Public Document Pack

Joint Commissioning Board

Thursday, 17th October, 2019
at 9.30 am

PLEASE NOTE TIME OF MEETING

CCG Rooms C&D, CCG HQ, Oakley Road, Southampton

This meeting is open to the public

Members

Dr Kelsey (Chair)
James Rimmer
Councillor Hammond (Vice-Chair)
Councillor Fielker
Councillor Shields
Matt Stevens

Please send apologies to:

Emily Chapman, Board Administrator,

Tel: 02380 296029

Email: emilychapman1@nhs.net

PUBLIC INFORMATION

Role of the Joint Commissioning Board

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

Public Representations

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

Benefits from Integrated Commissioning

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

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

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

Fire Procedure – in the event of a fire or other emergency an alarm will sound and you will be advised by 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 2019/20

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

CONDUCT OF MEETING

Terms of Reference

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

Business to be discussed

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

Rules of Procedure

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

Quorum

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

Disclosure of Interests

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

AGENDA

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

1 WELCOME AND APOLOGIES

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

Dr Mark Kelsey		

3 MINUTES OF THE PREVIOUS MEETING/ ACTION TRACKER (Pages 1 - 6)

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

4 DIRECT PAYMENT SUPPORT SERVICES (Pages 7 - 30)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Sandy Jerrim	Decision	Attached

5 PROPOSAL FOR THE MAINSTREAMING OF HOSPITAL DISCHARGE PATHWAY 3 FOR PATIENTS/CLIENTS WITH COMPLEX NEEDS (Pages 31 - 54)

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

6 QUALITY REPORT (Pages 55 - 64)

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

7 PERFORMANCE REPORT (Pages 65 - 72)

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

8 HIGHLIGHT REPORT: BETTER CARE STEERING BOARD (Pages 73 - 74)

Lead	**Item For:** **Discussion** **Decision**	**Attachment**

	Information	
Dr Mark Kelsey	Information	Attached

9 BETTER CARE STEERING BOARD MINUTES (Pages 75 - 82)

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

Wednesday, 9 October 2019

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Meeting Minutes

Joint Commissioning Board - Public

The meeting was held on 20th June 2019, 09:30 – 11:00
West Wing Conference Room, Civic Centre

	NAME	INITIAL	TITLE	ORG
Present:	Councillor Chris Hammond	Cllr Hammond	Leader of the Council	SCC
	Councillor Dave Shields	Cllr Shields	Cabinet Member - Health and Sustainable Living	SCC
	Councillor Lorna Fielker	Cllr Fielker	Cabinet Member – Adult Social Care	SCC
	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG / SCC
In attendance:	Matt Stevens	MS	Lay Member for Patient and Public Involvement	SCCCG
	Kay Rothwell	KR	Deputy Chief Financial Officer	SCCCG
	Richard Crouch	RC	Chief Operating Officer	SCC
	Beccy Willis	BW	Head of Governance	SCCCG
	Clare Young	CY	Planning Manger	SCCCG
	Keith Petty	KP	Finance Business Partner	SCC
	Ed Grimshaw	EG	Democratic Support Officer	SCC
	Chris Pelletier	CP	Associate Director	SCCCG / SCC
	Matthew Waters	MW	Senior Commissioning Manager	SCC
	Emily Chapman (minutes)	EC	Business Manager	SCCCG
Apologies:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	James Rimmer	JR	Chief Financial Officer	SCCCG
	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Jo Knight	JK	Service Lead – Finance Business Partnering	SCC

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted. It was noted that Stephanie Ramsey would represent Dr Mark Kelsey to ensure the meeting was quorate.	

2.	**Declarations of Interest**	
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship No declarations were made above those already on the Conflict of Interest register.	
3.	**Previous Minutes/Matters Arising & Action Tracker**	
	The minutes from the previous meeting dated 13th December 2018 were agreed as an accurate reflection of the meeting. **Matters Arising** None raised. **Action Tracker** The outstanding actions were reviewed and the action tracker updated.	
4.	**Market Position Statement – Older People 2019-2022**	
	The Committee received the Market Position Statement (MPS) for Older People 2019 -2022. MW outlined the highlights of the papers. Cllr Shields asked how we can communicate with stakeholders on how this position statement will be used, and how it impacts service users etc. MW responded that this will be a live document which outlines the direction of travel for the Local Authority and the CCG. The next step is to circulate this statement within the market; the intention is to segment the market to target the relevant sections to the relevant recipient. MS queried the communications plan for this statement, and also how we encourage national larger providers to Southampton. MW responded there is a communications plan in place. The key is to ensure it is not limited to our current providers. Work is taking place to send it to providers we don't currently commission with both in, and outside of Hampshire. MS also queried if the Local Authority can offer money or space as an incentive to get providers to the city. MW responded we need to understand the appetite within the market to expand within Southampton, and then those details would be developed. RC queried if we review other Market Position Statements outside of the Southampton system. MW responded we do review MPS in other areas which helped inform and develop this MPS. Southampton City is open to new ideas and ways to develop. Cllr Hammond raised the MPS is important as it provides transparency, with the potential for innovation.	

