. Every effort should be made to cater for the specific identified needs of each citizen, and wherever practicable to keep 'friendship groups' together and take time and great care to minimise the disruption for these very vulnerable service users and maximise the time available for preparation. Further good practice guidance is set out in research by ADASS (the Association of Directors of Adult Social Services) and the University of Birmingham on achieving positive outcomes during moves, especially with unplanned or short-notice failures.

1.4. Any assessment and planning processes involving vulnerable adults affected by a potential failure will also be need to be underpinned throughout by the principles of the *Mental Capacity Act 2005*

1.5. Failures and exits may be caused by a number of factors - for example:

- Closure by Regulators
- Termination of contract by Commissioners
- Loss of premises due to damage
- Closure by Owners due to increasing financial pressures; or the outright failure of
- their business leading to the appointment of a Corporate Insolvency Practitioner e.g. a Receiver, Administrator etc.
- Business/organisational redesign and transformation

1.6. Any resulting requirement for transfer of service users to alternative care facilities would be dependent on the assessed needs of the citizen and the availability of spare capacity in the local market. The preferred and expressed choices of location and of care provider of Service users/carers should be gained and fully taken into account.

1.7. Lead responsibilities for dealing with different categories of resident will fall as follows (see also ***Section 6,*** below):

- Council-funded and self-funded – Local Authority
- Continuing Healthcare funded – NHS
- Joint funded – Local Authority or NHS with largest % of funding split to lead
- Out of City Local Authority – Local Authority to identify relevant funding authority and agree responsibility for managing transfer

This procedure can be applied to all types of provider services, including,

- Residential Units
- Supported Living
- Home Care and Support
- Day Services
- Other key services

And the timescale of the potential closure can be

- Immediate and/or unplanned
- Longer term planned closure by a set date

1.8. Actual or prospective failure or exit of a single provider imposes stress on a local care market, whereas the failure of a medium or large corporate Provider - often involving several Care Services in the same area at the same time - will present enormous challenges that may require the involvement of a number of NHS's and Local Authorities to identify alternative capacity and to maintain service provision.

1.9. **It is recognised that every situation is different and it is up to the responsible statutory sector Managers to decide the best approach for the situation presenting at the time, interpreting this Operational Procedure flexibly to suit the specifics of the case while still being guided by its principles.** Any case-specific 'contingency' or 'resilience' planning will to a large extent be determined by the time available prior to failure, and the Lead Officer will need to adapt procedures and use available resources to minimise disruption to Service Users as far as possible.

1.10. Factors such as the cause of the failure or exit, the timescale, local availability of provision and staffing resources, will all affect the feasibility of using a standard management approach - however, the Management Checklist in ***Appendix A*** provides a useful framework.

2. Aim and Purpose of this Operational Procedure

2.1. The main aim of this document is to provide a framework for Managers to ensure:

- Service users/adults at risk are fully protected and their wellbeing and safety is at the forefront of planning and action.
- that there is effective and coordinated planning and communication between all parties involved in the proposed and/or actual failure arrangements

2.2. This Procedure identifies actions in the event of an unplanned or potential care provider failure, including the officers responsible for these actions.

2.3. It is intended as a generic approach to situations of this type. There should be a coordinated and agreed plan for any provider failure event.

2.4. The options for alternative provision will depend upon individual circumstances and are listed in ***Section 8.***

2.5. In the case of unplanned failures or exits affecting a major service Provider that overwhelms the ability of SCC and the CCG being able to relocate service users, SCC and the CCG may also want to consider activating Emergency Planning procedures for the City Council and partners.

2.6. The procedure for emergency failures resulting from fire, flooding, explosion etc. will be dealt with as part of major Emergency Planning responses (if required), and care providers business continuity plans.

3. Definition of Failure and Provider Exit From the Market

3.1.
The failure may be as a result of a decision by the Care Quality Commission (CQC) under their powers to require an emergency closure; or through a decision by commissioners to

decommission care (e.g. as a result of a major event such as serious safeguarding concerns), resulting in the care provision closing. This may also cover other failures, for example due to an emergency e.g. infection control, flooding etc.; or due to a decision by the Provider (or any Corporate Insolvency Practitioner that has been appointed) to cease trading.

3.3 Provider exit from the market may arise in circumstances where organisations make a planned decision to withdraw from providing care within the city.

3.3. This Procedure will be implemented as part of a Contingency or Resilience Plan in situations where failure or exit is a serious prospect whether that is confirmed or not, or where the timescale before prospective or actual failure cannot yet reasonably be determined. Reference should be made to the Management Checklist ***(Appendix A)*** to determine which sections are relevant in the specific circumstances of the current case.

4. Activation of the Procedure

4.1. The decision that results in a failure of Care Provision may come from a variety of sources; for example:

- It may be invoked by the Care Quality Commission under its powers.
- A decision to decommission care leading to failure may be taken by the Director of Quality and Integration or the Service Director – Adults, Housing and Communities. The formal decision to activate this Procedure will come from the same lead personnel, and the expectation is that SCC and the CCG will agree activation and work in partnership.
- The Provider may give the appropriate 'Contract Termination Notice' period under their Contract.
- The Provider may themselves decide that the financial position of the individual service, or their overall portfolio of services, is becoming so very acute that it cannot continue to operate for a period sufficient to market the business and attract a new owner, nor to effect a planned 'orderly run-down' of the operation, i.e. one that would probably require a timescale of some months before failure.
- The Provider's business may have become "insolvent" (i.e. it can no longer meet its bills as and when they routinely fall due for payment, *and/or* its liabilities materially exceed its assets and there is no reasonable prospect of that being reversed in a realistic time-frame). In these circumstances the Directors/Owners have a legal duty not to continue trading while insolvent, so they should follow one of several Corporate Insolvency processes, which are likely to result in the appointment by the Courts of an Administrator or Receiver. That Officer's principal duty is to maximise the return for the Creditors (the people to whom the business owes money). Therefore they will often be willing to continue to operate the services(s) for a short period in hope of finding a buyer of it as a 'going concern' since that will generally fetch more than a dissolved business – but they will not do so indefinitely.
- Where closure is necessitated following significant and/or severe safeguarding concerns/enquiries, resulting in a decision that the provider is unable to provide safe care to its service users, and/or the inability of the provider to comply with an agreed action plan to rectify deficits, placing service users at risk of harm.

