Public Document Pack

Joint Commissioning Board

Thursday, 9th August, 2018
at 9.30 am

PLEASE NOTE TIME OF MEETING

Conference Room - CCG HQ

This meeting is open to the public

Members

Dr Kelsey (Chair)
June Bridle
John Richards
Councillor Hammond (Vice-Chair)
Councillor Fielker
Councillor Shields

Please send apologies to:

Emily Chapmanr, Board Administrator,

Tel: 02380 296029

Email: emilychapman1@nhs.net

PUBLIC INFORMATION

Role of the Joint Commissioning Board

The Board has been established by the City Council and Clinical Commissioning Group to commission health and social care in the City of Southampton. It will encourage collaborative planning, ensure achievement of strategic objectives and provide assurance to the governing bodies of the partners of the integrated commissioning fund on the progress and outcomes of the work of the integrated commissioning function

Public Representations

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

Benefits from Integrated Commissioning

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

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

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

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

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

Dates of Meetings: Municipal Year 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**
Dr Mark Kelsey		

2 DECLARATIONS OF INTEREST

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

Lead	**Item For:**	**Attachment**

	Discussion Decision Information	
Dr Mark Kelsey		

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

Lead	**Item For: Discussion Decision Information**	**Attachment**
Dr Mark Kelsey	Decision	Attached

4 D2A PATHWAY 3 EVALUATION REPORT JULY 2018 (Pages 9 - 22)

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

5 BETTER CARE 201819 Q1 REPORT (Pages 23 - 48)

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

Wednesday, 1 August 2018

Meeting Minutes

Joint Commissioning Board - Public

The meeting was held on 11th June 2018, 09:30 – 10:30
Conference Room, Oakley Road

	NAME	INITIAL	TITLE	ORG
Present:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	Councillor Chris Hammond	CH	Leader of the Council	SCC
	Councillor Dave Shields	Cllr Shields	Health and Sustainable Living	SCC
	Councillor Warwick Payne	Cllr Payne	Adults, Housing and Communities	SCC
	John Richards	JRichards	Chief Executive Officer	SCCCG
	June Bridle	JB	Lay Member (Governance)	SCCCG
In attendance:	Richard Crouch	RC	Acting Chief Executive Officer	SCC
	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG / SCC
	Suki Sitaram	SA	Chief Strategy Officer	SCC
	James Rimmer	JRimmer	Chief Financial Officer	SCCCG
	Mel Creighton	MC	Chief Financial Officer	SCC
	Beccy Willis	BW	Head of Business	SCCCG
	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Donna Chapman	DC	Associate Director	SCCCG/ SCC
Apologies:	None received			

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted	
2.	**Appointment of Chair / Vice Chair**	
	It was agreed that Dr Mark Kelsey would remain Chair of this Board and that Councillor Chris Hammond would take the role of Vice Chair	

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 No declarations were made above those already on the Conflict of Interest register.	
4.	**Previous Minutes/Matters Arising & Action Tracker**	
	The minutes from the previous meeting dated 8th March 2018 were agreed as an accurate reflection of the meeting. **Matters Arising** There were no matters arising **Action Tracker** The outstanding actions were reviewed and the action tracker updated.	
5.	**Memorandum of Understanding / Terms of Reference**	
	SR explained the purpose of the Memorandum of Understanding and the Terms of Reference which were originally agreed when the JCB establishment was approved by Full Council and Governing Body. JR commented that the he was pleased to see that the MOU still is very relevant. The Board agreed the Memorandum of Understanding **ACTION: The Terms of Reference were agreed with the minor amendment of formally noting in the Terms Of Reference who the members of the Board are. CH advised that the membership is listed on the front of the agenda, it was agreed to also put titles on for the CCG members**	**BW/CH**
6.	**Better Care Quarterly Report – Q4**	
	The Board received the Better Care Quarter 4 2017/18 Report. Donna Chapman (DC) attended the meeting to talk through the highlights of the paper. DC tabled revised papers due to a minor change in finance details. The Health and Wellbeing Board has delegated responsibility for oversight of the better care work to the JCB. The Board was advised that 2018/19 Better Care national guidance is still awaited. Performance for 2017/18 (appendix 4) was considered: - Non elective admission rate held static from previous year despite	

	1.9% population increase - Delayed Transfers of Care (DTOC) did not achieve national target but has significantly reduced when compared to 2016/17 - Permanent admissions to residential homes exceeded target due to “home first” focus, discharge to assess and extra care developments **Key achievements:** 1. Rehabilitation and Re-ablement service – Integrated Health and Social care teams who support the discharge process, the work this team has been doing has reduced Delayed Transfers of Care. Consequence has been reductions in need for ongoing care and releasing of homecare capacity. 2. Pilot city wide team providing training to residential homes worked specifically with 15 homes due to their high rate of admissions, carrying out assessments; have seen a reduction in non-elective admissions from those homes. DC will be making a recommendation to roll this out across the city 3. Worked with voluntary and community sector, launched a lot of new services 4. Extra Care – trajectory to increase the number of extra care units, seen people moving from nursing into extra care 5. Domiciliary Care Market – invested some of the Better Care fund into improving the better care market increasing number of hours and 7 day availability. It was stated that this demonstrates the value of integrated working and the achievements made make a huge difference to people’s quality of life. It was also agreed that there are benefits of having a clear plan for Better Care and sticking to it. The approach and outcomes has attracted notice nationally. It was questioned as do we have any mechanism to capture the data on which programmes have delivered what? But in reality the outcomes are due to a collection of initiatives. It was also asked whether any forecasts have been undertaken on savings per extra care beds. SR advised that there is some planning around the projections for extra care, looking at demand and an estimate as to where savings could be achieved DC advised that one of the challenges is the culture change across all providers and that it doesn’t happen quickly. Councillor Shields asked how is this all being communicated and can we look at case studies and stories not only to our own staff but how we can use to a wider audience RC raised it was positive to see quantative and qualitative evaluation. Approach locally not seen in all areas of the country so we need to keep building on the success and have strong ambition. **ACTION: Briefing on Social Care Green Paper to the Board once available.**	**SR**

	The Board thanked DC and team for the report and all the work that has been undertaken.	
7.	**Integrated Commissioning Plan**	
	SR presented the Integrated Commissioning Plan which is based on national guidance, market analysis, feedback on engagement and JSNA. There are 4 key work themes: • Integration • Prevention • Quality • Managing and developing the market Each theme has key work streams, key metrics, milestones and key measures of success which will be reported to the board. Lots of the work is very complex and transformational. JRim asked whether the ICU has the resources to do all of this work. SR advised that staffing is a key issue and will bring a paper to a future meeting on staffing structures and savings impact. Councillor Shields asked how we engage the right children's expertise for discussion at JCB? SR advised that regular briefings are held with lead Councillors, Children's Multi Agency Board other key provider leads but perhaps we should invite the relevant councillors or officer to children's items at JCB. SS acknowledged the additional effort that the ICU team has put in to lead change or support others, when things don't go to plan and suggested that there is a need to consider the ICU when budgets are being set and the stick to the spirit of the JCB Terms of Reference. RC also advised that SR sits on both the Adult and Children's transformation teams and can ensure that any national changes are reflected in the ICU plan. JR suggested that as many of the improvements we have jointly been able to deliver have delivered savings for both organisations, we are here to improve the outcomes for the city and so proposed including JRIM Board to look at the total investment across partnership to ensure it's aligned with key priorities and outcomes. MC advised that her and JRim have agreed to work closer on budget setting processes. **ACTION: It was agreed that an evaluation of 17/18 ICU business plan to be brought to a future meeting**	**SR** **SR** **SR**

	Action: Savings and Integrated Commissioning Plan 2018/19 to come to a future meeting The Board approved the Integrated Commissioning Plan 2018/19 – 2020/2021 as the business priorities for the next two years.	**BW**
8.	**Quality Update on Social Care Providers**	
	SR gave an update on Social Care Providers specifically to gain agreement on the Provider Failure and Exit guidance. 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, 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 Councillor Payne advised that Cabinet has signed Ethical Care and Residential Care Charters. Councillor Shields asked whether numbers could be shared outside of the meeting with how we compare with neighbouring areas Councillor Hammond suggested that Brexit may impact the availability of workforce, so what kind of forecasting have we done to look at how much it will affect the local market. SR advised that forecasting work is underway to look at future workforce **Action: SR to provide a detailed briefing at a future meeting** The Board approved the Provider Failure and Exit guidance	**SR**
9.	**Better Care Steering Board Terms of Reference**	
	The Board were asked to approve the Better Care Steering Board Terms of Reference as a subcommittee of the Joint Commissioning Board The Board approved the Better Care Steering Board Terms of Reference	
10.	**Better Care Steering Board Minutes**	
	The Board received the Better Care Steering Board Minutes for information.	
Date of next meeting		
12th July 2018, 9.30-10.30, Conference Room 3, Civic Centre		

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Joint Commisioning Board - Action Tracker (Public)					
Date of meeting	**Subject**	**Action**	**Lead**	**Deadline**	**Progress**
11/06/2018	Terms of Reference	add in who members of the Board are, also add titles for CCG members	BW/CH	Jul-18	Complete
11/06/2018	Better Care Quarterly Report – Q4	Briefing on Social Care Green Paper to the Board once available.	SR	TBC	date TBC
11/06/2018	Integrated Commissioning Plan	Staffing structures and savings impact to be a future agenda item	SR	Sep-18	scheduled for September 18
11/06/2018	Integrated Commissioning Plan	Evaluation of 17/18 Integrated Commissioning Plan to be brought to a future meeting	SR	TBC	date TBC
11/06/2018	Quality Update on Social Care Providers	SR to provide a detailed briefing at a future meeting	SR	TBC	date TBC

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DECISION-MAKER:		**Joint Commissioning Board**		
SUBJECT:		**Pathway 3 Discharge to Assess Pilot – Evaluation Report & Recommendations**		
DATE OF DECISION:		**9 August 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**		

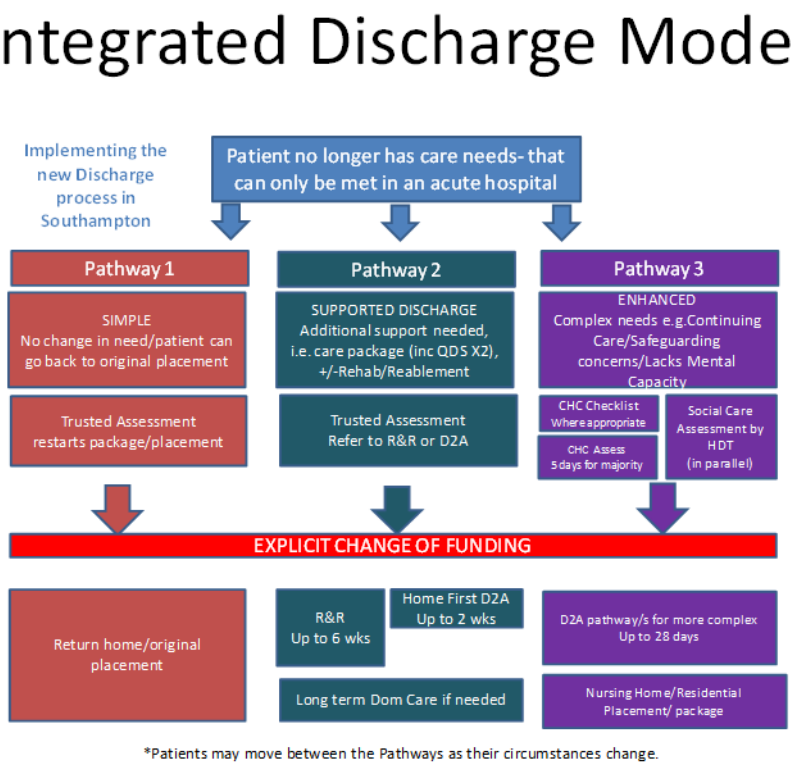
STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE

BRIEF SUMMARY
This report provides a summary of the key learning points and recommendations following the pilot of a Discharge to Assess scheme for patients on Pathway 3 over the period 1 November 2017 – 30 June 2018.