	Cllr Fielker agreed that the document was clear and easy to read and passed on her thanks to the team who produced the MPS. Cllr Fielker: - Approved the content of the document - Agreed the publication of the document MS/CP left the meeting.	
5.	**5 Year Health and Care Strategy – Transforming Health and Care for the people of Southampton**	
	CY presented the 5 Year Health and Care Strategy to the Board. It was noted that the Strategy is still in draft format. Communication has gone out to key stakeholders and partners within the city to request endorsement of the strategy, and for it to be taken through the appropriate governance routes for approval. The suggestion is that the Better Care Steering Board (BCSB) will be the vehicle to manage the implementation and achievement of the outcomes 5 Year Health and Care Strategy. DS noted that this document has been produced in conjunction with many stakeholders across the system. RC raised it is important to ensure this Strategy links with the Integrated Commissioning Unit (ICU) Business Plan to avoid duplication. It should also have clear outcomes. CY responded that this will be built upon in the next phase when developing the 5 year detailed plans. Cllr Hammond raised it is important to include the reasons as to why the top areas for mortality rates are as they are. Cllr Fielker raised it is important to see where we benchmark nationally to focus on where we are an outlier. Joint Commissioning Board endorsed the current draft of the five year strategic plan. CY left the meeting.	
6.	**Integrated Commissioning Unit Business Plan**	
	The Board received the Integrated Commissioning Unit (ICU) Business Plan; SR outlined the highlights of the plan. It was noted it is important to celebrate the achievements and to consider how these are communicated to local councillors. DS queried if we need to take a summary of achievements and ambitions to full Council. This will be explored.	

	The Board approved the Integrated Commissioning Unit Business Plan. The Board noted the key measures of success and agreed that these will be used to report effectiveness of the plan.	
7.	**Better Care Governance**	
	The Board received the Better Care Governance papers and SR outlined the highlights**.** The Board had a discussion on dying well and the importance of this within the Strategy. Lots of work is taking place on the dying well work stream. Cllr Shields raised ensuring local councillors in communities are promoting the work undertaken within the Better Care system. The Joint Commissioning Board approved the proposed governance model for Better Care Southampton.	
8.	**Joint Commissioning Board Terms of Reference**	
	The Board received the Joint Commissioning Board (JCB) Terms of Reference (ToR) which have been updated in line with their annual review date. BW talked the Board through the main changes as follows: - General tidy up - Expanded on the scope of the meeting - Added delegated limits for CCG as £500k - Addition that JCB will receive the Better Care Steering Board minutes The delegated limits for SCC will be confirmed post this meeting. The Board agreed the following amendment: - Ensure it is clear, from a Local Authority perspective, on who can be a decision maker in exceptional circumstances With the agreed amendment, the Board approved the Joint Commissioning Board Terms of Reference.	
9.	**Next Meeting Date**	
	17th October 2019, 09:30 – 11:30, Conference Room, NHS Southampton HQ, Oakley Road, Millbrook, SO16 4GX	

Agenda Item 3

Appendix 1

Joint Commisioning Board - Action Tracker (Public)					
Date of meeting	**Subject**	**Action**	**Lead**	**Deadline**	**Progress**
No outstanding actions					

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DECISION-MAKER:		CABINET MEMBER FOR ADULT SOCIAL CARE FOLLOWING CONSULTATION WITH THE JOINT COMMISSIONING BOARD		
SUBJECT:		**DIRECT PAYMENT SUPPORT SERVICE**		
DATE OF DECISION:		**17 OCTOBER 2019**		
REPORT OF:		**CABINET MEMBER FOR ADULT CARE**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Sandra Jerrim	Tel:	023 80296039
	E-mail:	S.Jerrim@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	023 80296941
	E-mail:	Stephanie.Ramsey@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

A joint task force (JTF) was set up in October 2018 to support Southampton City Council (SCC) to look at ways of improving the delivery and take up of direct payments (DP) in Southampton by those accessing Adult Social care, and subsequently make recommendations to SCC Director of Adult Social Care (Paul Juan) and Director Integration and Quality (Stephanie Ramsey). The report and recommendations are attached as Appendix 1

The recommendations have been considered by the SCC Director of Adult Social Care and Director Integration and Quality who support the recommendation to carry out procurement for a Direct Payment Support service. This will provide the core service around a number of other developments being taken forward by the SCC Director of Adult Social Care and Director Integration and Quality covering

- Improved Advice, Information and Guidance
- Training to the SCC workforce
- Access to support planning and brokerage services
- Access to Personal Assistants

This paper focuses on the procurement of the Direct Payment Support Service

RECOMMENDATIONS:

	(i)	That the board note the recommendation from the Joint task Force to carry out a procurement of a Direct Payment Support Service.
	(ii)	The Leader of the Council delegates authority to the Director of Quality & Integration, following consultation with the Leader and Cabinet Member for Adult Social Care to decide on the final model of a commissioned Direct Payment Support service.
	(iii)	The Leader of the Council delegates authority to the Director of Quality & Integration following consultation with the Service Director Legal & Governance to carry out a procurement process for the provision of a Direct Payment Support service and to enter into contracts in accordance with the Contract Procedure Rules.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The current Direct Payment Support service contract ends in March 2020
2.	The proposed service responds to the recommendations of the JTF and will contribute to a wider range of key services designed to support the offer of direct payments in Southampton.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
3.	An exemption to the current contract has been considered but would not meet the needs of the customer or services. Nor would it support the wider range of key services that are being developed to support the offer of direct payments in Southampton.
4.	Do nothing was considered, which would result in the current service being decommissioned. This was rejected as it is contrary to the personalisation approaches being pursued by SCC.
DETAIL (Including consultation carried out)	
5.	A joint task force (JTF) was set up in October 2018 to support Southampton City Council (SCC) to look at ways of improving the delivery and take up of direct payments (DP) in Southampton by those accessing Adult Social care.
6.	Since commencing the JTF has gone on to engage representatives from Children services (CS) and Continuing Health Care (CHS) in some areas of the discussions and have been reflected in the relevant recommendations
7.	The JTF involved people with lived experience and representatives from local services including Spectrum, Carers in Southampton (CiS), Community Independence Service (CIS), Solent Mind, Citizen Advice Bureau, Adult Social Care (ASC), Mencap and commissioners from the Integrated Commissioning Unit (ICU). A representative from Children Services joined the JTF from March 2019**.**
8.	The JTF met from October 2018 and considered approaches and learning from other areas, the experience of people in receipt of direct payments as well as the knowledge and experience of those working in the local health and social care system. The group also considered different ways the services could be secured whether commissioned or spot purchased as block contracts or part of a person's package of care. The report is attached as Appendix 1.
9.	The JTF recommends procurement of a Direct Payment Support Service which will be a core Service that will carry out a number of functions. The Direct Payment Support service will - Host and facilitate a new Support Planning and Brokerage (SPB) online platform (secured via SCC) - Host and facilitate a new Personal Assistant (PA) online platform (secured via SCC) - Provide some face to face to support for those needing some assistance to access the online systems - Help with PA employment issues. - Help with some DP issues
10.	This service will • provide support to an estimated 100 individuals with PA employment support per annum

<table>
<tr><td></td><td>

- provide support to an estimated 180 individuals, who are unable to do it themselves, to access the PA /SPB online system per annum

Identify and recruit a minimum 100 PA's and 50 employers onto the systems within the first year of operation, and go on to maintain or grow this number over the life of the contract in response to local demand.
</td></tr>
<tr><td>11.</td><td>The recommendations have been considered and the SCC Director of Adult Social Care and Director Integration and Quality both support the procurement of a new Direct Payment Service for a period of 4 (years (3+1)</td></tr>
<tr><td colspan="2">RESOURCE IMPLICATIONS</td></tr>
<tr><td colspan="2"><u>Capital/Revenue</u></td></tr>
<tr><td>12.</td><td>Expenditure on the current service is £76,500 per annum against an available budget of £97,500. The available budget will increase from April 1st 2020 to £128,000, with the full amount being available for the new service. The total amount over the 4 years will be £512,000
<table>
<tr><td></td><td>Current (2019/20)</td><td>Future (2020 onwards)</td></tr>
<tr><td>Current expenditure on direct payment support service</td><td>£76,500</td><td>£128,000</td></tr>
<tr><td>Direct payment allocated budget</td><td>£97,500</td><td>£128,000</td></tr>
</table>
</td></tr>
<tr><td colspan="2"><u>Property/Other</u></td></tr>
<tr><td>13.</td><td>None</td></tr>
<tr><td colspan="2">LEGAL IMPLICATIONS</td></tr>
<tr><td colspan="2"><u>Statutory power to undertake proposals in the report</u>:</td></tr>
<tr><td>14.</td><td>The proposals will meet social care functions under the Care Act 2014, in particular promoting people's wellbeing, by supporting people to maintain their independence by providing people with more choice about the care they wish to receive through a personal budget, including direct payments of their personal budget. This method of commissioning is authorised by virtue of s.1 Localism Act 2011.</td></tr>
<tr><td colspan="2"><u>Other Legal Implications</u>:</td></tr>
<tr><td>15.</td><td>Procurement will be carried out in accordance with the Council's Contract Procedure Rules and Financial procedure Rules and having regard to the Equality Act 2010 and the Human Rights Act 1998 in considering the impact of commissioned services on end service users.</td></tr>
<tr><td colspan="2">CONFLICT OF INTEREST IMPLICATIOINS</td></tr>
<tr><td>16.</td><td>None</td></tr>
<tr><td colspan="2">RISK MANAGEMENT IMPLICATIONS</td></tr>
<tr><td>17.</td><td>The main risks associated with this decision are