4.2 Situations of the above nature do sometimes arise "out of the blue", but more typically there will have been an accrual of "warning signs" over a period of time, and/or the services management and staff may have openly shared word that its future is at real risk, possibly accompanied by media reports. SCC and CCG Officers should be alert to such signs and should notify their senior management so the implications can be considered and the likelihood assessed.

4.3 As soon as failure notification is received or real risk of potential failure is identified,

SCC Service Director – Adults, Housing and Communities, and the CCG Associate Director of Quality/Deputy Chief Nurse must be **notified immediately** by telephone with confirmation in writing (email).

4.4 Staff passing information to either of these "Leads" **must** ensure it has been received and acknowledged. If they are unavailable the contact should be made to their nominated deputy. It is 'not acceptable' to leave a message with administrative staff.

4.5 The SCC or CCG Lead will instruct appropriate Officers to verify the failure or potential failure with CQC, and/or the Care Providers Owner, and determine what other relevant parties need to be contacted, by whom, and when.

4.6 Where the failure is related to the alleged or substantiated abuse of one or more vulnerable adults, the SCC Adult Social Care representative and Adult Safeguarding Lead must be notified. Safeguarding Alerts must be made in accordance with the 4LSAB *Adult Safeguarding Policy and Procedure,* to the Single Point of Access Team(SPA) for triage and transmission to Safeguarding Adults Team (SAT).

4.7 The SCC or CCG Lead will immediately call a Joint Incident Steering Group Meeting to take place at the earliest practicable opportunity, to initiate action under this procedure and agree a plan of action. In view of the potential implications for the health and well-being and safety of service users, the relevant Officers must treat the situation as necessitating their personal involvement at a very high priority. In order to ensure timely involvement of all key parties, including CQC, this may occasionally necessitate 'virtual' meetings such as through teleconference, and/or the nomination of appropriate 'deputies'. See ***Section 7*** 'Joint Incident Steering Group' for meeting membership.

4.8 Dependent upon the urgency of the situation, it may be necessary to convene such a meeting outside of 'normal office hours'. Provider failures that occur outside of normal office hours should be referred to SCC and CCG on call arrangements as outlined in Appendix C

5. Key Contacts

5.1. The 'Key Contacts' who should be notified and invited to the initial Joint Incident Steering Group Meeting are:

SCC Service Director – Adults, Housing and Communities
SCC Director of Children's Services – Local Authority
ICU Director of Integration / Chief Nurse – CCG/ICU
Associate Director of Quality / Deputy Chief Nurse – CCG
SCC Director of Adult Social Care
Lead commissioner
Head of Safeguarding CCG
Associate Director of Provider Relationships (Market Development Lead)

6. Responsibilities and Roles

6.1. The responsible agency for fully health funded service users receiving care from providers at risk of failure is NHS Southampton City CCG, or equivalent. This also includes responsibility for coordinating arrangements on behalf of residents whose care is fully funded and commissioned by other health bodies, i.e. "Out of Area" CCGs.

6.2. Southampton City Council is the responsible agency for part-funded and fully social care funded service users whose places have been commissioned or funded by the Council. Southampton City Council also has responsibility for supporting all self-funded service users within the City to find alternative provision and for ensuring that any move is well managed

6.3. Southampton City Council will take responsibility for co-ordinating and ensuring the immediate welfare of all service users funded or commissioned by other Local Authorities; however funding responsibility and the detailed longer-term care planning of affected service users will remain with the placing authorities.

6.4. SCC and CCG Quality Team will take co-ordinating and communications responsibility for managing any project group arising from a sudden home failure within the Southampton City boundary.

6.5. All officers will need to commit to the process and identify any impact upon usual work to their line manager. Officers will need to confirm their delegated authority throughout the process to ensure timely decisions can be made.

7. Joint Incident Steering Group

7.1. The first meeting of the Steering Group is to be arranged at the earliest practicable opportunity following the identification of a provider failure (or potential failure). The chairing arrangements will be confirmed at the first meeting. This first meeting must take place within 3 working days of the Incident being notified.

7.2. The first meeting will confirm who will be the Council's Lead Officer for the Group. The Lead Officer will:

- have responsibility for ensuring that all decisions are made and implemented in a timely manner.
- ensure minutes are taken of each meeting with agreed actions (timescales noted), and circulated to team members and copied to the relevant heads of service
- the Group will decide on the frequency of its meetings, agreeing a core group of members who are kept informed and responsible for the proactive cascade of information to colleagues in their own service area (e.g. copy appropriate emails and reports to relevant people who are not necessarily group members but may have a 'need to know')
- Issues relating to publicity and the release of information will be considered, and a suitable balance struck so that where failure is not yet a certain outcome, the situation is not exacerbated and the Provider's entitlement to 'commercial confidentiality' is not infringed
- the Group will also discuss, if deemed appropriate, potential measures to prevent or delay failure e.g. short-term additional funding or assistance from SCC or the CGG

7.3. At the first meeting an Operational Group will be agreed to lead the work on the closure, reporting to the SG.
The operational group is responsible for identifying all affected service users and ensuring all service users are supported to move to alternative provision in a timely manner. The chair of the operational group will become a member of the JISG if not already. A full database of all affected service users will be compiled

7.4. Those to be invited must include:

- ICU Quality and Safeguarding team representative
- CCG Continuing Care representative
- SCC Procurement representative
- SCC Adult Social Care representative

- Care Quality Commission
- Lead Minute Taker
- Communications Lead
- SCC legal representative (note: NHS do not maintain this function 'in-house')

It may be appropriate also to invite other "interested parties" to certain meetings, or parts of meetings, where they have a specific contribution to make, but not as "ongoing" participants. These could include, for example:

- NHS Trust Representative or Safeguarding Practitioner
- Finance Lead (CCG and SCC)
- Relevant provider management
- Advocacy representative
- Family / Carers representatives
- South Central Ambulance Service representative
- Hampshire Constabulary
- Southampton City Council Health and Safety representatives
- SCC Market Development Lead –where failure may have significant impact upon the local market
- SCC Portfolio Holder for Social Care and/or Health - to be co-opted or briefed in a 'community leadership' role, depending on the severity of the failure issue.