RECOMMENDATIONS:		
	(i)	To note the findings and key learning points from the pilot.
	(ii)	To consider the recommendation that Discharge to Assess should be implemented for complex patients/clients as an intrinsic part of pathway 3, managed by the Integrated Discharge Bureau (IDB) and give support for this to be worked up in more detail.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The consistent delivery of safe, appropriate and timely discharge from the acute hospital setting continues to challenge the majority of health and social care systems, particularly where the needs involved are complex.
2.	This report concerns the evaluation of a pilot to test a discharge to assess (D2A) scheme for clients/ patients with more complex needs (referred to as patients/clients on "Pathway 3") and recommendations for a future model. This is a key element of Southampton's action plan to reduce delayed transfers of care (DTOC) and part of the "8 high impact change model" for improving discharge published jointly by the LGA, DH, Monitor, NHS England and ADASS in 2015. Southampton has a significant challenge to achieve the nationally set target for reducing DTOC (26.6 delays per day by Sept 2018 from a baseline of 38.8) and failure to reduce social care attributable delays could directly impact the additional social care monies invested by Government via Better Care. Assessment of long term health and social care needs outside of the acute setting is better for our population, individual system partners and the system as a whole.
3.	Alongside the nationally set target for reducing overall DTOC, there is a national target for reducing the percentage of assessments of eligibility for Continuing

	Healthcare (CHC) undertaken in the acute setting to 15% or less.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	NOT APPLICABLE
DETAIL (Including consultation carried out)	
1.	**Background** Three pathways for discharge have been developed to provide a standardised approach, which is now recognised across the whole South West System. • **Pathway 1 Simple discharges** – these are managed by the hospital ward staff through trusted assessment with support as necessary from the Integrated Discharge Bureau (IDB) and strong links back to the patient's/client's community care team who will proactively work with the hospital. Primarily this includes care package re-starts and return to home or previous placement. Ward staff are responsible for identifying and assessing these patients and refer onto the discharge officers within the hospital to organise discharge. • **Pathway 2 Supported discharges** – these discharges are managed by the Southampton Urgent Response Service (URS) which is part of the Integrated Rehab and Reablement Service. A D2A scheme using home care is now well established and the URS will in-reach into the hospital to work with ward staff to facilitate discharge. This includes those situations where additional support in the community is required for example a long term care package, rehabilitation, reablement or bed based care. Ward staff are responsible for identifying and directing these patients to the URS which will then facilitate discharge. • **Pathway 3 Enhanced discharges** – these discharges are managed by the IDB and Hospital Discharge Team (HDT). This involves those patients requiring complex assessments or those with obviously complex long term care needs. This can include safeguarding concerns, those lacking mental capacity and those likely to be eligible for Continuing Healthcare. Ward staff are responsible for identifying and directing these patients to the IDB which will then facilitate discharge.
2.	These 3 pathways are illustrated in the diagram below.

	
3.	Discharge to assess (D2A) is recognised nationally as best practice for ensuring timely discharge and is defined as: "discharge to assess will involve people who have ongoing complex care need but have been clinically optimised such that they no longer require an acute hospital bed for this care and their assessment can take place outside the hospital setting, in their local community, ideally in their own home".
4.	The benefits of assessing people's long term care needs outside the hospital environment have been well documented and are predicated on the principle that people feel more empowered and are better able to function in their home setting leading to a more informed and accurate assessment of their needs. This can reduce ongoing requirements and costs of packages of care.
5.	Discharge to assess is now well embedded for patients/clients with less complex needs (but still requiring additional support post discharge) on pathway 2, where assessment takes place in their own homes and has evidenced a reduction in long term care needs. This has led to savings and cost avoidance in social care packages. The intention is to adopt a similar D2A approach for patients/clients with more complex needs (referred to as being on Pathway 3). However, owing to their complexity of need, a more intensive package of care is usually required to support their assessment in the community and opportunities for savings are limited.
6	The Joint Commissioning Board therefore gave approval in September 2017 to fund a pilot of a D2A scheme specifically for Pathway 3 using a mix of bed based provision (provided by nursing and residential homes) and home care whilst people are assessed, underpinned by a pooled budget with equal contributions from the CCG and City Council. The pilot was established to test out a number of objectives on a small scale prior to moving to a permanent D2A scheme for all clients on Pathway 3:

	• to test a mixed model of D2A placement for this client group, particularly the viability and impact of using a robust home care package for some clients/patients • to evaluate the impact on DTOC overall in terms of both numbers and costs • to test processes and how much assessment capacity is required to maintain throughput on this D2A pathway
7.	**Overview of Pilot** The pilot was a "discharge to assess" scheme for patients who are medically fit and able to leave hospital but due to the complexity or likely complexity of their long term care needs, require further assessment and support in the community setting.
8.	A mixture of assessment placements were commissioned:- • 4 x "standard" nursing home beds • 4 x "complex" nursing home beds • 4 x "residential" beds • 1 x "live in" home care placement The assessment placement was for a maximum of 28 days but with the aim of completing the majority of the work within a three week period (this allowing one week for arrangement of onward placement).
9.	For the purposes of the pilot the proposal was developed on a maximum demand level of 4 referrals a week.
10.	The pilot included the recruitment of 1 WTE nurse and 1 WTE social worker primarily to undertake assessment in the community setting and ensure timely move on to long term care. These posts were to additionally liaise with appropriate members of the IDB (both health and social care) in supporting the "pull" of appropriate patients from hospital. Overall responsibility for the identification of potential patients for this scheme and facilitating safe and appropriate discharge once agreed remained with UHS staff in the hospital.
11.	The pilot was initially scheduled to run from 1 November 2017 – 30 April 2018 but was extended to 30 June 2018 to enable a fuller evaluation.
12.	There was an established project group working on the delivery of Pathway 3 that continued to meet regularly throughout the pilot and beyond. A weekly teleconference was also established to support the process.
13.	**Summary of Pilot Activity** The table below presents the operational data from the pilot for the period 1 November 2017 – 30 June 2018.

Metric	Assessment Bed/Packag	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Operational													
No. of hospital readmissions from assessment beds							1	1		1	1		1
No. of patients accessing the assessment beds/packages	complex nursing home						1	1					
	standard nursing home					1	3	6	7	3	5	4	3
	residential care							1					
	home care							1					
No. of placements extended beyond 4 weeks							2	1	2		3	1	2
No. of declines to pathway 3 D2A on grounds of patient cho						4	6	2	5	1	2	3	
No. of declines from the homes for pathway 3 patients						1					1	1	2
No. deaths (within the 28 day placements)							2	3	2	2	1	1	1

14.	This shows that during the 8 month period there were: • 36 patients/clients who went onto the pilot (an average of 4-5 a month) of

	whom the vast majority went into the standard nursing home placements (32 out of the 36) • 23 patients/clients who declined the pathway on the grounds of patient choice • about one third of assessments took longer than the scheduled 28 days • there were 5 readmissions and 12 deaths which were reviewed and found to reflect the complexity of the client group The reasons behind this data are discussed in more detail in the following sections.
	<u>Learning from the Pilot</u>
15.	**Client group:** The pilot focussed on providing a D2A pathway for the more complex patients/clients whose needs are beyond those on Pathway 2 e.g. people who may be eligible for CHC, may lack mental capacity, may have safeguarding concerns. Typically this group are likely to require high levels of long term care, often in residential or nursing home provision, and are likely to have long stays in hospital prior to discharge. They are also those patients/clients most likely to be subject to discharge delays owing to complexity of assessment and difficulties sourcing long term care, delays in nursing home placements being one of the top reasons for DTOC. In Southampton, following significant developments within the rehabilitation and reablement pathway, including the embedding of D2A as the default position for any client on Pathway 2, the majority of delays now relate to patients/clients on Pathway 3 – they are relatively a small group in patient/client numbers, however with a high number of delayed days attributable to them. The pilot identified that on average there were 1-2 patients a week suitable for D2A on this pathway (as opposed to the initial estimate of 4 a week), although over time it is expected that this number will increase to 2-3 a week as staff become more familiar with D2A as an option for this client group. The pilot also identified that, whilst many would be eligible for an assessment of CHC, **less than 2%** would go on to be proven eligible for CHC and **the majority will be social care funded clients** (Self funders estimated to account for 5-15% of this client group) who will require social care funded nursing home placements.
16.	**Assessment Placement/Capacity:** An aim of the pilot was to test a mixed model of assessment placements including residential care, nursing care and support in a person's home. The pilot demonstrated that the vast majority of clients were only suitable for nursing home care, owing to their level of complexity, 32 out of the 36 clients being placed in standard nursing home provision. To support this client group at home required a level of live in and double up care which was generally at a cost that was prohibitive to the scheme and potentially raised expectations which were not sustainable in the long term. It is however considered that there could be some benefit in maintaining a home support option in future for the small group of patients/clients with delirium where (although not tested in this pilot) there is national evidence to show that a time limited period of assessment and reablement in their own homes can lead to the delirium resolving and improved outcomes. The pilot also demonstrated the need for flexibility to source assessment

placements from a wide range of nursing home providers. A small number of block contracts were initially set up for the pilot to enable the commissioner to build a relationship with particular providers; however this took time to set up and a number of the providers were outside the city (owing to the lack of nursing home capacity in Southampton) which was unpopular with some clients and their families because of travel distance. The decision was therefore taken mid pilot to decommission some placements in favour of spot purchasing which enabled greater flexibility and better value for money as it avoided voids. The only exception to this was a block contract with one nursing home in Southampton able to offer both standard and complex placements. The relationship with this particular home has proved positive and offers other opportunities for future relationship building including the possibility of trusted assessment (this would ultimately impact favourably on hospital delays).

Going forward, it is recommended that any future model sources the majority of its assessment placements through spot purchasing with a wide range of providers with perhaps just one small block contract arrangement with one nursing home provider to build on the positive relationships established through the pilot. It is recommended that this capacity is focussed on nursing home beds (mainly standard with some complex) with a small budget to spot purchase some flexible care to support some clients with resolvable conditions (i.e. delirium) in their own home.

In terms of placement capacity, the pilot also demonstrated that there was a need in some cases for a longer period of assessment. Around a third of the patients on the scheme remained in placement beyond 4 weeks because of the challenges associated with completing the more complex assessments. It is therefore recommended that sufficient capacity is built in to any future model to allow for an average period of 5 weeks assessment for all clients.

17. **Impact on national targets, length of hospital stay and long term care costs:** The pilot demonstrated that the use of D2A for patients/clients on Pathway 3 has a positive impact on reducing length of stay, reducing discharge delays for both the Council and CCG and contributing towards achievement of the CHC target to reduce the percentage of assessments carried out in an acute setting.

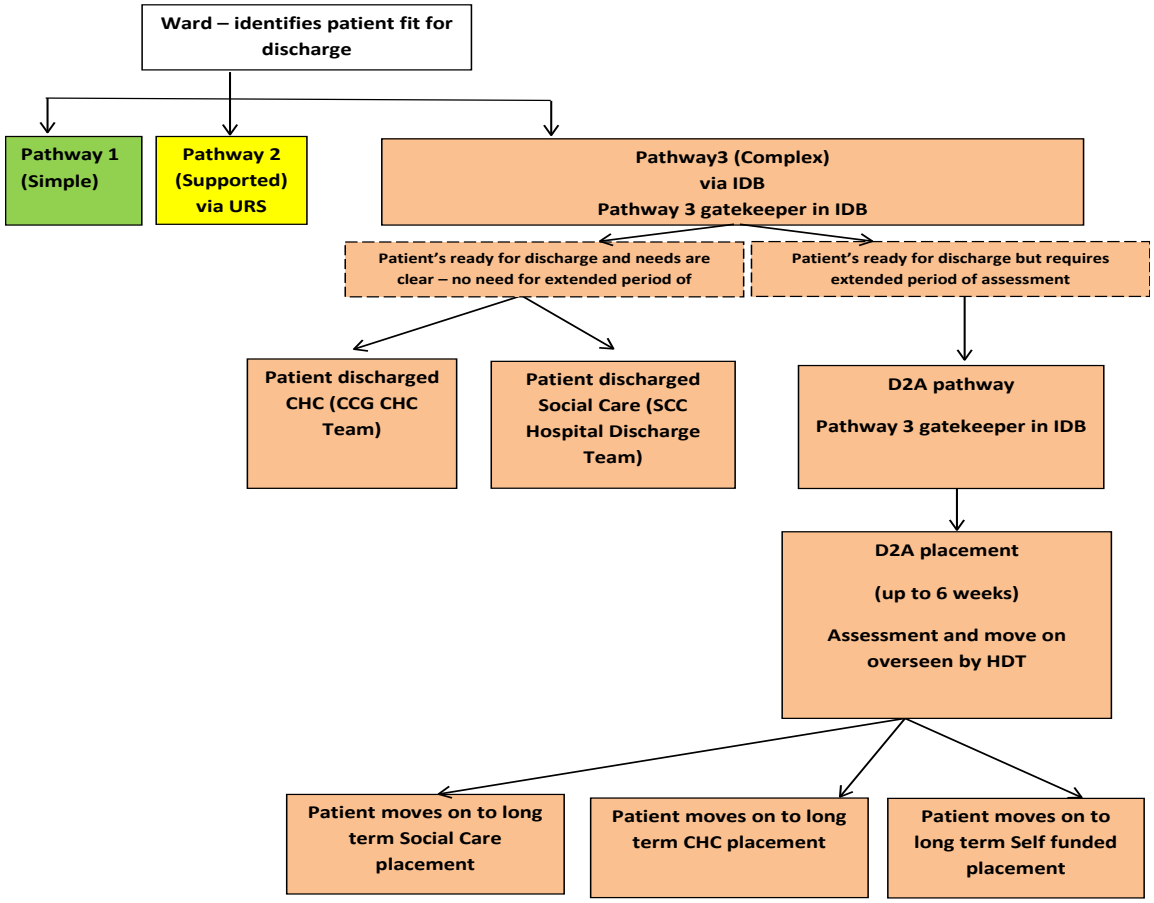
During the pilot period CHC assessments undertaken in the acute hospital decreased from 86% (pre pilot position) to 10% (June position). The pilot was only one factor in this reduction, but the overall additional focus it created on the assessment of long term care needs in a non-acute (outside of hospital) setting during the pilot period was a major positive. This is shown in the table below which shows the number and percentage of CHC assessments undertaken in hospital:

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
% CHC Assessments in acute setting	86%	56%	50%	29%	23%	19%	15%	15%	10%

Unfortunately, owing to the data analyst post becoming vacant within the Integrated Discharge Bureau, it was not possible to consistently monitor length of stay for the full duration of the pilot; however data for the period November 2017 – January

	2018 showed the **average length of hospital stay for patients on Pathway 3 D2A was 40 days, whereas it was 71 days for patients who were offered D2A but declined it.** This indicates the potential for a significant reduction in DTOC and possibly excess bed days.
18.	Impact on reducing costs was less evident. Given the complexity of clients, the majority of whom required a nursing home placement, it proved very unlikely that significant reductions would be achieved in reducing packages of care and most clients went into long term placements with similar levels of care provided at the time of assessment. The only client group where it is felt that there may be benefits in reducing long term care costs are those with delirium mentioned above in Paragraph16 (based on national research evidence). There is a developing awareness that some patients with delirium are placed in long term residential care unnecessarily when a period of intensive care within a home environment would allow for the delirium to resolve. These patients could be managed on this pathway with a D2A or "bridging" type approach in any future model.
19.	**Patient/Client Experience:** During the pilot a questionnaire was used to follow up with individual clients / families on their experience. The main feedback from clients who went onto the D2A pilot was: • Assessment in placement was viewed as positive, particularly by those clients who went on to remain in the same home for their long term care. • Assessment in placement was viewed as less pressured with more opportunity to ask questions and seek clarification from staff. The main areas of more negative feedback came from people who declined the D2A pilot and related to: • Limited choice of placement, which was particularly an issue in relation to those contracted homes which were outside of the city where travel distance was a concern to families • Having to move on from placement (i.e. having to move twice, once into the assessment placement and then again into the long term care placement) 23 clients/families declined the D2A scheme for these reasons which will need to be taken into account for future implementation. The issue around limited choice has already been discussed in Paragraph 16 and will be addressed through the greater flexibility in sourcing placements offered by a spot purchasing approach. Placement moves could be reduced by placing a client wherever possible in their long term placement directly from hospital and carrying out the assessment there. This should be considered wherever possible going forward; the use of spot purchasing arrangements with a wide range of providers to source placements (as opposed to block contracted beds) is more likely to support this.
20.	**Discharge Processes:** The pilot particularly highlighted the need for simple, standardised and high quality discharge processes. There were two key learning points with regard to process: • firstly that D2A needs to be seen as an integral part of the standardised

	discharge pathways, in this case Pathway 3, as opposed to anything separate. It is recommended going forward that D2A for Pathway 3 clients/patients is managed by the IDB as part of Pathway 3 and that a gate keeping function is identified in the IDB to work directly with the wards on a daily basis to appropriately target patients who would benefit from D2A and support the timely "pull" from the wards. • secondly that good quality discharge in terms of good communication with nursing homes, provision of comprehensive and accurate patient/client information, timely arrangement of transport, provision of the right medication and equipment is key to ensuring a timely and proactive response from care providers. The pilot highlighted some difficulties in this area which are being addressed by UHSFT. The relationship with the care market going forward is key to the success of rolling out D2A for this client group, particularly in progressing 7 day working.
21.	**<u>Summary and Recommendations</u>** In summary, the pilot demonstrated that D2A can be implemented for Pathway 3 clients and improves patient/client experience in terms of providing a less pressurised environment for assessment and reducing unnecessary long stays in hospital which are known to lead to poor outcomes for patients/clients. There are 2-3 clients a week in Southampton who would be eligible for D2A on Pathway 3 and the vast majority of these will require nursing home placements, the majority of whom will be social care clients. Needs are complex and most clients will go on to require nursing home care; however D2A provides an opportunity for any reablement and therefore cost reduction that is feasible. It is recommended that going forward D2A should be provided for complex patients/clients and that this should function as an intrinsic part of Pathway 3, managed by the IDB. In time, the long term aim would be to discharge clients wherever possible to their long term placement and assess there; however until this can be guaranteed for all clients, it is recommended that a joint budget split 50/50 between the CCG and SCC is held by the IDB for short term D2A placements.
22.	<u>Proposal for Pathway 3</u> Key principles for Pathway 3 should mirror those for all other pathways, namely: • discharge planning should commence as early as possible • decisions about long term care needs should wherever possible be made outside of the hospital setting • a strengths based approach should always be employed • trusted assessment should be promoted For any Pathway 3 discharge, there will be two key decisions: can the patient go straight to placement either funded by CHC or Social Care; or do they require a longer period of assessment, in which case they will go down the D2A route. It is proposed that there should be a new "gate keeping" function in the IDB to "pull"

	appropriate patients from the wards and to specifically oversee the D2A placements. It is proposed that assessment of the patient/client in their D2A placement, working with the CHC team if the patient checklists in for CHC assessment, and managing the move on of the patient/client at the end of their period of assessment is undertaken by the Hospital Discharge Team.
23.	This proposed model for Pathway 3 is illustrated in the diagram below. 
24.	With specific reference to Pathway 3 D2A, the following recommendations are made: • The pooled fund is maintained to the end of the 2018/19 financial year between the CCG and Council on a 50/50 split to fund a mix of bed based (standard and complex nursing home) and a small number of home care D2A placements for a 4-6 week period, taking on board the lessons from the pilot that 4 weeks is not always long enough to support a comprehensive assessment of a client's long term care needs. This is then reviewed at the end of the year to inform 2019/20 budget planning. • It is proposed that the assessment placements are sourced through a mix of block contracting (it is recommended that a trusted nursing home partner is commissioned to provide up to 3 standard and complex beds til the end of 2018/19, building on the relationship developed with one nursing home during the pilot) and spot purchasing. • Discharge to a D2A placement should be seen as the default position for any

	patient/client whose long term needs require a period of assessment. • As already stated, there should be a gatekeeper function within the IDB, responsible for "pulling" appropriate patients from the wards and accessing the D2A placements and overseeing capacity. • The undertaking of the D2A assessment would sit with the Hospital Discharge Team (with CHC and/or community nursing teams as appropriate) along with overseeing the client's eventual move on to long term care.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
25.	The total budget for the pilot was £463,465 for 6 months. This comprised: Assessment Placements • Standard Nursing Home x 4 beds x 26 weeks x £850 = £88,400 • Complex Nursing Home x 4 beds x 26 weeks x £1,500 = £156,000 • Home Care x 4 packages x 26 weeks x £950 = £98,800 • Residential home x 4 beds x 26 weeks x £700 = £72,800 • TOTAL £416,000 Assessment Team • 1 wte nurse at Band 6 for 26 weeks = £ 22,242 (including on costs, top of the band) • 1 wte social worker or care manager for 26 weeks = approx. £20,000 • 0.25 wte band 7 supervision for 26 weeks = £5,223 • TOTAL £47,465
26.	UHS made a contribution of £75,000 which left £388,465 which was split 50/50 between the Council and CCG and set up as a pooled fund within the Better Care S75.

27. For the 8 month period 1 November – 30 June (extended length of pilot), the actual spend on the pilot was £377,477. This is less than the 6 month budget of £463,465, leaving an unspent surplus of £85,988. The main reason for this underspend was because a number of the placement provisions commissioned were ceased mid pilot in favour of increasing capacity with one contracted nursing home provider in the city and establishing a budget for spot purchasing placements (for the reasons already discussed in this report) and demand was lower than expected (1-2 referrals a week as opposed to 4). The following table summarises the financial outturn of the pilot project.

Description	Budget for Pilot (£)	Actual spend for pilot up to end of June 2018 (£)	Forecast variance (£)
Placement Budget	416,000	285,273	(130,727)
1.0 wte Nurse Cost	22,242	55,083	32,841
1.0 wte Social Worker/Care Manager	20,000	37,121	17,121
0.25 wte B7 supervision	5,223	0	(5,223)
	463,465	**377,477**	**(85,988)**
Funded by:			
University Hospital Southampton	(75,000)	(75,000)	0
Southampton City CCG	(197,965)	(160,220)	37,745
Southampton City Council	(190,500)	(142,258)	48,243
	(463,465)	**(377,477)**	**85,988**

28. For the remainder of 2018/19, in line with the recommendations of this report, it is recommended that the pooled budget based on a 50/50 split between the CCG and Council is maintained to purchase Pathway 3 D2A placements.

The annual budget requirement would be £803,400, calculated as follows:

- Standard and Complex Nursing Home x 3 beds x 52 weeks x £1,200 = £187,200 pa
- Standard and Complex Nursing Home (spot purchasing budget) x 6 beds x 52 weeks x £1,500 = £468,000 pa
- Home Care (spot purchasing budget) x 3 packages x 52 weeks x £950 = £148,200
- Total = £803,400

29. A budget has already been allocated from iBCF which would cover the Council's 50% costs in 2018/19 and the Clinical Commissioning Group have identified funding for their element of the costs. After this date no budget will be available to proceed unless alternative funding is secured. The position will therefore need to be reviewed towards the end of 2018/19.

Property/Other

30. There are no specific property implications associated with these recommendations.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

31. Not applicable

Other Legal Implications:

32. None

CONFLICT OF INTEREST IMPLICATIOINS	
33.	None
RISK MANAGEMENT IMPLICATIONS	
34.	The pilot has enabled D2A to be tested with patients/clients on Pathway 3 in a managed way and this has informed the development of future recommendations and management of risks. In particular: • the primary use of spot purchasing with a wide range of providers for sourcing placements has been recommended going forward in order to maximise flexibility, increase choice and enable some clients, where appropriate, to move to their long term placement straight away (with assessment happening in this placement). This in turn reduces the risk of client/family choice impacting on ability to move clients into D2A and the risk of paying for unused capacity. • building in D2A as an integral part of Pathway 3, managed by the IDB, as outlined in the recommendations going forward will simplify processes for ward staff, reducing the risk of some patients/clients not being considered for D2A in a timely way. The gate keeping function described in the recommendations will further support timely identification and discharge of patients. • allowing a slightly longer period of 4-6 weeks (on average 5 weeks) for assessment in the community will greatly reduce the risk of assessment placement capacity becoming "blocked" as a result of assessments taking longer than planned. This leaves a smaller number of residual risks which will need to be managed going forward, as set out below: • Managing the ongoing risk of client/family choice - it will be important to ensure that D2A is seen as the default for any client on Pathway 3 requiring a period of assessment. This will require awareness raising and training amongst ward staff and clear messaging for patients and their families, highlighting the rationale and the benefits to patient outcomes of minimising the time spent unnecessarily in a hospital bed. • Managing the risk of insufficient capacity in the Hospital Discharge Team to support the gatekeeping function and carry out the assessment within the D2A scheme, such that Pathway 3 operates effectively - in order for this to be supported within existing IDB/Hospital Discharge Team resources, there will be a need to ensure that Pathways 1 and 2 are completely managed by the wards and hospital discharge facilitators and the Urgent Response Service respectively. This has always been the intention but will now require a concerted effort to get there in order to free up the capacity in the IDB/HDT required for Pathway 3. • Managing the risk of poor quality discharge impacting negatively on the willingness of the social care market to support D2A for more complex patients/clients - work is ongoing within UHSFT to improve the quality of hospital discharge.