1. Reputational risk if
- The work of the JTF is not adequately considered and supported</td></tr>
</table>

	- The procurement of a Direct Payment Support service is not met with a commensurate growth in the number of people seeking to take up a direct payment. Management of this risk will be achieved through the wider service developments set out in the report and supported by the Director of Adult Social Care and Director Integration and Quality 2. Contract performance if - The provider lacks the ability to recruit sufficient numbers of people to the PA and SPB online systems. Management of this risk will be through regular and timely contract monitoring. - A lack of providers tender for the service. The risk is being mitigated by an increase in revenue and a longer contract, increasing to 5 years, with the option of further extension of 2 years. 3. The loss of established provider and impact this may have on local communities. Management of this risk will be achieved by a fair, but simple procurement process that encourages the participation of community and voluntary sector providers
POLICY FRAMEWORK IMPLICATIONS	
18.	Southampton City Strategy (2015- 2025) is a partnership strategy which sets out the vision for the whole city: 'Southampton a city of opportunity where everyone thrives' The Southampton City Council Strategy (2016-2020): People in Southampton live safe, healthy, independent lives.

KEY DECISION?	**Yes**
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION

Appendices	
1.	Direct Payments – Joint Task Force Report and Recommendations.

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.	**Yes**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**Yes**
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.		
2.		

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Direct Payments – Joint Task Force Report and Recommendations

Introduction

A joint task force (JTF) was set up in October 2018 to support Southampton City Council (SCC) to look at ways of improving the delivery and take up of direct payments (DP) in Southampton by those accessing Adult Social care, and subsequently make recommendations to SCC Director of Adult Social Care (Paul Juan) and Director Integration and Quality (Stephanie Ramsey).

The JTF was set to run for a period of 6 months (Oct 2018 to March 2019) however, the JTF has been extended to July 2019 to enable the work to be completed.

The JTF membership agreed at the start of the process to focus on 4 key areas

- Developing a Personal Assistant finder service/system
- Developing Support Planning and Brokerage approaches or service
- Reviewing the approach to advice, Information and Guidance (AIG) and
- Training to the SCC workforce.

This report pulls together the work of the JTF and puts forward recommendations for SCC senior managers about the way DP support services should be designed and delivered in the future.

Since commencing the JTF has gone on to engage representatives from Children services (CS) and Continuing Health Care (CHS) in some areas of the discussions. The recommendations note where there is scope now or in the future, to design and develop services to support people who are accessing either CS or CHC.

The Joint Task Force

Membership

The JTF involved people with lived experience and representatives from local services including Spectrum, Carers in Southampton (CiS), Community Independence Service (CIS), Solent Mind, Citizen Advice Bureau, Adult Social Care (ASC), Mencap and commissioners from the Integrated Commissioning Unit (ICU). A representative from CS joined the JTF from March 2019.

Methodology

The work of the JTF was to jointly explore and inform the design and delivery of four core service areas (listed above) which were identified as necessary to support the delivery of direct payments to more people in Southampton.

The group considered approaches and learning from other areas, the experience of people in receipt of direct payments as well as the knowledge and experience of those working in the local health and social care system. The group also considered different ways the services could be secured whether commissioned or spot purchased as block contracts or part of a person's package of care.

The group has met regularly throughout this time and at several of the meetings, explored some of the service areas in greater detail.

Areas of focus

The following outlines the four areas examined and the resulting recommendations for each of the service areas.

Advice, Information and Guidance

AIG has often been central to contracted DP support services, providing information to those seeking a DP. AIG has also been available through ASC and online information services and is recognised as a principle gateway for individuals who may be eligible to receive Direct Payments in Southampton. However, there remains uncertainty and caution for many potential DP users around taking up a DP.

To better understand and find potential ways to maximise the opportunities to inform individuals about DPs, the Southampton AIG services (Citizens Advice Southampton, Age UK Southampton, No Limits, CLEAR & EU Welcome project, Rose Road Association, the Environment Centre and SARC) was asked to carry out a piece of work by the commissioning lead.

This work will report in October 2019, beyond the life of the JTF. However, the approach and scope were discussed and supported by the JTF and findings will be used to inform future commissioning intentions. Where possible, members of the JTF will be asked to consider the findings and proposals that arise from this work.

The work seeks to develop a stronger understanding of and potential opportunities to share the principles of Direct Payments (choice and control) across the Advice in Southampton workforce for the benefit of clients.

The work involves working with service users, advisers and caseworkers to understand the barriers and issues for clients and carers in accessing Direct Payments and from this develop and deliver a package of training that can be delivered face to face or disseminated on-line to inform and support front-line staff. The learning will be considered and used to inform future commissioning intentions.

Southampton City Council, like other Local Authorities are actively promoting and pursuing a greater use of a primarily on-line or leaflet based approach to the provision of advice, information and guidance. Whether directly related or not, it is clear the current provision of information has not led to any increase in take-up. This should be taken into account in the work by Southampton AIG services and in any future commissioning plans. In discussion at the JTF meetings it was noted that Information on its own can be of limited value without additional support to help people use the information to apply to their own situations and make informed choices. Support, where possible should include peers who use DPs themselves, helping people see the benefits and share the passion of DPs.