8. Potential Options for Alternative Service Provision

8.1. Potential options may include:

- 'Spot purchase' from other Care Providers
- Reserving services in other suitable locations
- Consultancy advice from a specialist practitioner
- Input or support from an appropriate related provider to work with the failing provider.
- Temporary staffing, (e.g. via local Agencies)
- Temporary management, (e.g. via using a consultancy company)
- TUPE staff and transfer client group serviced to an alternate provider
- Alternative contracted management/nursing team provision
- Short-term additional funding
- Fee variation over and above normal 'expected to pay' rates to secure suitable service provision
- Other actions as deemed necessary based on individual circumstances

8.2 The Group will allocate responsibility for researching and pursuing these options depending upon the specific circumstances of the case.

8.3 It should not simply be assumed - especially in the case of a Provider operating a number of services, and/or where an Insolvency Practitioner is acting - that any payments we make which are intended by us for supporting the continuation of service provision at a specific service will necessarily be applied for that purpose, in that location, by the Provider or Insolvency Practitioner. An explicit written agreement must first be sought and obtained. Payments may need to be withheld by commissioners and only paid when situation is resolved.

8.4 Wherever possible all transfers of service users between care providers should occur within normal working hours.

Appendix A

Management Checklist

The following checklist provides a **framework for managing care provider failure.** ***Please note that this list is not exhaustive.*** The Joint Incident Steering Group must determine actions as necessary based on the circumstances, noting that the checklist is for use with both Home Care and Care Home providers.

The checklist should also be used in the event of a **potential failure where the timescale is unknown.** In this case, although all aspects should still be considered, and appropriate preparatory work based on these points should be begun where necessary, not all points will yet be applicable until the position clarifies.

See Appendix C for an example of immediate actions where a home care provider failure occurs and appendix D for a detailed Operational framework for all necessary actions when a care home provider is closed.

Date initiated:
Name of Service(s):
Steering Group Members: (Confirm Chair)

	Action	Responsibility			Applicability
		SCC	CCG	Provider	
		Initials of Responsible officer			Care Home – CH Home Care – HC Both - All
1	**Steering Group** For Group membership – see Section 7				All
1.1	Assemble Team and plan the work				All
1.2	Appoint Team Leader(s)				All
	Initial work/clarification				
2.1	Establish timescales for failure(s)				All
2.2	Establish number of Service Users affected, and User category, and who funds them				All
2.3	Liaise with Placements Service to gain information about resource availability in other services				All
2.4	Liaise with provider and other Home Care agencies to seek opportunities for staff TUPE and grouped transfers				HC
2.5	Consult and advise other Local Authorities as necessary				All
2.6	Establish tasks and timescales and allocate them				All
2.7	Allocate lead workers, (preferably based on site/Liason officer in the case of home care) with equipment and management				All

	support requirements				
2.8	Consider equipment issues: mattresses, furniture, hoists, packing boxes etc. Who owns it? Can it be transferred? Does any belong to the Millbrook?				CH
2.9	Arrange a meeting with Owners/registered manager/other relevant parties				All
2.10	Clarify if the service provider has a Business Continuity Plan in place as part of the contractual arrangements that can be used. In the current circumstances, is it still viable				All
2.11	Agree when and how Service users and Carers are informed (and by whom) of the need to change provider at an early stage.				All
2.12	Ensure that the Owner allows free and open access by professionals to the service over the relocation/reallocation period				All
2.13	Agree the 'need to know' information that should be shared with other parties e.g. care professionals; GP; NHS urgent care lead; other potential Care Providers[1]				All
2.14	Formal scripts to be developed with the lead Communications Department for: - • staff working with service users and relatives • provider staff • press				All
2.15	Consider the need for independent advocacy and other community support for service users/carers				All
2.16	Identify key Care Provider Management staff to be involved				All
2.17	Identify site(s) for offsite meetings for Management Team/Care staff if required				All
2.18	Identify other agencies to be involved				All
2.19	CCG to activate Serious Incident Procedure if required. SCC to follow Incident Procedure, and in addition, does this situation meet the criteria for a				All

[1] [***Note*** that even though a Provider may be considered at serious risk of 'business failure', their affairs are still covered by the principle of ***'commercial confidentiality'***, and care should be taken that without the Provider's agreement specific information is not disclosed to third parties which might actually precipitate the business's final demise].

	Serious Incident? If so, invoke that policy.				
2.20	Consider whether failure of this Provision is likely to have a have a significant impact on overall local market supply for this type of service				All
2.21	Ensure all officers have considered the impact of the failure process upon other work streams and escalated as necessary to line manager				All
3	**Service Users**				
3.1	Prepare an accurate database of all service users, and their needs – and confirm numbers with provider. Also any special factors e.g.:such as 'friendship groups' where it may be desirable to keep people together if possible; home care runs/delivery approach; and provider RAG rating. Current placement/packages costs and fees to be included				All
3.2	Confirm where responsibility lies for assessing any Self-Funding or Out of Area service users				All
3.3	Check current Registration category				All
3.4	Set up operational team to assess service users to identify possible changes in need or category of care				All
3.5	Check if any very frail people and those nearing end of life need exceptional arrangements				All
3.6	Identify service users wishing to change provision/ move sooner rather than later				All
3.7	Identify service users who should be assessed early in the project work due to their predisposition to stress, anxiety or complexity, or for other factors				All
3.8	Ensure all necessary Mental Capacity Assessments of Service Users are Identified and carried out, particularly focussing on decisions about accommodation. Accompanying record of Best Interests decision making process to be made. IMCASappointed for those lacking family/friends.				All
3.9	Identify need for advocacy services to support Service users.				All
3.10	Identify service users with active 'Deprivation of Liberty'(DOLS) authorisations. Ensure the provider as Managing Authority refers all those who are DOLS-				CH