POLICY FRAMEWORK IMPLICATIONS	
35.	The development of a D2A option for Pathway 3 clients supports the delivery of outcomes in the Council Strategy (particularly the priority outcomes that "People in Southampton live safe, healthy and independent lives" 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. It is also a key element of the 8 High Impact Change Model for managing transfers of care which all Local Authorities and CCGs are expected to implement.

KEY DECISION?	**Not Applicable - No decision required**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	None

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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DECISION-MAKER:		**Joint Commissioning Board**		
SUBJECT:		**Better Care Quarter 1 2018/19 Report**		
DATE OF DECISION:		**9 August 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**		

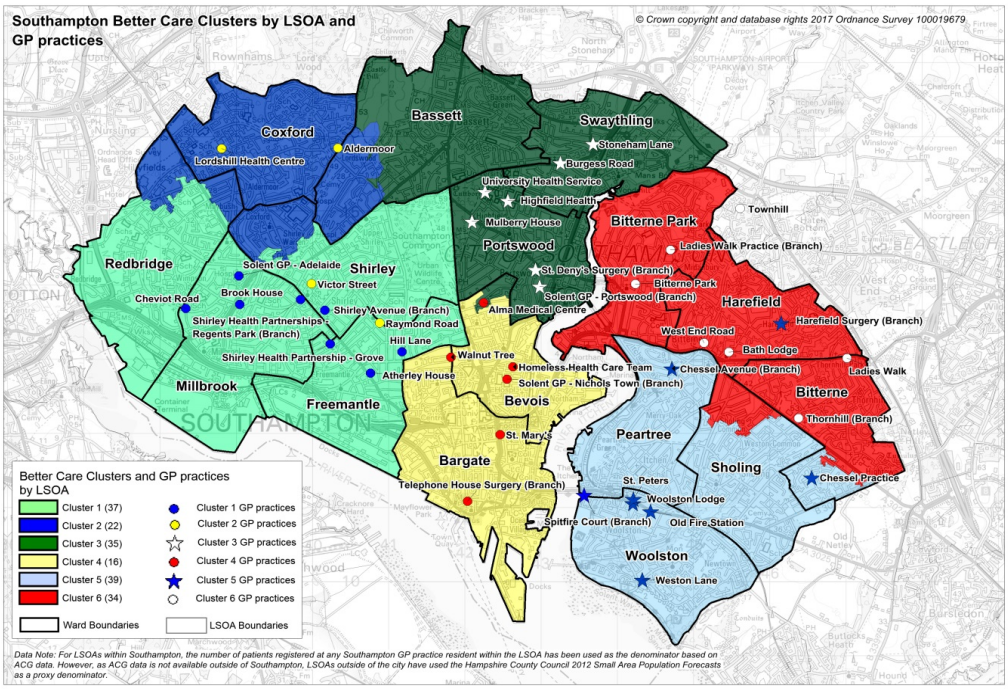
STATEMENT OF CONFIDENTIALITY		
NOT APPLICABLE		
BRIEF SUMMARY		
This report provides a review of performance for Quarter One 2018/19 against Southampton's Better Care programme and pooled fund. Detailed data on the performance indicators can be found at Appendix 1.		
RECOMMENDATIONS:		
	(i)	To note Quarter One performance 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).	
2.	National Better Care Fund Operating guidance was published on 19 July 2018 for 2018/19 along with revised targets for delayed transfers of care (DTOC). The guidance reiterates the previous guidance published for 2017-19 and does not require local areas to revise their plans for 2018-19. The DTOC metric set for Southampton in 2018/19 has been based on the Quarter 3 2017/18 position and requires Southampton to reduce average daily delays to 26.6 (comprising 11.3 NHS delays, 11 Adult Social Care delays and 4.4 Joint delays) by September 2018 and then to maintain this position to year end. The Quarter 3 position was 38.8 average daily delays (16.2 NHS delays, 18.3 Adult Social Care delays and 4.4 joint delays). The new 18/19 target represents a slightly less ambitious trajectory than that of 2017/18 and a much more equal split of NHS and Adult Social Care delays. The targets in Southampton's Better Care performance report have been updated to reflect this revised trajectory.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	NOT APPLICABLE	
DETAIL (Including consultation carried out)		
1.	**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 Rehabilitation 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. Southampton's 6 key priorities as identified in the 2017-19 Better Care Plan are set out below: • 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 The **Better Care Fund** pools resources from both the CCG and Local Authority to support the delivery of the Better Care Programme. In 2018/19 this totals just over £109M (£73.5M from the CCG and £35.9M from the Council), making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which is £16.18M, 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
2.	**Performance as at Q1 2018/19** The table below provides the Performance against the key Better Care national indicators. Owing to monthly reporting time lags, it is only possible to provide activity data up to 31 May 2018 (June 2018 activity data will be available on 9 August 2018).

Month 2 (Apr - May 18)

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

Metric	Year to Date vs. Target	Year to Date vs. Last Year	Commentary
Urgent Care Demand			
Non elective admissions	Slightly worse (6% higher than target)	Better (4% lower than last year)	• As at Month 2, NEL admissions are 4% lower than last year, but 6% higher than target.
Discharge & Out of Hospital Model			

DTOC rate (May snapshot)	Target Not Achieved* (4.9% vs. 4.6% target)	Better* (1.3% lower than last year)	• Provider DTOC rates in May:
			  • UHS 6.1%
			  • Solent 2.0%
			  • Southern Health: 0% (as per above)

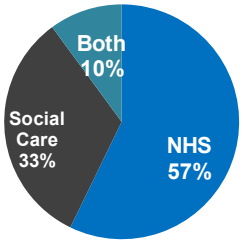
Delayed days	Target Not Achieved* (10% higher than target)	Better* (19% lower than last year)	
Permanent admissions into residential care	Slightly worse (7% higher than target)	Worse (12% higher than last year)	• April admissions were 53% higher than the previous year, however in May these have come down and are 16% lower than May last year.
Prevention			
Injuries due to falls	Target Not Achieved (10% higher than target)	Slightly worse (1% higher than last year)	• April admissions for falls were 9% higher than April last year. • May admissions for falls were 11% higher than May last year.

3. **Performance Headlines**

- **Permanent admissions to residential and nursing homes** During 2017/18 Southampton saw a significant reduction in admissions to residential and nursing homes. Whilst the April – May 2018 data would suggest a worsening of performance, it should be noted that monthly numbers are low and can lead to significant fluctuations, particularly when looking at such a small period. Analysis of the data shows that April admissions were 53% higher than in April last year; May admissions were 16% lower. In April there were 17 nursing home admissions and 9 residential home admissions, compared to 9 and 8 respectively in April 2017. April 2017 saw an unusually low number of nursing home admissions, with only 9 admissions when the previous 4 years prior to that had an average of 15 nursing home admissions for April.
- **Delayed transfers of care** Whilst significantly improved from last year (Apr - May 18 data showing 19% reduction in Delayed days compared to the same 2 months in the previous year and the data for the whole of 17/18 was 30% lower than 16/17), a number of key challenges continue to make the target difficult to achieve:
    - workforce capacity in the domiciliary care market particularly to support higher levels of need for more complex clients e.g. requiring calls at specific times or double up calls 3 or 4 times a day. To address this pressure, further investment is being made in the Domiciliary Care retainer contract from Q2 onwards.
    - nursing home capacity to take more complex clients (the Integrated Commissioning Unit is working with a number of providers to increase capacity for dementia clients, including investment of capital, although this is reliant on building work and so benefits will not be seen until next year)
    - Increasing levels of complexity, particularly being seen since start of calendar year. Discharges are at their highest levels; however demand and complexity is impacting on ability to achieve the 3.5%

target. This is also putting pressure on specialist rehabilitation facilities where there have been increased waits this quarter for beds to become available.

Analysis of the April-May 2018 data shows that the greatest pressure is in NHS delays. Adult Social Care delays are 12% below target whilst NHS delays are 48% above target. This is reflective of increased complexity.



The relative split of delays is shown in the pie-chart on the left.

Delays in all hospitals are below what they were this time last year (UHS 3% less, Solent 46% less and Southern Health 83% less), although not achieving the target. This reflects the considerable work undertaken in the community hospitals to improve discharge, which has been supported by the Hospital Discharge Team which now provides a social work presence in the community hospitals as well as the acute hospital.

- **Non Elective admissions** Whilst some of the reduction can be attributed to changes in coding within the hospital, a number of initiatives are known to be having an impact as follows:
  - Extension of the Adult Mental Health Crisis Lounge opening hours - now open 24 hours a day, 7 days a week.
  - The South Central Ambulance Service Demand Management Scheme which is evidencing a reduction in use of urgent care services for those being supported (high intensity users)
  - The Case Management Scheme which is evidencing significant reductions in use of acute emergency services 6months post period of case management compared to the 6 month period before: 60% reduction in non elective admissions, 60% reduction in Emergency Department attendances, 59% reduction in Ambulance 999 calls
  - The additional Alcohol Support services which are providing inreach support in the hospital to help engage people into community support and treatment. This has resulted in a significant increase in successful referrals into community treatment, improving engagement and outcomes for people with alcohol use disorders .
- **Falls** A number of initiatives have been put in place to reduce falls, although some only starting in Quarter 3 2017/18, 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.

4.	**Key highlights for Quarter One 2018/19** **Priority 1: More rapid expansion of the integration agenda across the full life-course, building on the city's model of person centred integrated care based around 6 geographical clusters**

- The CCG and Council have contributed to a piece of work with the Hampshire and IOW STP to better define "cluster working" across the STP footprint, which has included a stock take of progress within the city to identify key areas for development. A Better Care Programme Manager has been appointed (commenced May 2018) to progress work with each cluster as well as city wide to develop a much clearer operational model for cluster working.
- Social work capacity has been increased in the new community-based social wellbeing teams and in the new integrated learning disability team to champion a Strengths Based Approach to improve outcomes for individuals, make best use of community and other resources and reduce, where possible, dependence on services.
- The integrated prevention and early help service for children 0-19 and their families under a single management structure formally went live in April 2018 under S75 Partnership arrangements. The Service brings together teams from both the Council and Solent NHS Trust (incorporating the Healthy Child Programme, Children's Centres and local Troubled Families programme) and operates in localities aligned to the city's 6 clusters.

Priority 2: A much stronger focus on prevention and early intervention

- The new Southampton Living Well Service formally went live in April 2018, which will transform the current older person's day services into a new wellbeing and activity offer delivered through Community Wellbeing Centres based within communities and wider community activity.
- Local Solutions Groups went live from April 2018 in each cluster to bring together voluntary, community, faith, business sector to map neighbourhood resources to aid signposting to community alternatives.
- Work has progressed to develop a model of Community Development for the city which will support growth of community activities, harnessing community assets. This is also being aligned to work on developing a city wide model for Community Navigation.
- A pilot to reduce frequent Emergency Department attendances and emergency admissions amongst some of the most vulnerable people in the city centre working with a voluntary sector provider went live in June 2018.

Priority 3: A more radical shift in the balance of care away from bed based provisions and into the community

- Work has continued to embed the High Impact Change Model for hospital discharge. The Discharge to Assess (D2A) pilot for Rehabilitation and Reablement clients has embedded across both the acute hospital and community hospitals and is showing a reduction in long term care needs.
- Additional hours have been purchased from the domiciliary care framework using iBCF funding to further support people to remain at home, bringing the total additional hours purchased this year to 11,340.
- The Enhanced Health in Care Home pilots are coming to an end this quarter with evaluation and recommendations for future roll out planned

	for Q2. The pilots have demonstrated a reduction in acute hospital activity from the 15 target residential homes. • There has been continued promotion of care technology to support people's independence. Referral numbers are holding steady at an average of 93 a month across the quarter with a conversion rate of 63% (referral to installation of equipment) which is slightly higher than the 2017/18 Q4 rate. An evaluation tool and benefits tracking process have been established for implementation going forward. • Work continues with the market to increase nursing home capacity. This includes the development of a new 44 bed nursing home in Rownhams for which planning permission has been granted. The Council is looking to contract with the owners for capital investment in the home in return for bed spaces at a reduced rate. The ICU is also working with homes across the city to encourage them to take clients with greater complexity by supporting with training and skills development. • The tender for future home care services has now been issued. **Priority 4: Significant growth in the community and voluntary sector** • As already described under Priority 3, there has been additional investment in the Community and Voluntary Sector to strengthen prevention services. In support of its 5th and 6th priorities (to develop new models of care which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies), the Better Care Steering Board has revisited the city's governance for Better Care and a new governance model was agreed in Q3. This also includes a revised system wide action plan to underpin our plans for integrated health and care and a Better Care Programme Manager jointly appointed and accountable to system partners to provide additional programme management capacity to implement at pace.
RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	The total value of the pooled fund for 2018/19 is just over £109M. As at quarter 1, overall performance against the pooled fund was a projected year end overspend of £0.07M, which represents a percentage variance against budget of 0.06%. The one area of overspend relates to the Learning Disabilities Scheme where there is a projected year end overspend of £0.34M, which is due to an increase in demand and complexity of client care. This is currently being offset by projected underspends on other schemes, primarily: • Integrated Rehab and Reablement and Hospital Discharge where there is a projected underspend of £0.10M, mainly related to staff vacancies (that are now being recruited to). • Prevention and Early Intervention (housing related support schemes) where there is a projected underspend of £0.10M. Financial performance against each Scheme is monitored on a monthly basis by the Better Care Finance and Performance Group.