1. AIG Recommendations

a) The learning from the AIG project is shared with the JTF members, representative from CHC and children service and both the learning and feedback are used to inform future commissioning intentions
b) To incorporate additional support into AIG and DP contracts to help people make informed choices and where possible this should be through peers who use a DP themselves.

Training

The training of the ASC workforce is recognised as a critical component to support the increased take up and use of DPs**.** When looking at training for the ASC workforce the JTF considered whether the

training could continue to be provided by the Learning and Development (L&D) team, or sourced externally through some form of commissioning approach.

Given the access to staff and costs to commission a separate service, the group supported a proposal for training to continue to be delivered by the L&D team. However, they recommend that the design and delivery of any training is coproduced with people already using DPs. If this doesn't happen the passion for what DPs can do is lost. This approach could also improve the outlook from staff who will be motivated by the positive messages and see it is more than just a mechanical transfer of cash.

The group also proposed users and those with lived experience attend service settings to advocate for change and in doing so, work beyond the ASC workforce.

It is felt important that this training is developed and delivered using co-production principles (There being a difference between co-production and participation: participation means being consulted while co-production means being equal partners and co-creators.)

Co-production should be broken down into the following:

- co-design, including planning of training
- co-delivery, including the role of service users in providing the training
- co-evaluation of the training

This approach should attract funding to enable those with lived experience (or those working closely with them) to be remunerated for their time. The emphasis and focus should prioritise engaging those with lived experiences.

2. <u>Training Recommendations</u>

a) The design and delivery of training to be co-produced with those with lived experience (or those working closely with them) and
b) A budget is made available to fund those with lived experience to be engaged in this approach.

Support Planning and Brokerage

At the start of the JTF review of DP support, the group considered the relationship between the assessment, the support planning and the finding of services to meet the identified needs, often referred to as Brokerage. The group reflected on a strong theme within personalisation supporting the individual to be an active, if not lead participant in developing their support plan and through this actively identifying the services that would best meet their needs. To this end, the design of the services presented here **separates out the functions of assessment from support planning and brokerage**.

Both the skills and capacity of those putting together support plans is critical to the uptake of DPs. Staff targeted at this point in the process have the opportunity to explain the pro's and con's of taking a DP, work through the challenges and make best use of the money available. Evidence from national bodies (TLAP/ILSG) shows how this delivers more users onto DPs.