	liable to SCC/Other DOLS Teams for new assessments/ authorisation.				
3.11	Identify Service Users with 'Health and Welfare Deputies', and those with 'Lasting Powers of Attorney' for Health and Welfare decisions, and ensure contact is made with the relevant parties				All
3.12	Establish if any service users/carers are subject to current Safeguarding enquiries.				All
3.13	Establish details of all Service users with "Money Management" arrangements in place with SCC, to include Appointeeship, Client Affairs.				All
4	**Financial Responsibilities**				
4.1	Ensure managers have the ability to commit all resources to the failure process including financial as well as staffing				All
4.2	Any Out of Area funded Service Users? Make external commissioners aware of situation, and confirm whether they wish the Steering Group to act on their behalf to relocate Service Users				CH
4.3	Identify SCC-funded residents, and identify any Section 117 MHA funded residents in particular.				CH
4.4	Identify NHS-funded service users				All
4.5	Identify whether there are any private self-funded Service Users and who will take responsibility for their care. Check capacity and their representation *(see 3.8. above)*				All
4.6	Take advice from legal services about any relevant contractual, financial and other statutory matters; this to include notice/contact termination periods.				All
4.7	Identify service users with Deputyship in relation to financial affairs, all Enduring Powers of Attorney and all those with Lasting Powers of Attorney for Property & Affairs. Contact relevant parties and ensure records of their involvement are made, particularly in relation to any changed cost to new placements.				All
5	**Carers and 'Significant Others'**				
5.1	Ascertain the names, addresses and telephone numbers of relatives, friends and representatives, as appropriate				All
5.2	Identify Carers who may themselves have special factors to consider – own health, Out of Area etc				All
5.3	Seek fullest involvement of relatives/' significant others' in the relocation/reallocation process				All
5.4	Consider necessity for commissioning				All

	advocacy for carers affected (but bear in mind resources implications before proceeding)				
5.5	Consider and where necessary undertake carers assessments				All
5.6	Clarify which Service users are unbefriended, and enable them to be represented.				All
6	**Consultations/Information Management**				
6.1	To ensure the process runs smoothly it is essential that all groups are consulted: • Service Users • Care Staff • Families/representatives • Portfolio holders/councillors in relevant ward/with relevant porfolio • Public/press, via Communications lead • Appropriate internal staff all agencies				All
6.2	Ensure Residents meetings are arranged with appropriate levels of management representation				CH
6.3	Ensure Relatives meetings are arranged with appropriate levels of management representation				CH
6.4	Ensure clarity of roles for each agency in meetings with residents, relatives and staff				CH
7	**Relocation/reallocation (if decision is made to close/cease trading in the city)**				
7.1	Re-assessment of service users and adequate resource requirements to complete. Team of staff to be set up to assess, coordinate and manage all moves and changes of providers. Where necessary/possible, named staff members to be allocated to Service users. Reviews of new placements/packages to be carried out.				All
7.2	Group service users to reflect TUPE transfer arrangement to another Home Care provider – where this is possible				HC
7.3	Check choice (s) of area/services available that are compatible with service user need/ category with resident/carer				All

7.4	Maximise resident/carer ability to make an informed choice about compatible area/services/Homes available, in adherence to the principles of the *Mental Capacity Act 2005*				All
7.5	Are there friendships between service users that need to be maintained?				CH
7.6	Ensure new provider is registered for the category of care required and can meet needs				All
7.7	Liaise with CQC, CCG, SCC staff to ensure information is known about potential/actual new Care Providers, establish clear and complete knowledge about the service quality and performance of these organisations.				All
7.8	Offer opportunity for citizen/carer to view/visit/trial visit Care Provider				CH
7.9	Seek Care staff help to inform/visit potential provision with citizen where applicable				CH
7.10	Decision by citizen/carer on new provision and date to move				All
7.11	Arrange help to take or escort citizen to potential new providers on placement if needed				CH
7.12	Arrange schedule transport to new provision, in and out of area e.g. car/minibus/ambulance –identify cost and who pays..				CH
7.13	Consideration of equipment issues, and arrangements for its transfer and installation *(see also 2.7 above)*				CH
7.14	Ensure service users are accompanied by someone familiar on the day of the move, including carers if possible				CH
7.15	Use current Care staff to the fullest; passing on their knowledge of service users to new providers, escorting, transporting etc				CH
7.16	Staff handover to new providers – verbal and written. Care summaries, including care plan that details health and social care needs				All
7.17	Respect Care staff friendships with residents and likely concerns for their future welfare. Find opportunities for current Care Staff to verbally discuss service users care needs summary with receiving Care Staff, where appropriate				CH
7.18	Maintain a log of decisions and				All

	movement of service users				
7.19	Move/reallocate service users at their own pace/convenience as far as possible.				All
7.20	Establish a programme of Social Worker/ Nursing reviews and resource implications to ensure Service users well-being after the move.				CH
7.21	Medications and treatment details to go with residents				CH
7.22	Particular attention to be made to ensure correct identification of relocated service users				CH
7.23	Any changes of GP and new provision to be recorded in all appropriate systems of all necessary organisations involved				CH
7.24	Placements made Out of Area should be notified to the receiving NHS/Local Authority				CH
7.25	Provider Service User information/case files/summaries/transfer with Service Users where possible or copies made and transferred				All
7.26	Consider how many family members/friends might visit the resident in the new Care provision; can we assist them to do so?				CH
7.27	Notify Department of Work and Pensions of change of Home				CH
7.28	Liaise closely with the ICU Contracts Team (new contracts need to be issued, old contracts terminated)				All
7.29	Consider a plan for time scales of moves, to enable new providers to gradually accommodate new residents over a period of time. However this also needs to take account of (a) anxieties of Service users/carers and (b) ability of failing provider to maintain a diminishing service.				CH
7.30	Consider the desirability of temporary/second moves, in part to allow choice for service users, where availability of preferred provider is delayed.				CH
8	**Quality Assurance**				
8.1	Ensure there is an effective process for recording and resolving complaints and disputes, and that itis widely understood and universally applied between the ‘interested agencies’.				All
8.2	Conduct a debrief after every incident to				All