Property/Other	
6.	There are no specific property implications arising from the Better Care pooled fund.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	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.
Other Legal Implications:	
8.	None
CONFLICT OF INTEREST IMPLICATIOINS	
9.	None
RISK MANAGEMENT IMPLICATIONS	
10.	Risks on specific Better Care Fund Schemes are monitored on a monthly basis. 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 in May 2018 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	
11.	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.
12.	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 Performance Report – Month 2 2018/19
2.	
3.	
4.	

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**	
2.		

Southampton City
Better Care Performance Report

Month 2, 2018/19
(Apr – May)

Clare Young

Better Care Southampton
working together to make a difference

City-Wide Dashboard

Month 2 (Apr – May 18)

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

Metric	Year to Date vs. Target	Year to Date vs. Last Year	Commentary
Urgent Care Demand			
Non elective admissions	Slightly worse (6% higher than target)	Better (4% lower than last year)	• As at Month 2, NEL admissions are **4% lower** than last year, but 6% higher than target.
Non elective short stay admissions (<24 hours)	No Target set	Better (4% lower than last year)	• NEL short stays are significantly lower last year – this is probably due to the coding changes that were introduced in August 2017, where very short stays into CDU ward are now coded as and A&E attendance only.
Non elective longer stay admissions (>24 hours)	No Target set	Slightly worse (5% higher than last year)	• Both working age adults and older people age groups have seen an increase in longer stay admissions year on year; 6% increase and 5% increase respectively.
A&E attendances (all types)	No target set	Slightly worse (3% higher than last year)	• All three age groups have seen an increase in A&E attendances. Older people attendances have seen the greatest increase; 8% year on year.
Discharge & Out of Hospital Model			

DTOC rate (May snapshot)	Target Not Achieved* (4.9% vs. 4.6% target)	Better* (1.3% lower than last year)	• *Southern Health reported 0 delayed days in May, which is assumed to be a data reporting issue. The overall DTOC performance will therefore be skewed because of no data from Southern Health.
			• Provider DTOC rates in May:
			  • UHS 6.1%
			  • Solent 2.0%
			  • Southern Health: 0% (as per above)

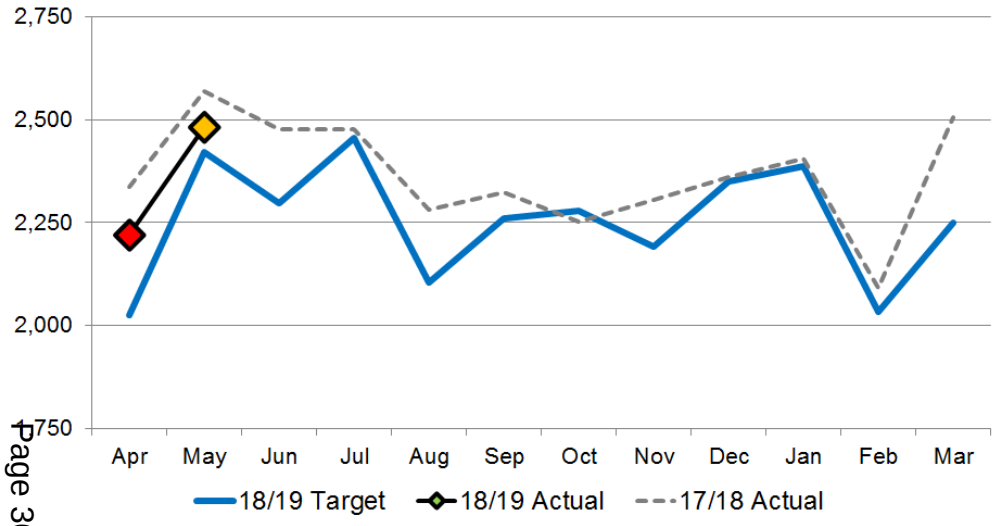
Delayed days	Target Not Achieved* (10% higher than target)	Better* (19% lower than last year)	
Permanent admissions into residential care	Slightly worse (7% higher than target)	Worse (12% higher than last year)	• April admissions were 53% higher than the previous year, however in May these have come down and are 16% lower than May last year.
Prevention			
Injuries due to falls	Target Not Achieved (10% higher than target)	Slightly worse (1% higher than last year)	• April admissions for falls were 9% higher than April last year. • May admissions for falls were 11% higher than May last year.

Urgent Care Demand

Urgent Care Demand – All Ages

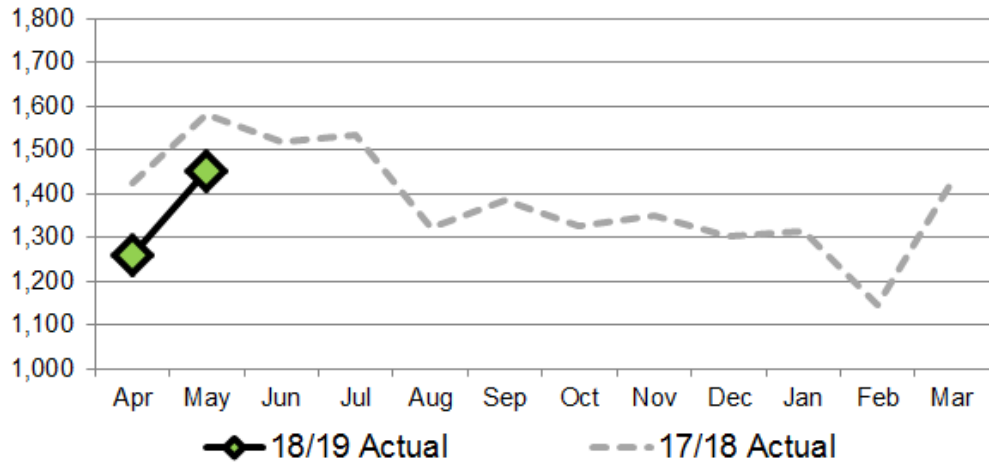
NEL Admissions (all providers)

6% higher than target | 4% lower than last year



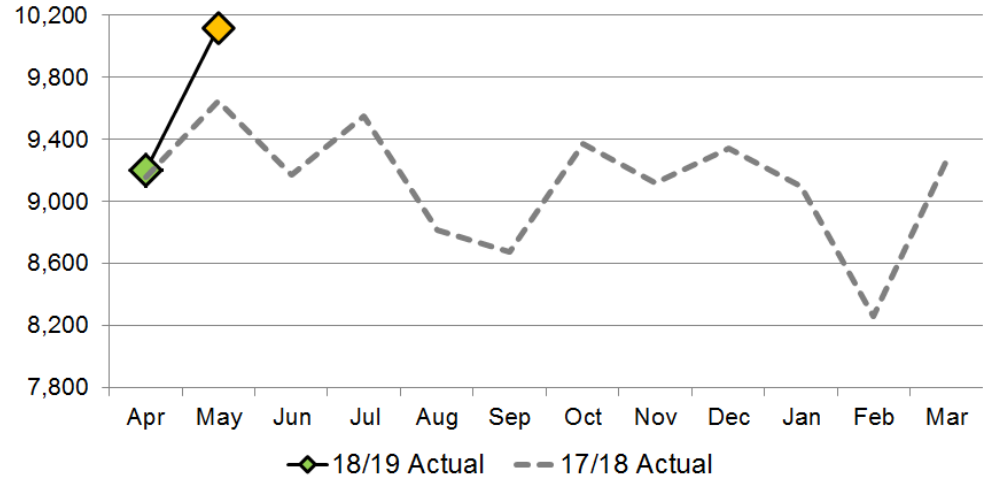
NEL Short Stay Admissions (<24hr) (all providers)

10% lower than last year



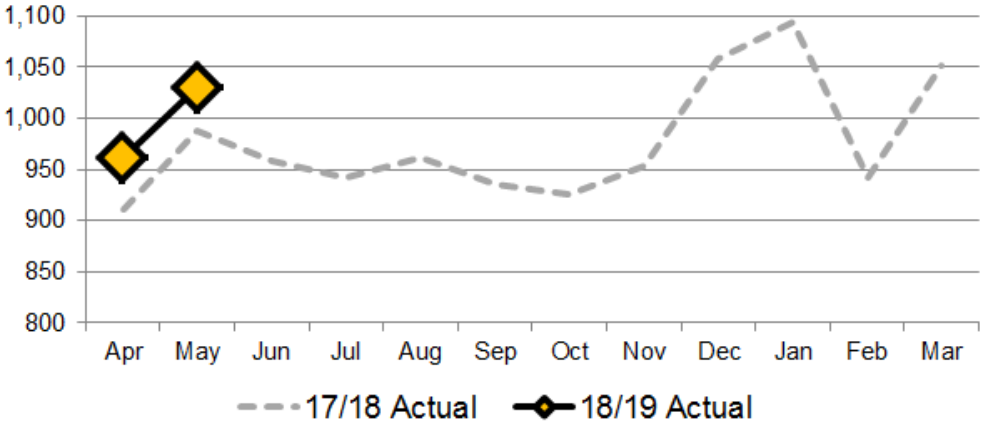
A&E Attendances (Types 1, 2 and 3 – all providers)

3% higher than last year



NEL Long Stay Admissions (>24hr) (all providers)

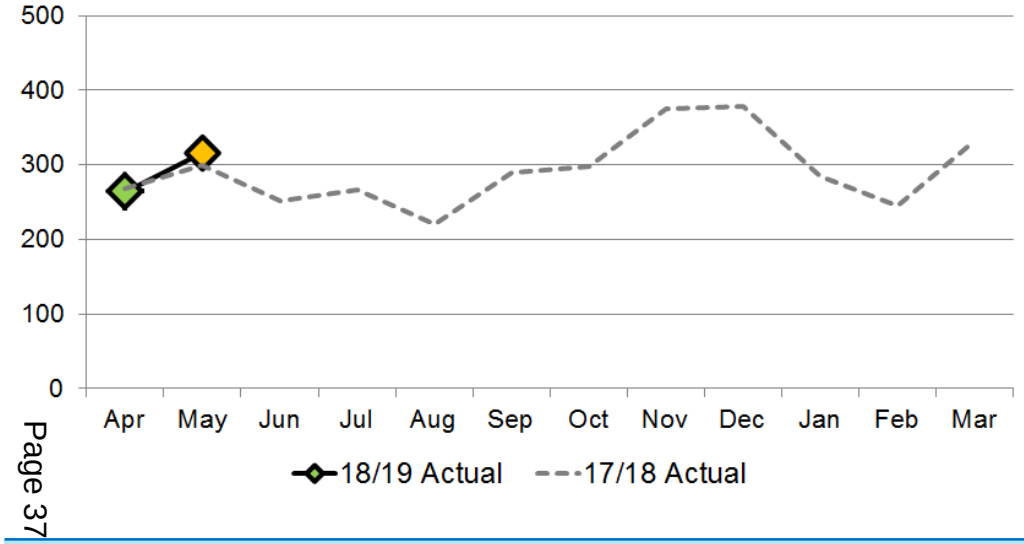
5% higher than last year



Urgent Care Demand – Children & Young People (0-17yrs)

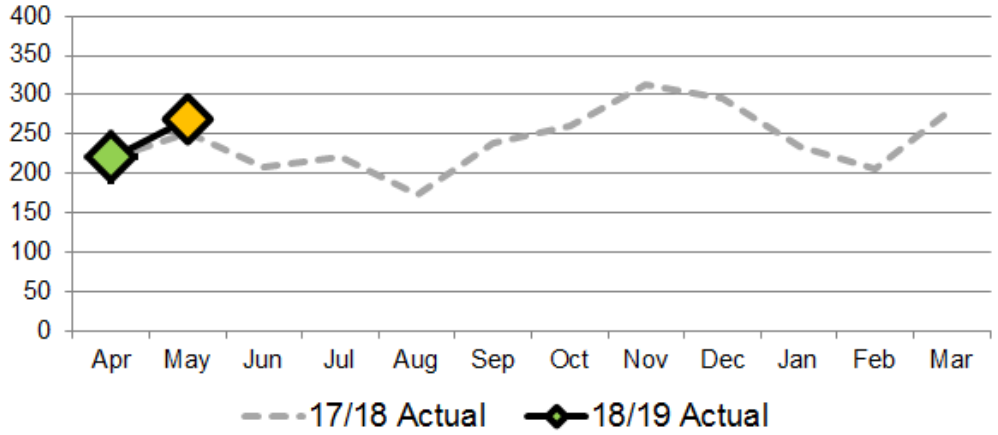
NEL Admissions (all providers)