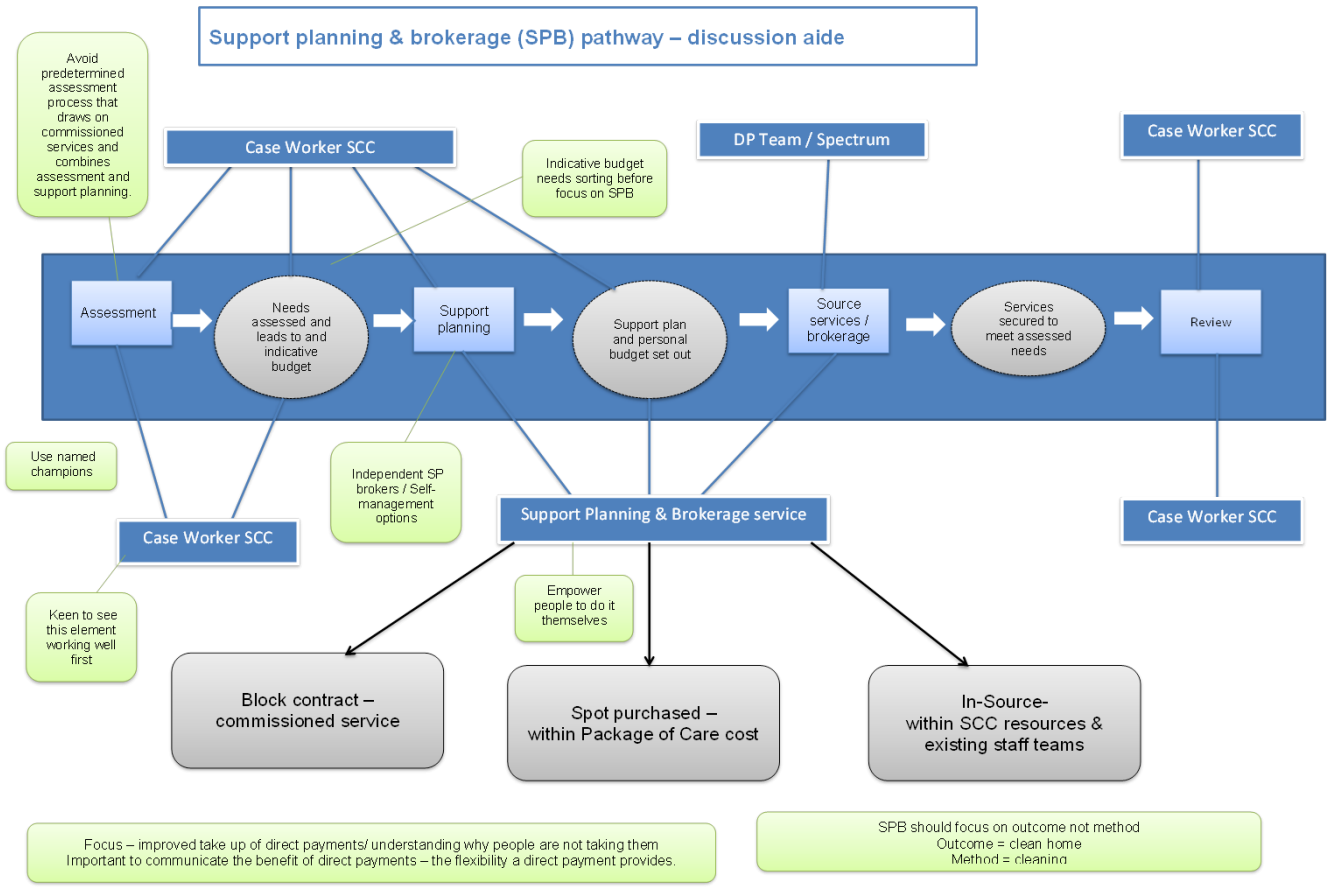


Diagram 1

The design and recommendations from the JTF builds from this perspective and have, through the JTF discussions, identified this approach as an opportunity to present the range of personal budgets available to an individual; direct payment, third party, managed budget or a mix of these options, from which the individual can have greater choice about the most appropriate way to receive their personal budget.

The proposed and agreed approach within the JTF enables individuals to have greater choice in who they work with to develop their support plan and explore the range of services they might access to meet their needs. Not everyone will select to have a direct payment, but evidence suggests more people will opt for this approach.

There are other potential benefits from the SPB approach, notably

- More individuals access community based services to meet both their eligible and non-eligible needs
- Individuals have greater choice and control from the outset through greater involvement in the SPB process.
- The SPB service will afford more capacity within ASC and early estimates suggest at a lower cost.

Delivery model

A Support Planning & Brokerage (SPB) approach will help and support an individual to plan how their needs will be met using the personal budget, and where necessary, assist them in sourcing and securing the services of agencies or individuals. This is currently undertaken by ASC staff, but is considered to be

an overly automated approach where the default option of commissioned services are secured, rather than the more optimum strength based user led approach is used. The proposed and agreed approach within the JTF is seen as a way to enable individuals to have greater choice in who they work with to develop both their support plan and explore the range of services they might access to meet their needs.

When considering the SPB approach a number of delivery models were considered and came under three different approaches, with variations within two of them.

1. A SPB team, secured internally in SCC or commissioned externally as a block contract
2. A SPB system, that provides access to a range of SPB staff, drawn from one or more settings/agencies, purchased against an agreed price model with funding contained within an individual's Package of Care costs.
3. A SPB service offered by ASC staff, referred to as an In House model.

The second of these options (No.2) , the SPB System, has been drawn from an approach developed in Buckinghamshire but shaped through the discussions at the JTF meetings. This approach provides an additional amount alongside the client's package of care (POC) cost. The amount varies according to the level of need and/or complexity of the clients circumstances. The system, which is an online system, will benefit from oversight from the Core service which will have responsibility for overseeing and developing the SPB service, including the recruitment and training of staff onto the system. Support planners/ brokers are not employed by the Local Authority or supporting agency. This approach is similar to the way a PA system works, where individuals who seek to undertake support planning and brokerage advertise on the SPB system.

There is strong support from the membership of the JTF for a human facilitation element of both the PA and SPB services. This would support those with no access online and those who are daunted by online systems. It is anticipated this would be provided through a Core service outlined later in this paper.

The delivery of SPB through an internal, SCC based team (No. 3) was considered. An in-house service could provide the support planning and brokerage service through either a dedicated support planning and brokerage team, or through existing staff working with clients. For a range of reasons, neither approach has worked to date. Capacity of staff to carry out good support planning has led to easier, more simplistic routes being used (e.g. contracted services) and separate teams have found referrals have been those individuals with complex circumstances that are difficult to resolve. **There was no support within the JTF for an internally developed SPB team or service.**

The JTF members support the provision of an SPB service however; there were mixed views on which of the two externally provided delivery mechanism would be best applied in Southampton; a commissioned block contract (No.1) or a SPB system (No.2) paid through an individual's Package of Care costs.

When opting for a community based service it was noted that the benefits and lower rates of bulk purchasing through commissioned services may be lost.

Arguably, these need not be mutually exclusive, with a block contract containing the same pricing model as a SPB system. However, this would require a shift of funding from ASC to the commissioned service and seek to ensure the demand matches the value and volume of the service commissioned, something that has presented as a long standing challenge in Southampton for previous DP services.