	identify good practice, lessons identified and further actions to be taken				
8.3	Ensure operational staff are supported and offered supervision, particularly to respond to conflict and criticism from other parties				All
9	**Record Keeping**				
9.1	Maintain a record of meetings, decisions made				All
9.2	Designate an administrative lead to collate all records				All
9.3	Service User outcomes should be recorded, particularly with regard to their health and emotional well-being				All
9.4	Maintain a risk log that is reviewed throughout the failure process				All
10	**Lessons Learned**				
10.1	All agencies should participate in a Review of the process once the procedure is completed. The outcome of this de-brief should be to identify recommendations for future inter agency learning, including policy, procedure and practical guidance				All
10.2	The Review should produce a Report and Recommendations to be submitted to the relevant groups and management levels within each agency, including the Local Adult Safeguarding Board				All
10.3	Consideration of referral to the LSAB Case Review or Monitoring and Evaluation Group should be included in the de-brief and review.				All
Additional Notes:					

Appendix B

Glossary

Care Homes Consultancy
Care Home Consultancy companies offer support to Care Homes in a range of areas e.g. business review, addressing specific problems, compliance auditing, cost reduction, planning for the future etc.

Care Quality Commission (CQC)
The Care Quality Commission (CQC) is an independent regulator of health and social care in England. The CQC regulates health and adult social care services provided by NHS, local authorities, private companies and voluntary organisations. The CQC also protects the rights of people detained under the *Mental Health Act 1983.*

Deprivation of Liberty Safeguards (DOLS)
These Safeguards form an additional element to the *Mental Capacity Act 2005*. They provide legal protection for those vulnerable people aged 18 or over who are, or may become, deprived of their liberty in a hospital or care home, whether placed under public or private arrangements. They relate to people who lack capacity to consent to particular treatment or care that is recognised by others as being in their best interests, or which will protect them from harm. Where this care might involve depriving people of their liberty in either care homes or hospitals, extra safeguards have been introduced to protect their rights and to ensure that the care and treatment they receive are in their best interests. They do not apply to people detained under the *Mental Health Act 1983.*

Deputy
Someone appointed by the Court of Protection with ongoing legal authority to make decisions on behalf of a person who lacks capacity to make particular decisions.

Enduring Power of Attorney
A 'Power of Attorney', generally, is the legal authorisation to act on someone else's behalf in a legal or business matter. An ***Enduring*** Power of Attorney in our current context deals with the donor's property and financial affairs. It will have been have been set up while the donor has capacity, and it was/will be activated by the Court of Protection when the donor's capacity to take decisions is at issue. An EPA does not come to an end if the donor becomes mentally incapable of managing his or her own affairs. The attorney named under an EPA ***does not*** have the power to make decisions about personal care and welfare. Since 2007 these have been replaced by ***Lasting*** *Powers of Attorney (see below),* though existing EPAs will continue to operate, and those signed before 2007 but not yet registered may still be registered.

Independent Mental Capacity Advocacy (IMCA)
The *Mental Capacity Act 2005* provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. In response the Government created provision for the Independent Mental Capacity Advocate (IMCA) service. The purpose of the IMCA Service is to help vulnerable people who lack capacity who are facing important decisions made by the NHS and Local Authorities about serious medical treatment and changes of residence e.g. moving to a hospital or Care Home. NHS bodies and Local Authorities will have a duty to consult the IMCA in decisions involving people who have no family or friends.

Lasting Power of Attorney
A Lasting Power of Attorney is a legal document. It allows a person giving it (the 'donor') to appoint someone they trust as an 'attorney' to make decisions on the donor's behalf. A

Lasting Power of Attorney cannot be used until it is registered with the Office of the Public Guardian.
There are **two different types** of Lasting Power of Attorney:

- **A Health and Welfare LPA** allows the donor to choose one or more people to make decisions for things such as medical treatment. A Health and Welfare Lasting Power of Attorney can **only** be used if the donor lacks the ability to make decisions for him/herself.
- **A Property and Financial Affairs LPA** lets the donor choose one or more people to make property and financial affairs decisions for them. This could include decisions about paying bills or selling their home. They can appoint someone as an attorney to look after their property and financial affairs at any time, **or** they can include a condition that means the attorney can only make decisions when the donor loses the ability to do so.
  *[See also '**Enduring** Power of Attorney', above]*

Mental Capacity Act (2005)
A law providing a framework for people who lack capacity to make decisions about themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.

Safeguarding of Vulnerable Adults
Relating to the legislation, policy and procedures *(especially the 4LSAB Multi Agency Adult Safeguarding Policy and Procedures)* that deal with the safeguarding of vulnerable adults.

APPENDIX C
Home Care Provider Exit/Failure Immediate Action Plan - Example

Key – PL – project lead, ASC – Adult Social Care, C – Commissioners, H – Housing, EPPR – Emergency Planning Lead/support, D – Director support, PS – Placement Service, ORG – System Resilience rep, A – Admin support

Now	Lead Officers	Progress and escalation	Lead Officers/escalation
Coordination of Response Development of project coordination hub	C	Agreed project leadership, representatives and provision of hub	
Client list Refresh of Client list with renewed rag rating. Request client information from Provider directly. Initial contact with clients/families to provide reassurance	ASC C ASC	Suspension of all other call offs from current framework and URS except in exceptional circumstances. CPS identify current resource availability – home care, res, nursing and pass to identify lead officer.	
Transfer planning Work with other care providers to identify transfer options Identify potential to transfer care in rounds under TUPE arrangement. Begin transfers of any high risk cases to available capacity Immediate review of TUPE options within SCC. Establish immediate timescale for	C C & ASC PS PL PL	Identified staff make contact with all providers to ascertain options for increasing capacity quickly to include • use of overtime and bank staff • rapid recruitment • Early use of staff in process of recruitment subject to risk assessment • transfer of resources from low risk packages	