4% lower than last year



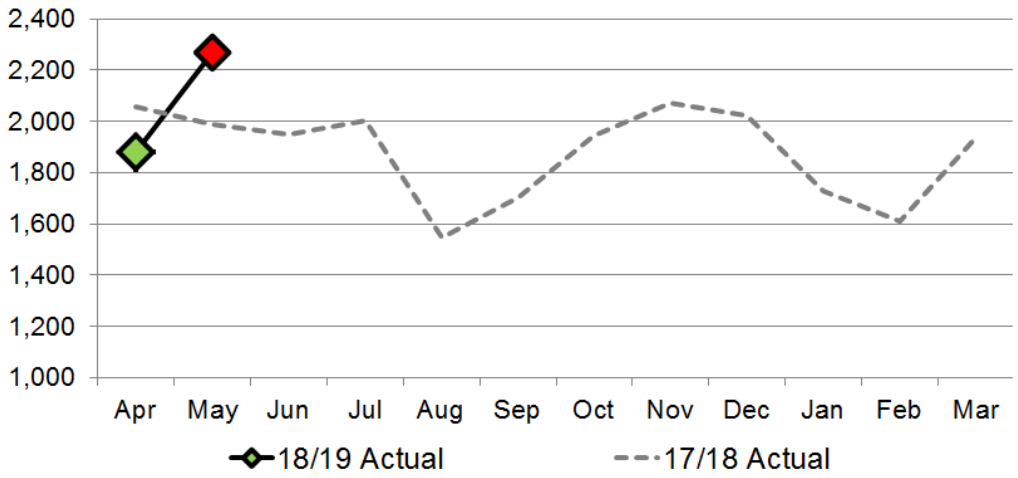
NEL Short Stay Admissions (<24hr) (all providers)

4% higher than last year



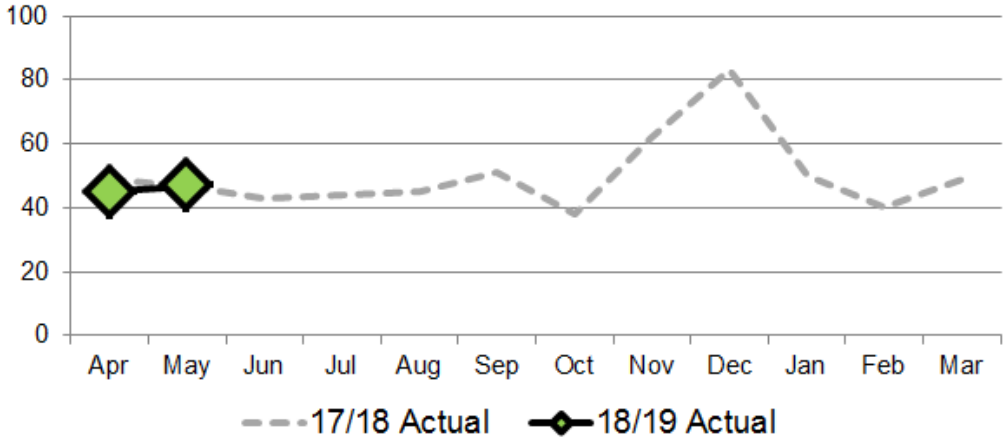
A&E Attendances (Types 1, 2 and 3 – all providers)

3% higher than last year



NEL Long Stay Admissions (>24hr) (all providers)

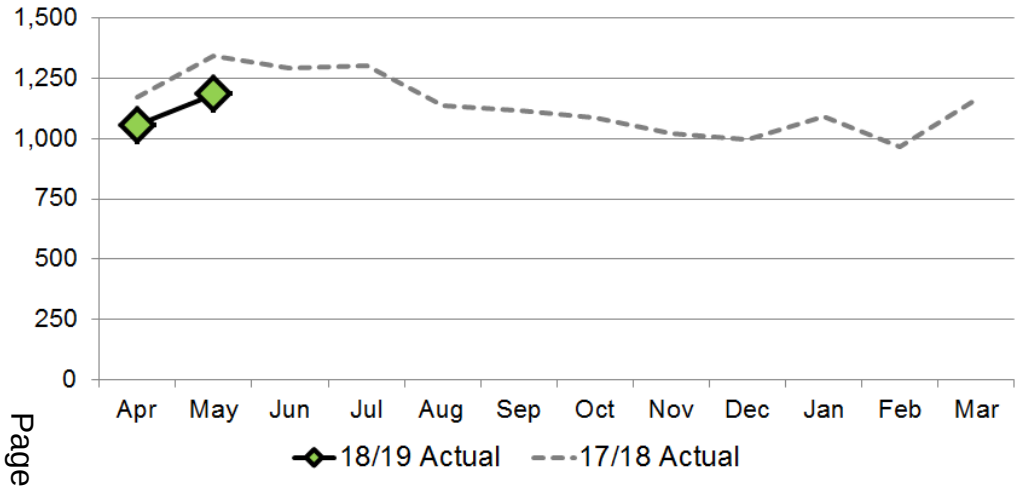
4% lower than last year



Urgent Care Demand – Working Age Adults (18-64yrs)

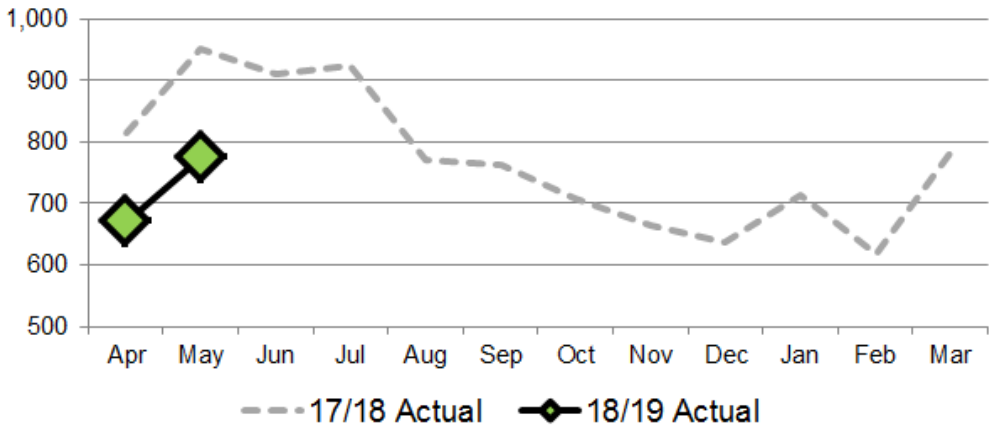
NEL Admissions (all providers)

4% lower than last year



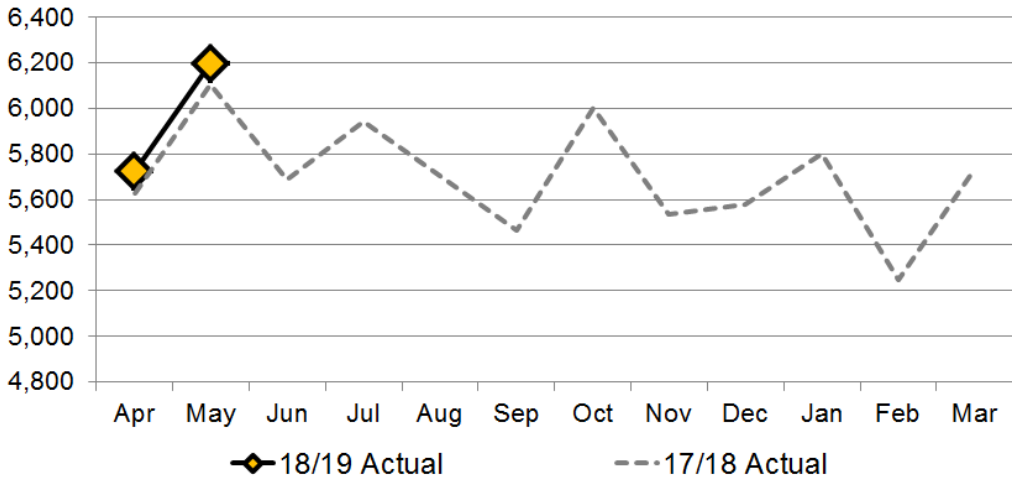
NEL Short Stay Admissions (<24hr) (all providers)

18% lower than last year



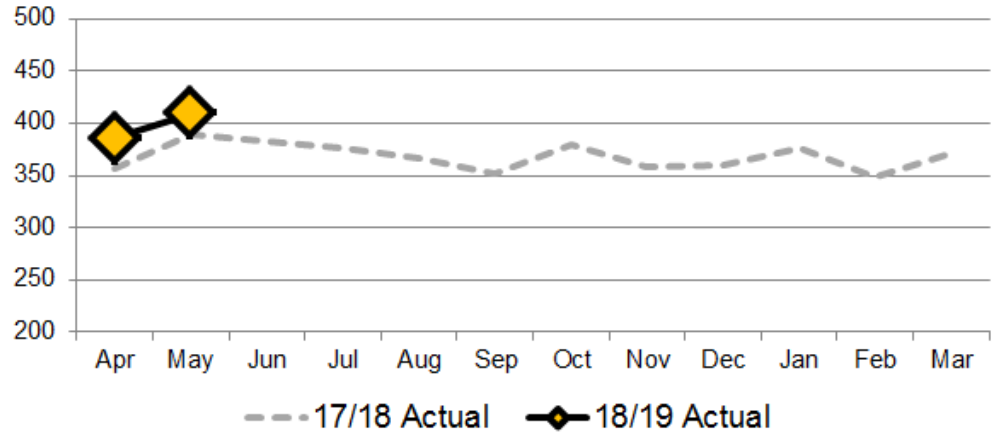
A&E Attendances (Types 1, 2 and 3 – all providers)

2% higher than last year



NEL Long Stay Admissions (>24hr) (all providers)

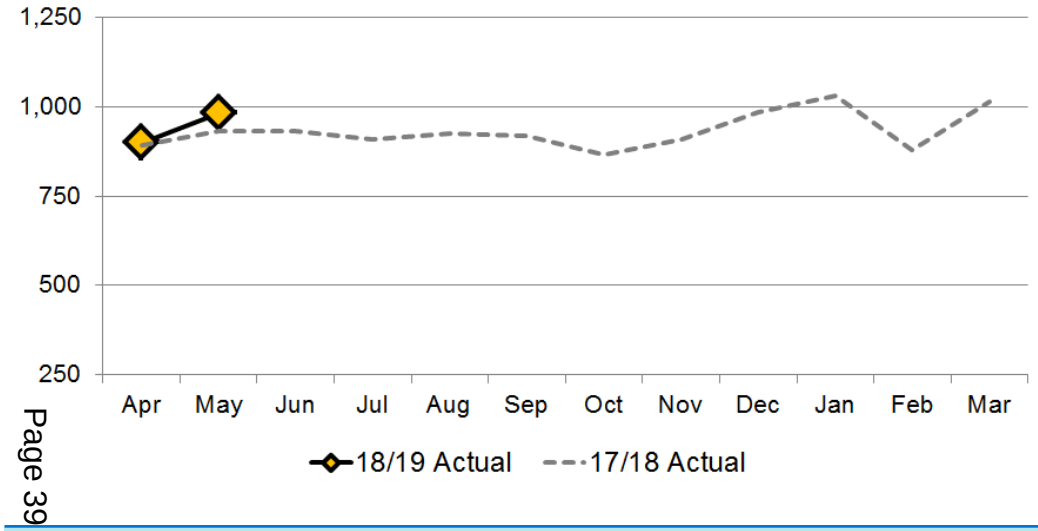
6% higher than last year



Urgent Care Demand – Older People (64yrs+)