The SPB system (No. 2) would allow greater flexibility depending on the number of people identified in the target groups, but would be at risk if the economies of scale (numbers seeking SPB support and number of SPB staff) were not sufficient, as known to occur with the development of some PA finder models.

These issues have been explored by members of the JTF and the SPB system (No 2) is the supported option and reflected in the recommendations.

Target audiences

The initial approach considered the SPB model being available to only those taking a DP. However, on closer examination the SPB approach was likely to be a key determinant in whether an individual took a DP or not. Therefore the recommendation is for all ASC clients to be provided with access to separate SPB support.

In making this recommendation, it is recognised this approach would benefit from further testing and development, so the recommendations includes an approach that is incremental and dynamic, building on the learning from experience. A small SPB pilot has been set up with two agencies, so not a fully functioning web based service (in the absence on an online system and low referral numbers). This will provide some early learning and help inform the approach to be taken; incremental or across all of ASC.

Where the approach is incremental, it should not be targeted to one client group (e.g. just older persons), but across all client groups, engaging small numbers in each client group, in particular mental health who have not been actively engaged in options to take a DP previously, to ensure learning and development is dynamic and prepares for a wider roll out at a later date. A preference has been expressed by several members of the JTF for the roll out to be to everyone rather than incremental.

The pilot should also consider the inclusion of some existing ASC clients at the point of a review as well as a range of clients new to ASC. This will help explore the opportunities and potential challenges across a range of settings.

The JTF have expressed a desire to see this approach made available across all of ASC from the outset but appreciates the benefits a pilot offers. Where services are targeted the ASC operational lead and commissioning leads have proposed the following groups

- Those new to ASC with no experience of ASC
- Some or all reviews, in particular those who are unhappy with their current service offer.
- Groups identified through analysis of current DP clients

Targeting those new to ASC provides an opportunity to proactively draw on a strengths based approach and encourage greater use of community based services and provides an opportunity to support the client to take up a direct payment.

Targeting those clients who are due for reviews provides an opportunity to remind clients of their personal budget and the different ways they may wish to receive it. Targeting reviews may also help with any ongoing delays in reviews being carried out and has the potential to draw on more community based services.

The analysis of those in receipt of DPs (see Appendix A) highlights there are particular client groups more likely to access a DP, but also show age is not a barrier. Those with a POC under £400 are also more likely to take a DP than those with higher cost packages of care.

Releasing ASC capacity

One of the potential benefits of the SPB approach is the impact it is likely to have across ASC teams, reducing demand on their time, while improving the customer experience. This will not reduce the time needed to carry out assessments but will increase time for developing and implementing the support plan in a way that is both strength based and community centred. With ASC staff focusing on the assessment of need and identifying the indicative budget, potentially including reviews, the more strength based approach of designing the support plan against and indicative budget and informed by local knowledge is anticipated to see improved outcomes, increased take up of DP as well as reduced pressures on the ASC teams.

This will need to be monitored during the first 1 - 2 years of the new approach being implemented, allowing time for the changes to embed, the SPB workforce to be developed and the confidence in expanding the strength based approach to be fully realised.

SPB pro's and Cons of community located SPB model vs ASC completing SPB

SPB community located		**SPB ASC located**	
Pro	**Con**	**Pro**	**Con**
• Lived experience • Peer support available • Reach into community options • Coverage of eligible and non-eligible needs • Stronger cost management thorough pricing model. • Clear commitment of time to SPB • Increased engagement of clients in planning their support and choosing services • Supported by JTF	• Requires two touch points (assessment and SPB) • Requires volume of SPBs to make if viable • Online system may be a deterrent to some clients • Time to set up PA compared to using a commissioned service.	• One person carries out assessment, support planning and secure services • Not reliant on volume for service to be offered/viable • Offers a face to face service.	• Fewer links to wider community needs • Less likely to consider and address non-eligible needs • Limited access to people with lived experience • Less control over costs and time per client (to little/too much) • Services are often default commissioned services • Clients are not as engaged in planning their own support & services • Not supported by the JTF • Time to set up PA compared to using a commissioned service.

Table 1

The table above captures points raised in the JTF discussions about the different approaches and helps to illustrate why a community based SPB system was the preferred option.

SPB approach and Care Placement Service

The SPB approach provides an alternative to the service offered through Care Placement Service (CPS). Consideration will need to be given to the impact on the CPS as the SPB offer is developed, in particular the impact of multiple relationships with different SPB staff, especially if there are a lot of independent support planner and brokers.

Should the number of clients taking a DP increase significantly then the demand for the CPS may reduce significantly as more people access services through a direct payment and not commissioned services, although arguable any increased take up of DP is likely to offset increased demand rather than reduce the capacity needed in the CPS.

Pathways between the SPB service and the Care Placement Service (CPS) will need to be developed to enable those who choose a managed service to have access to the existing support from CPS.