failure with provider/receiver			
Additional support Collate information on Extra Care Housing element to identify: • TUPE options • Support tasks which could be picked up by other means (SCC internal service, housing management provider) • SCC and Saxon Wield ORG – liaison with system partners to brief and seek escalation and support arrangements. Briefing of SVS regarding risk of provider failure, requesting advice regarding approaching CVSE groups/orgs Self funder information – request scale of provision from provider to self funders in the city Establish with provider/receiver/national agencies	H ORG PL PL PL and D	Partners to be contacted to identify resource that can be brought in for short term cover including bank staff • SCC internal team • Health trusts • Voluntary sector Desk top review of all service users to identify any carer or informal support which could be used in the short term where appropriate Contact carers support service to identify additional advice and support available for carers. Contact providers including health trusts to open discussions on potential TUPE transfers. Immediate reporting requirements - CCG Serious incident reporting	

external support arrangements.			
Communications Redraft external and internal coms messages – including for clients, partners, public and council Agree contact approach with provider for client communications and reassurance Daily sitrep reporting to key groups and partners Briefing of key representatives in SCC	PL with communications support ASC PL D		
Monitoring Start log of actions, concerns and complaints – all actions to be logged Clarify immediate reporting requirements	A PL with ORG and EPPR		

APPENDIX D –Southampton City Council
PROCESS FOR EMERGENCY HOME CLOSURE; Operational Plan

Task	Who responsible
Identify lead manager to co-ordinate the process. A deputy should also agreed.	Service Manager
Set up central major incident room so that all staff assigned roles are together in one place. Ensure IT etc is available and accessible.	Lead co-ordinating manager
Coordinate all activity about service users on a Database, which is updated daily. This to contain full information about Citizen's needs, views and wishes; outline assessment, including mental capacity, and to be used to record progress with assessments, planning, new providers and subsequent reviews.	Lead co-ordinating manager
Establish Team and assign specific roles to each staff member: • Lead co-ordinating manager • Deputy co-ordinating manager • Reassessments • Mental Capacity Assessment • Best Interests Meetings • Vacancies • Financial matters and advice • Placements and new care home liaison • Moving and handling assessment and equipment • Transport • Family liaison • Medication, personal belongings and packing • Case record update • Staff support • Media/councillor/MP enquiries • Business support	Lead co-ordinating manager
Briefing session at beginning of day	Service manager and lead co-ordinating manager

• What will happen • Timescales • Permissions • Inform co-ordinating manager of issues / problems • Assign roles Agree plans for briefing / updates later in the day	
Establish core group of specialist practitioners to provide support during the move care manager, OT, nurse, mental health, business support	Lead co-ordinating manager
Consider need for Business Support to assist Operational Process	Lead co-ordinating manager
Designate senior manager to keep directors and councillors briefed and link to legal, communications Development of media statement	Lead co-ordinating manager Lead co-ordinating manager and Communications team
Liaise with CQC to whom they will communicate the decision, when information can be released This to be communicated amongst designated staff	Service Manager Lead co-ordinating manager
Prepare script for all staff dealing with family and other queries, to be circulated to all relevant teams Brief relevant teams SPA, Gateway, Complaints	Lead co-ordinating manager
Leads to inform their teams and senior practitioners to brief their teams	Team leaders and senior practitioners
List of mobile numbers for leads and designated staff	Lead/deputy coordinating manager
List of contact details for other agencies as required • District nursing • Ambulance service • Equipment service • Removals • Legal • Out of Hours services • Transport	Lead/deputy coordinating manager
Consider requesting police presence regarding media, families and property if necessary	Lead co-ordinating manager / Team Leaders
Despatch designated staff members and team leaders to the home to	Lead co-ordinating manager

oversee transfer including family liaison, resident support, medication and packing	
Lead OT to do moving and handling assessments and identify any specialist equipment required by the resident in the new home. Liaise with home and where needed equipment service	Lead OT
Conduct risk assessments for staff presence at premises and escort duty A log of SW at the property to be maintained. SW to call in to sign off if going on/off shift	Lead/deputy co-ordinating manager
Each resident to be assigned to a named social worker who will oversee their transfer. Once the move is complete this must be notified to the lead co-ordinating manager Designated team leader for updating case records is informed and updates PARIS	
Prepare rota of staff prepared to work late and / or at the weekend	Lead co-ordinating manager/deputy
Identify emergency care home team and resources to pay for this, e.g. escorts, home manger, care staff, nurses	Lead co-ordinating manager
SCC “appointed” home manager and care team will enter premises when the order is through as SCC will now have responsibility	SCC Home Manager
Advance agreement regarding additional costs and budget codes for: • Placements • Overtime for staff and child care • Travel costs for families • Taxis and other transport • Private ambulances • Packing boxes • Removals	Lead co-ordinating manager
Practical arrangements • Removal van • Packing boxes • Negotiations regarding use / loan of specialist equipment • Blankets	Lead Coordinating Manager/deputy

• Food and drink (residents and staff) • Mobile phones for staff	
Hold debriefing sessions for all staff involved, in the move and the safeguarding investigation to cover: • Emotional aspects • Effectiveness of process • Lessons learnt • Employee support	Leakd co-ordinating manager