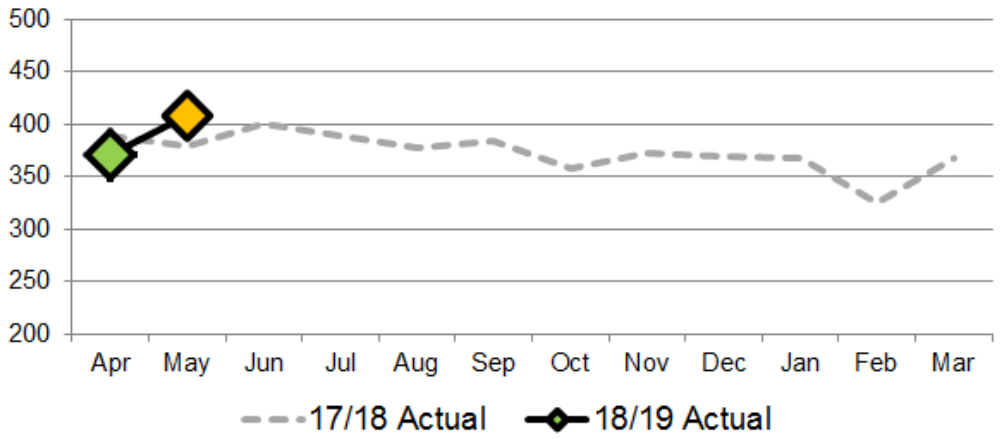
NEL Admissions (all providers)

4% lower than last year



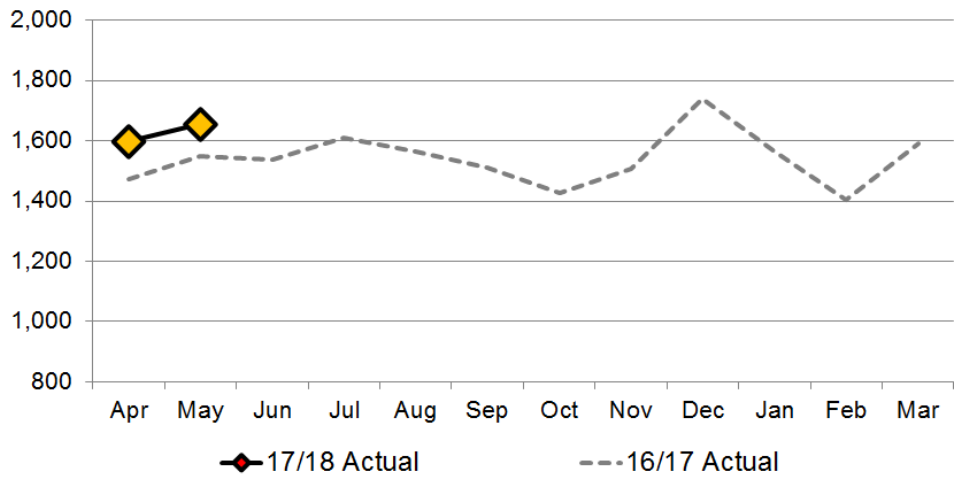
NEL Short Stay Admissions (<24hr) (all providers)

1% higher than last year



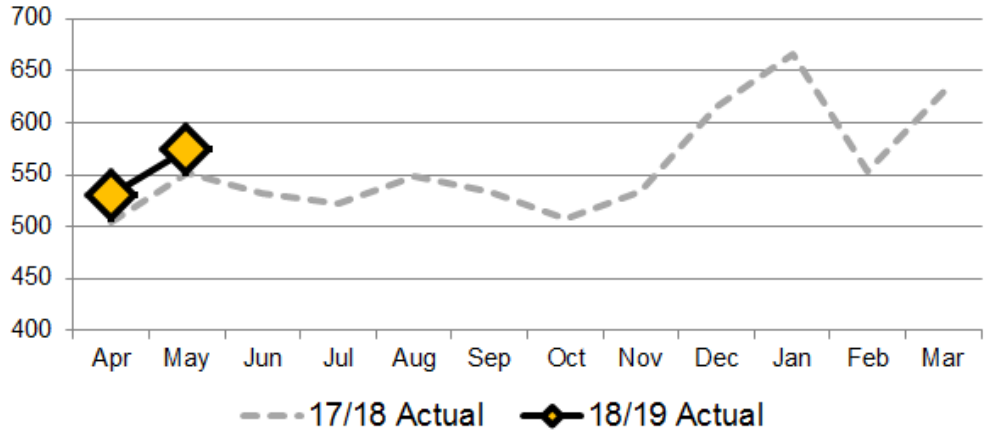
A&E Attendances (Types 1, 2 and 3 – all providers)

8% higher than last year



NEL Long Stay Admissions (>24hr) (all providers)

5% higher than last year



NEL Admissions – Top 15 Primary Diagnoses (Year to Date)

Children (0-17yrs)

	Activity
B349 - Viral infection, unspecified	61
J069 - Acute upper respiratory infection, unspecified	38
J039 - Acute tonsillitis, unspecified	31
A099 - Gastroenteritis and colitis of unspecified origin	17
J22X - Unspecified acute lower respiratory infection	14
A084 - Viral intestinal infection, unspecified	12
R104 - Other and unspecified abdominal pain	12
R458 - Other symptoms and signs involving emotional state	11
R11X - Nausea and vomiting	10
Z038 - Observation for other suspected diseases and conditions	10
J219 - Acute bronchiolitis, unspecified	10
N390 - Urinary tract infection, site not specified	10
P599 - Neonatal jaundice, unspecified	9
R568 - Other and unspecified convulsions	9
R509 - Fever, unspecified	9
T391 - Poisoning: 4-Aminophenol derivatives	8

Older People (65yrs+)

	Activity
N390 - Urinary tract infection, site not specified	80
J181 - Lobar pneumonia, unspecified	74
R296 - Tendency to fall, not elsewhere classified	68
J440 - Chronic obstructive pulmonary disease with acute lower respiratory infection	57
R074 - Chest pain, unspecified	47
J189 - Pneumonia, unspecified	43
K590 - Constipation	38
R55X - Syncope and collapse	37
A419 - Sepsis, unspecified	34
S7200 - Fracture of neck of femur	33
J22X - Unspecified acute lower respiratory infection	29
J441 - Chronic obstructive pulmonary disease with acute exacerbation, unspecified	29
L031 - Cellulitis of other parts of limb	29
N179 - Acute renal failure, unspecified	23
R072 - Precordial pain	23
M2555 - Pain in joint	22

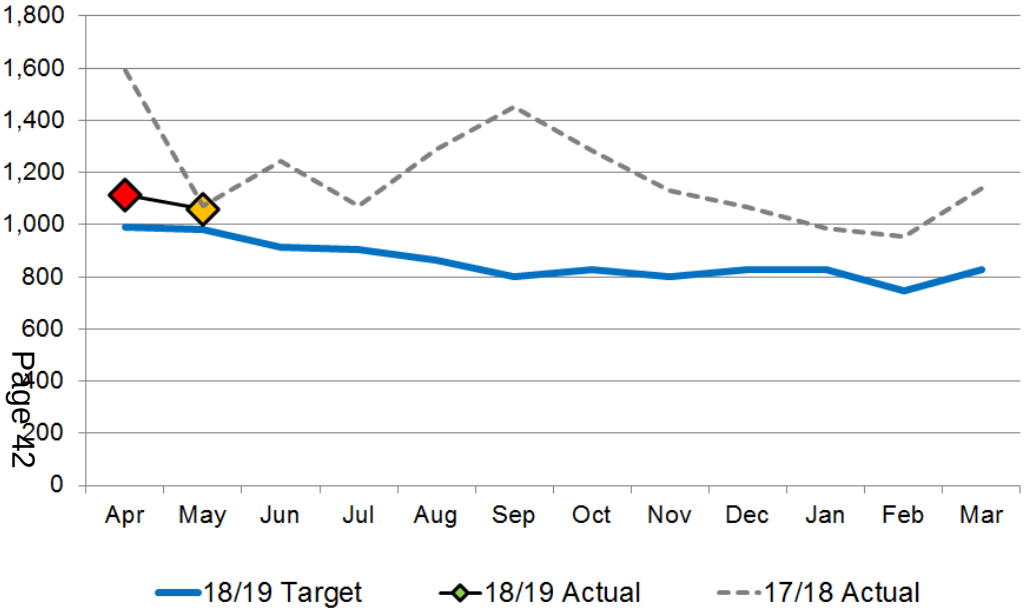
Working Age Adults (18-64yrs)

	Activity
R104 - Other and unspecified abdominal pain	76
R074 - Chest pain, unspecified	58
R103 - Pain localized to other parts of lower abdomen	41
R101 - Pain localized to upper abdomen	41
N390 - Urinary tract infection, site not specified	39
A099 - Gastroenteritis and colitis of unspecified origin	36
J181 - Lobar pneumonia, unspecified	32
T391 - Poisoning: 4-Aminophenol derivatives	31
R072 - Precordial pain	30
R073 - Other chest pain	30
R51X - Headache	29
G439 - Migraine, unspecified	28
J440 - Chronic obstructive pulmonary disease with acute lower respiratory infection	27
R568 - Other and unspecified convulsions	27
K358 - Acute appendicitis, other and unspecified	24
K590 - Constipation	22

Discharge & Out of Hospital Model

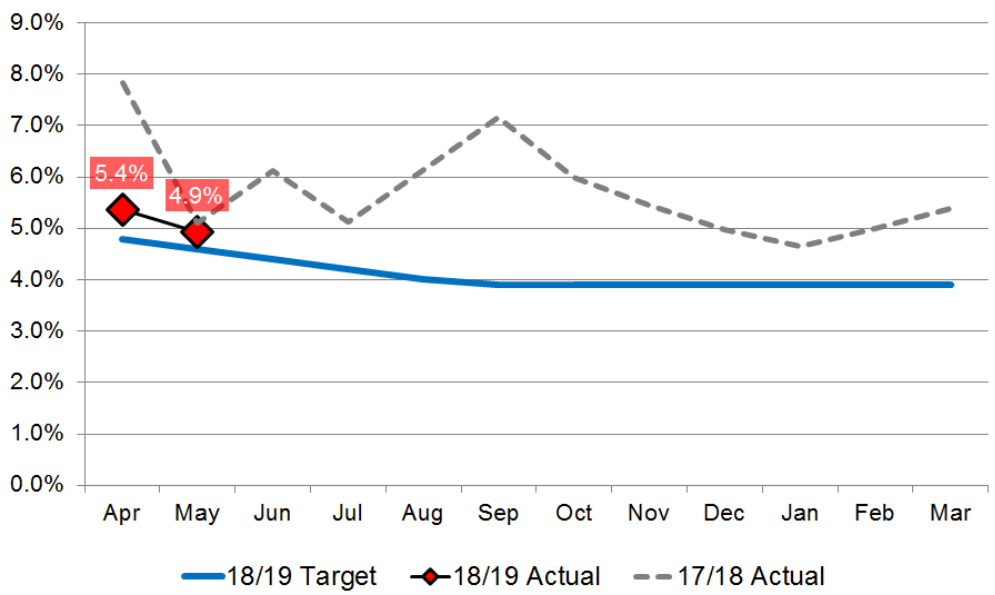
Delayed Transfers of Care (DTOC)

Delayed Days	YTD Target	YTD Actual
	1,972	2,173



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

DTOC Rate	May Target	May Actual
	4.6%	4.9%

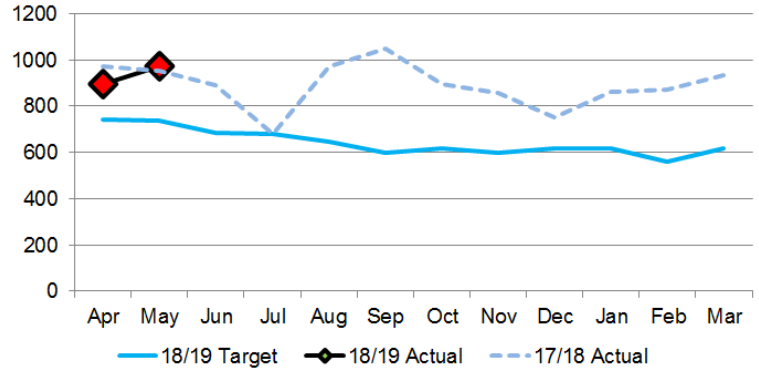


(DTOC rate, 18yrs+, Total - UHS, Solent, Southern Health)

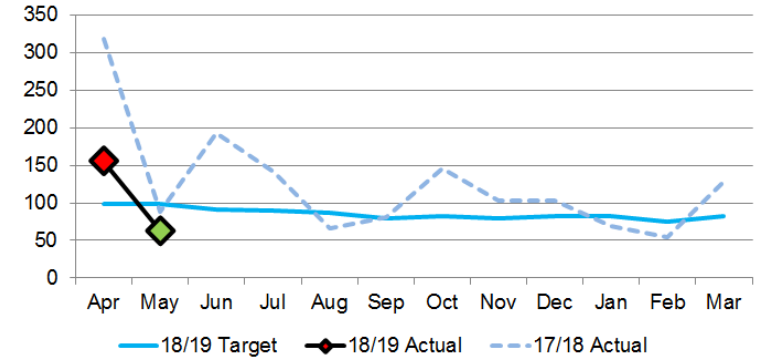
Delayed Transfers of Care (DTOC)