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TERMS OF REFERENCE			
	SYSTEM CHIEFS/LDS BOARD	**BETTER CARE SOUTHAMPTON STEERING BOARD**	**BETTER CARE SOUTHAMPTON WORKING GROUP**
Overarching Role	System Wide Oversight	Setting and Driving Better Care Strategy	Implementation of Better Care Strategy and Work Programmes
Purpose	To provide collective leadership to shape, influence and develop the whole local system in the City and to facilitate the delivery of the agreed joint programmes of work to deliver the Southampton elements of the Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Plan (STP). To empower the Better Care Southampton Steering Board to set and drive the Better Care Strategy for the city.	To set strategic direction and drive the development of integrated person centred service delivery in Southampton. The board is responsible for: • Taking a system-wide view of outcomes and service provision • Ensuring resources across the board are prioritised and organised in a joined up way to maximise outcomes. • Ensuring a person centred and proactive focus in all service delivery and decision making. • Delivering the agreed plans for Better Care in Southampton, mitigating risks and removing blocks to progress. • Ensuring stakeholders across the system are engaged and informed.	To drive forward the implementation of Better Care in Southampton. This includes: • Accelerate the pace of integration to maintain and improve on the quality of services provided to the local population. • Be responsible to the steering group for delivering change, including the design of and adherence to a project plan to deliver the future care model agreed by the steering group • Maintain a focus on the benefit for local people. • Ensure engagement with local citizens, patients, service users and wider community stakeholders. • Direct implementation of innovative ways to deliver priorities for the health economy in line with the 5 Year Forward View.
Activities	• Sponsorship of key programmes • Sharing current thinking and perspectives • Monitoring and reporting of progress • Resolving or escalating any cross-organisational problems that impede progress	• Strategically inform delivery of the overall work programme. • 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 on the likely financial benefits, and assess the risk of underperformance robustly and transparently; • Resolve strategic and directional clashes between projects/programmes; • Monitor benefit realisation KPIs; • Take a system view and drive progress towards a viable future ACO structure; • 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.	• Identify and assess risks to the delivery of the programme; • Identify, design, monitor and report (to Steering Group) benefit realisation KPIs and performance metrics; • Co-ordinate projects which underpin the overall programme and management of their inter-dependencies including oversight of risks and issues, and the identification/measurement of projected benefits; • Have oversight of the enabling working groups – comms, finance, workforce/OD, IT and estates • Provide a forum which facilitates inter-service collaboration, shared learning, information sharing, peer support and joint working with a culture of innovation and entrepreneurism in the context of improvement. • Oversee the deployment of Better Local Care resources.
Core Membership	***Chief Executives*** of the principal commissioners and providers operating in the Southampton health and care system, that is: • Solent NHS Trust • University Hospitals Southampton FT • Southern Health FT • Southampton City Council • Southampton City CCG • Southampton Primary Care Limited (SPCL) There will also be standing invitations to • South Central Ambulance Services FT • NHS England Specialised Commissioning If a System Chief is unable to attend a particular meeting, whenever possible a suitably briefed executive director colleague should be asked to attend to represent the organisation concerned.	Up to 2 Representatives from each of the key organisations/sectors operating in the Southampton system (both commissioners and providers of services). 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 • Southampton City Council • Southampton City CCG • Southampton Primary Care Limited (SPCL) • Southampton Voluntary Services • System Chiefs to attend on a quarterly basis	Up to 2 Representatives from each of the key organisations/sectors operating in the Southampton system (both commissioners and providers of services). 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***) • Solent NHS Trust • University Hospitals Southampton FT • Southern Health FT • Southampton City Council • Southampton City CCG • Southampton Primary Care Limited (SPCL) • SMS • Southampton voluntary services • Cluster Leads/Deputies

TERMS OF REFERENCE			
	SYSTEM CHIEFS/LDS BOARD	**BETTER CARE SOUTHAMPTON STEERING BOARD**	**BETTER CARE SOUTHAMPTON WORKING GROUP**
		Plus Better Care Southampton Programme Manager who will be accountable to the Steering Board Members of the Board will be responsible for bringing to the Board's attention any decisions being made elsewhere which could adversely affect delivery of the work programme/delivery of integrated care. Anyone unable to attend the meeting should send a deputy sufficiently briefed and empowered to make decisions.	**Plus Better Care Southampton Programme Manager who will chair the Working Group** Anyone unable to attend the meeting should send a deputy sufficiently briefed and empowered to make decisions.
Extended Membership		***Once a quarter, the Better Care Southampton Steering Board will hold a wider thematic meeting with extended membership to include:*** • ***Members of the Better Care Southampton Working Group*** • ***Members of System Chiefs/LDS Board*** • ***South Central Ambulance Services FT*** • ***NHS England Specialised Commissioning*** • ***Care UK*** • ***Hampshire Constabulary*** • ***Schools and Colleges*** • ***Health Watch*** • ***DWP***	Additional representation may be invited to the meetings as required.
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	Monthly	Monthly
		It is proposed that both groups will come together once a quarter for a combined meeting	
Chair	To be nominated by group for 12 month period	To be nominated by group for 12 month period	Better Care Southampton Programme Manager
Quorum	At least one representative from a minimum of 3 provider organisations/services plus the chair or vice chair or proxy nominated by the chair.	At least one representative from a minimum of 3 provider organisations/services plus the chair or vice chair or proxy nominated by the chair.	At least one representative from a minimum of 3 provider organisations/services plus the chair or vice chair or proxy nominated by the chair.
Accountable to:		System Chiefs/LDS Board and Joint Commissioning 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. 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.		

SOUTHAMPTON CITY COUNCIL

NHS Southampton City Clinical Commissioning Group

These meeting minutes may become available to the public under the Freedom of Information Act 2000.

Retention of Records: These minutes will be confidentially destroyed 2 years after the date of the meeting, in line with CCG policy and guidance from the Department of Health.

Meeting Minutes: Better Care Southampton Steering Board

The meeting was held on: Wednesday 18th April 2018 15:00 – 17:00
Location: CCG Conference Room Oakley Road, Ground Floor.

	NAME	INITIAL	TITLE	ORG
Present:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	David Noyes	DN	Chief Operating Officer	Solent
	Ali Robins	AR	Chief Executive Officer	SPCL
	Jane Hayward	JH	Director of Transformation	UHS
	Jo Ash	JA	Chief Executive Officer	SVS
	Adam Cox	AC	Clinical Service Director for AMH	SHFT
	Stephanie Ramsey	SR	Director of Quality and Integration	SCCCG/SCC
	Donna Chapman	DC	Associate Director System Redesign	SCCCG/SCC
In Attendance	Clare Young	CY	Planning Manager & PMO	SCCCG
	Emily Chapman	EC	Business Manager (minutes)	SCCCG
Apologies	Suki Sitaram	SS	Chief Operations Officer	SCC
	Mark Morgan	MM	Director of Operations	SHFT

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted. It was noted that SR was representing for Suki Sitarum	
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.	