Delayed Days by Provider

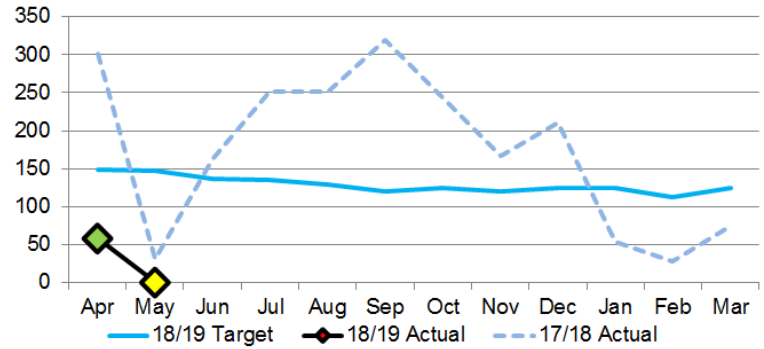
UHS



Solent



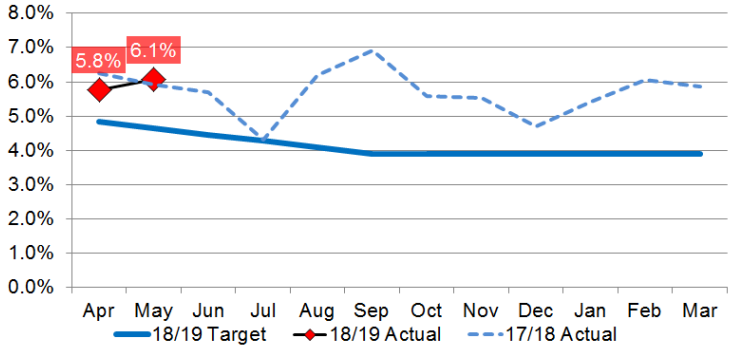
Southern Health



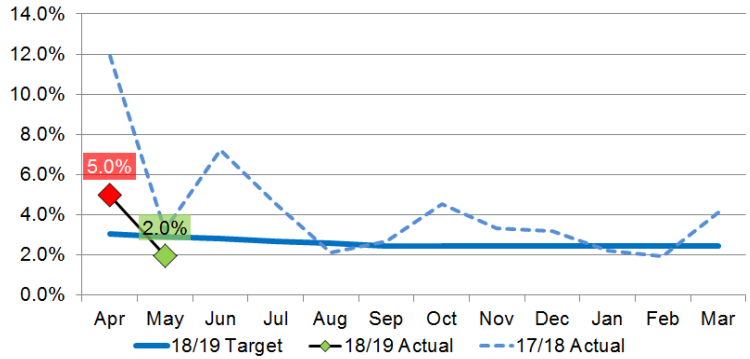
(Delayed days, 18yrs+, UHS, Solent, Southern Health)

DTOC Rate by Provider

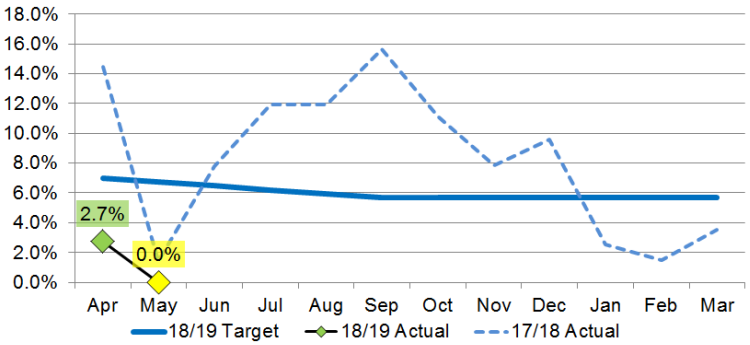
UHS



Solent



Southern Health

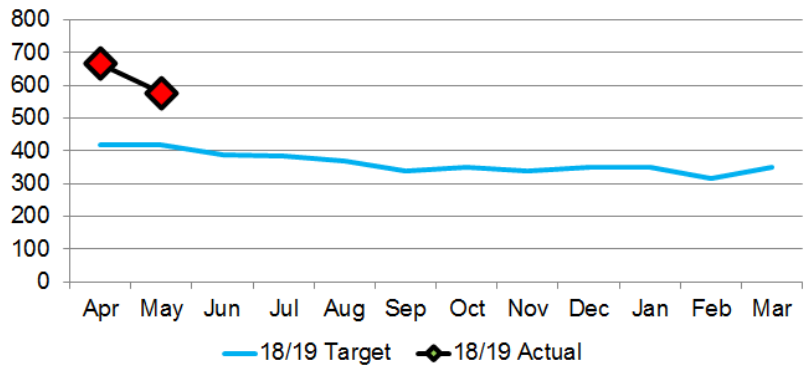


(DTOC rate, 18yrs+, UHS, Solent, Southern Health)

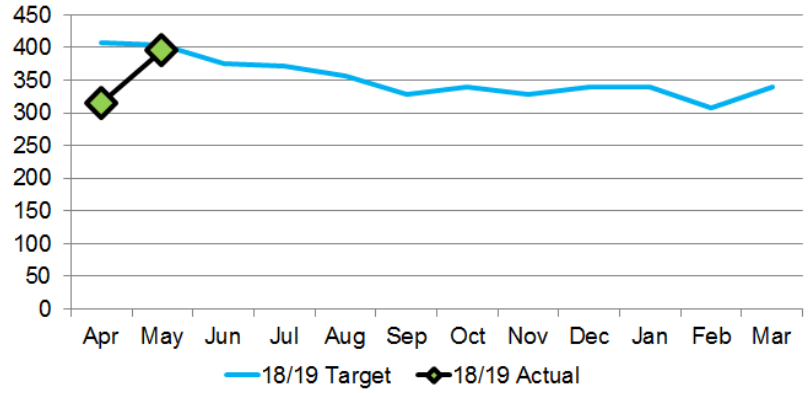
Delayed Transfers of Care (DTOC)

Delayed Days by Responsible Organisation

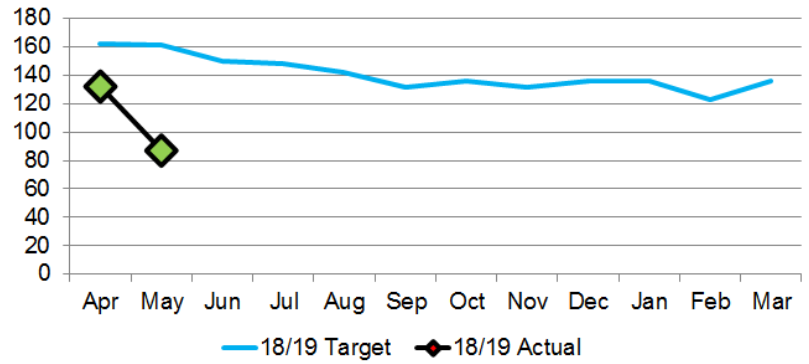
NHS



Social Care



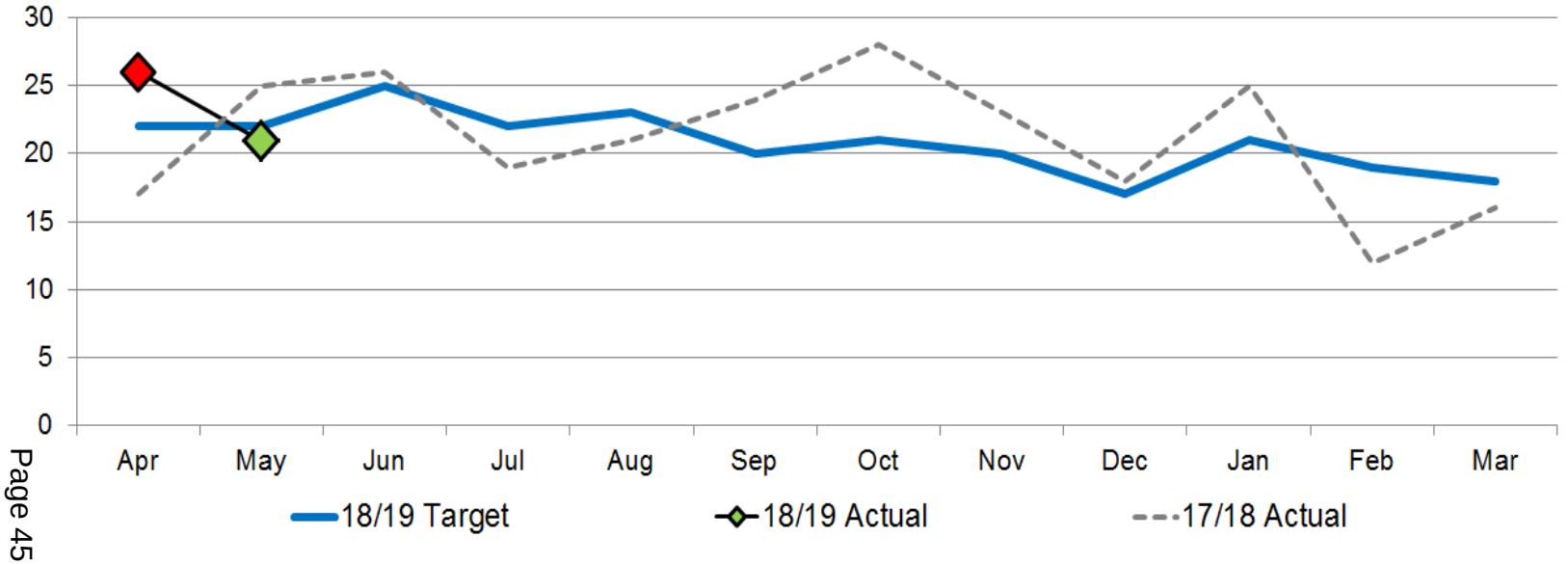
Joint



Permanent Admissions into Residential Care

7% higher than target

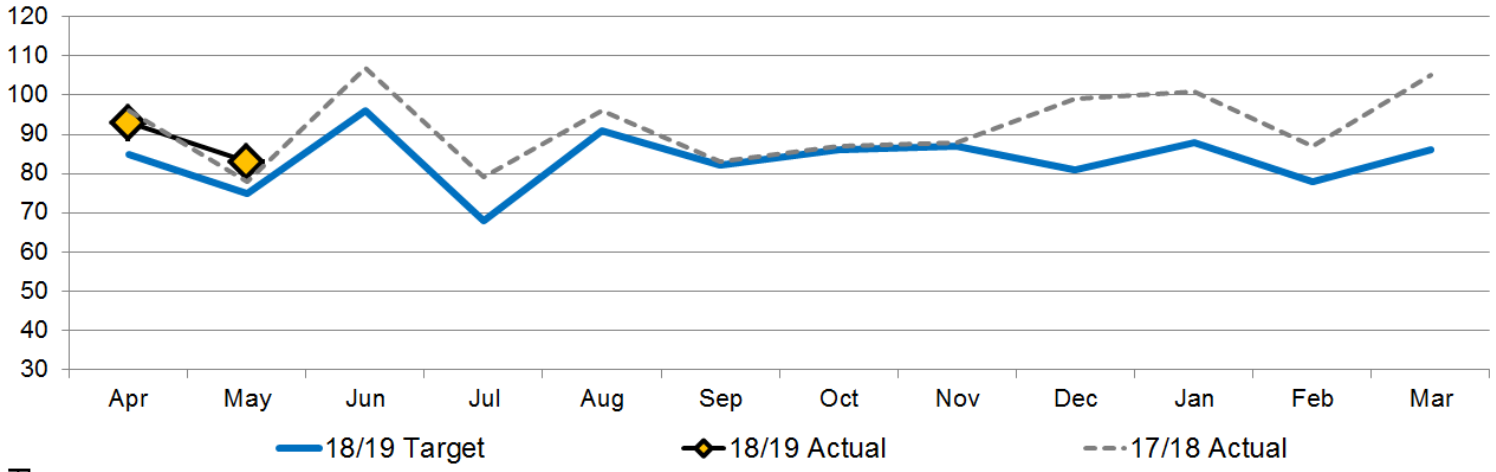
12% higher than last year



Prevention

Injuries due to falls

1% higher than last year



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