	UHS, Solent and SPCL have registered for bidding for the Enhanced and Urgent Primary Care Sevice service tender which is currently live. This was noted by the Chair and agreed it did not pose a conflict at this time as no decisions relating to this were on the agenda. No other declarations were made in relation to the agenda	
3.	**Minutes of the Previous Meeting, Matters Arising and Action Tracker**	
	The minutes of the meeting that took place on 21st March 2018 were agreed as a true, accurate record of the meeting. **Matters Arising** It was agreed that every three months System Chiefs would be invited to this meeting, this is scheduled for June 2018. The September 2018 meeting has also been opened up to invite the wider membership including fire, police etc.	
4.	**Operating Model**	
	The Board received the updated operating model. AR/DN introduced the paper to the Board, it is had several iterations and has received comments from all system partners along with support for the direction of travel. There was some discussion of the operating model document. The document seeks to set out how we operationalise the multidisciplinary working at cluster and sub-cluster level i.e. what is it we do and for which segments of the population The Board discussed if this document should be a 'framework' for what clusters need to consider and how they might think about it? The Board agreed the document needs further work and would be priority for new Programme Manager to iterate it towards something that can be shared with the cluster teams. Other points raised in the discussion were: • how do we train people to do an MDT? • digital technology will be critical to how this works- teleconferencing, administration etc. • how voluntary sector is involved as currently it is a very medical model • can we incorporate vignettes of how things might work? • It was agreed that success measures are needed, a set of KPIs should be alongside this which will link with the Better Care Deliverables.	

	The next steps were agreed: • The Steering Board agreed the model in principle with the understanding that there is more detailed work to do • The new Project Manager post to work on the document incorporating input from a range of agencies / organisations • SR to ensure a review from a Local Authority perspective and comments on the framework • vignettes of how things might work need to be developed	
5.	**Better Care Deliverables and Development of KPIs**	
	CY joined the meeting. The Board received the Better Care deliverables and development of KPIs paper. DC talked through the highlights of the papers. The Board discussed the KPIs and agreed that the outcome measures are important e.g. non elective admissions, deaths at home. It was discussed areas such as meeting attendance etc. need to managed through cluster leadership and how it is monitored, rather than included in broader KPIs. SR raised that national measures will need to be collected, but it would be good to tailor outcomes specifically for what needs to be achieved locally. It was suggested there is a need to add in more KPIs against Primary Care, Mental Health, digital areas such as use of Patient Online. It was also suggested that workforce development should be included as an important measure. The Board discussed the deliverables. JA queried if the timescales are realistic. DC responded that some of the work is already underway, this work measures where the work programmes are currently standing. It was raised that the deliverables in primary care could be strengthened and also Mental Health and Digital. The Board discussed how the Primary Care deliverable for 2018/19 could be separated as Primary Care Commissioning is led through other groups. However, it is important that primary care deliverables align with the better care work. The Mental Health deliverable relates to the work being done within the community e.g. tier 3.5 which is about the IAPT plus service. **ACTION: DC to add in comments made, and will circulate the updated version. These will be brought back to the next Board Meeting.**	**DC**

6.	**Performance Report**	
	The Board received the Better Care Performance report for month 11. CY talked through the highlights of the report. The Board discussed Delayed Transfers of Care (DTOC). The main issues within UHS relate to winter pressures. The Health DTOC appears to be high but this may relate to self funding patients. **ACTION: JH to review DTOC for Southampton to identify any trends related to health delays** Work is taking place in relation to falls. Links are being made with a consultant in UHS in relation to an audit in coding. It was suggested we may not continue to monitor injuries to falls, this would need to be reviewed as it is a local Better Care indicator but only relates to a small number of patients. AC left the meeting. The Board reviewed the GP streaming data which had been received recently. AR highlighted that The data reflected that the streaming is having a positive impact. Work is taking place to look at re-admissions also. CY left the meeting.	**JH**
7.	**Digital Update**	
	MK provided a verbal update on digital to the Board as follows: • Interoperability – the local solution is CHIE, there is an increase in use and also development of single sign on is going well • CHIE – waiting for version 3 updgrade which should take place around early June, work is taking place with Graphnet to deliver the timescale. • The Graphnet contract comes to an end in April 2019, the process for re-procurement has started to take place and will progress rapidly • Wider interoperability – SCC are going out to procurement for a new social care sytem, health have had input into this with positive discussions taking place, integration with health is key throughout the procurement • The Local Authority now have access to CHIE via Paris (this relates to registered social workers) due to IG issues this hasn't been broadened out to dom care providers etc AR raised GDPR in relation to HHR and Risk Stratification. A Privacy Impact Assesment will need to take place with risk assesments. MK raised that for CHIE the Information Governance has been updated in relation to GDPR. Practices have all signed a new Data Sharing Agreement and understand the implications of it.	

	MK highlighted that work is taking place on a LHCRE (Local Health and Care Record Exemplar) bid. HIOW are working with Dorset to create this bid which could provide up to £7.5m over 2 years to accelerate digital transformation. There is also a draft Southampton Digital Plan which will be shared. It was agreed that a verbal digital update should be a standing item on the agenda for the working group.	
8.	**Memorandum of Understanding – Project Manager post**	
	The Board received the draft Memorandum of Understanding for the Project Manager Post. AR has also created a document with legal services for the funding which will be received by System Chiefs. In realisty probably both documents are not needed. To review next steps following System Chiefs. SR to check the JD to ensure it aligns. The project manager has been appointed to and the candidate has accepted. The aim is for the candidate to start quickly. It was agreed that UHS would host the candidate's contractual employment; this will be explored outside of the meeting. **ACTION: DH/JH to determine who would host the project managers contractural employment**	**DN/JH**
9.	**Better Care Southampton Working Group minutes**	
	These will be circulated outside the meeting.	
10.	**Any Other Business**	
	JA raised the Community Solutions Groups for clusters are now up and running. An update to be provided to a future Board.	
Date of Next meeting: Thursday 17th May 2018, 15:00 – 17:00, CCG Conference Room, Oakley Road, SO16 4GX.		

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