3. SPB Recommendations

a) For a period of no less than 2 years, secure a suitable online SPB system hosted and supported by a commissioned Core Service (See below), including attracting people to join the system as SPBs
b) For the online SPB system to enable individuals to purchase SPB using their direct payment, third party managed budget or personal funds (self-funder).
c) To use the period of 2 years to seek to adopt this model as the adopted way of working for adults and explore suitability for CHC and Children Services.

Personal Assistant system

There are three elements to developing an improved PA offer in Southampton

1. Developing the PA workforce
2. A PA online system where clients can search and source a PA and
3. Support to clients with any employment issues pertaining to a PA.

The development of a PA workforce will be an output of the a new PA online system supported by the Core Service, where support to clients with an employment issue would also be available (see Core Service below).

A separate report covering a range of PA systems was prepared for the JTF and available on request. The report examined 7 different sites, with recognition that two of the sites are used in more than one location. Of the 7 sites, one is local with no online presence; one is a national online system with no option for face to face support. All others are online with varying degrees of support available depending on the commissioning approach taken (i.e. some have 1 – 2 full time staff supporting the online system).

Members of the JTF visited the online sites and some have experience of using them in the past, either as users or providers offering a PA service. The two systems that came to the fore are the Hampshire Personal Assistants in CARE (HCC), which is also used by Buckinghamshire, or the PA Noticeboard (PCC) used in both Portsmouth and IOW, originating from Brighton.

Hampshire County Council are one year into developing their site and willing to include Southampton into their online system. HCC developments over the coming year include CHC and CS. Portsmouth are

reviewing their approach and currently considering the same option with HCC, although not confirmed. SCC has been in discussion with HCC about their wider Connected Support system, a potential replacement to the current Southampton Information Directory (SID).

The national online system, PA pool, will remain available to any resident in Southampton, regardless of local decisions, but not felt adequate to meet all local PA requirements.

Different approaches provide a varied pricing model, with some low cost, pay to access sites (price per day/week/month) looking considerably cheaper than the pay to secure and match a PA service (Independent Lives and Enham Trust). An online system supports a strength based approach and allows for self-funders to access the service as well as those in receipt of ASC, CS or CHC funds. Both the preferred online systems would require additional funding for support staff.

As with the SPB online system, there would need to be a human element to the offer to enable those with no access to online services, or those daunted by such systems to be supported to access them.

Any new system should learn from past experience in Southampton and as such should include

- Sufficient time for the engagement and recruitment of PAs and employers
- To respond to the urban nature of Southampton, it should seek to have a critical mass in the region of 100 PAs and 50 employers to be able to deliver an effective service and a realistic chance for PAs to find work as well as a realistic chance for employers to find good PAs.

The provision of services in Southampton should have a good understanding of the Southampton dynamics, potentially an existing local presence.

The payment for PA hours of support is currently funded through clients POC and would remain funded in this way. With improved take up of DPs it is expected there will be an increased use of PAs rather than commissioned services such as Home Care.

4. PA Recommendations

a) For a period of no less than 2 years, secure a suitable online PA system hosted and supported by a commissioned service, including attracting people to join the system as PAs
b) For the online PA system to enable individuals to secure the time of a PA using their direct payment, third party managed budget or personal funds (self funder)

A delivery approach for the future

Combining all the findings from the JTF, the following is the recommended delivery approach. If supported by Director of ASC, Director of Integration and Quality and agreed through the relevant governance forums in SCC, both Commissioning and ASC operational leads will implement the relevant changes.

Core Service

The approach includes a Core Service that will carry out a number of functions. This would be a commissioned service with a contract in place for the normal period of time (5 years) but linked to the findings from the SPB developments. The relationship between the Core Service and other support services is set out below. The Core service will need sufficient resources to employ enough staff to the number of people needing help to access the SPB and PA online systems as well as help with PA employment issues.

The proposed approach, set out in the diagram below provides

- A core commissioned service that will
    - Host and facilitate the SPB online platform (secured via SCC)
    - Host and facilitate the PA online platform (secured via SCC)
    - Provide some face to face to support for those needing some assistance (not available via SPBs) although those who lack capacity should receive support from a separate identified advocate.
    - Help with PA employment issues.
- An SPB system that allows individuals to view, select and secure the service of an SPB against the level of funding provided in their package of care.
- An SPB service, accessed through the SPB system will
    - Help individuals develop a support plan to meet their assessed needs against an indicative budget
    - Secure services to meet their assessed needs and through this, inform the final value of their personal budget (subject to approval processes)
    - Utilise a strength based approach alongside community assets and services to meet both eligible and non-eligible needs.
    - Explore with the support of the SPB person, the method of using their personal budget (direct payment, third party or managed budget)
    - Tracks review dates for clients accessing the SPB service and works with ASC (as well as CHC and CS where appropriate) to consider SPB approach for reviews where appropriate.
- A PA system that allows individuals to view, select and secure the services of PA's against the identified needs in their support plan.
    - For those using their personal budget
    - For those seeking these services using their own funds (self funder)

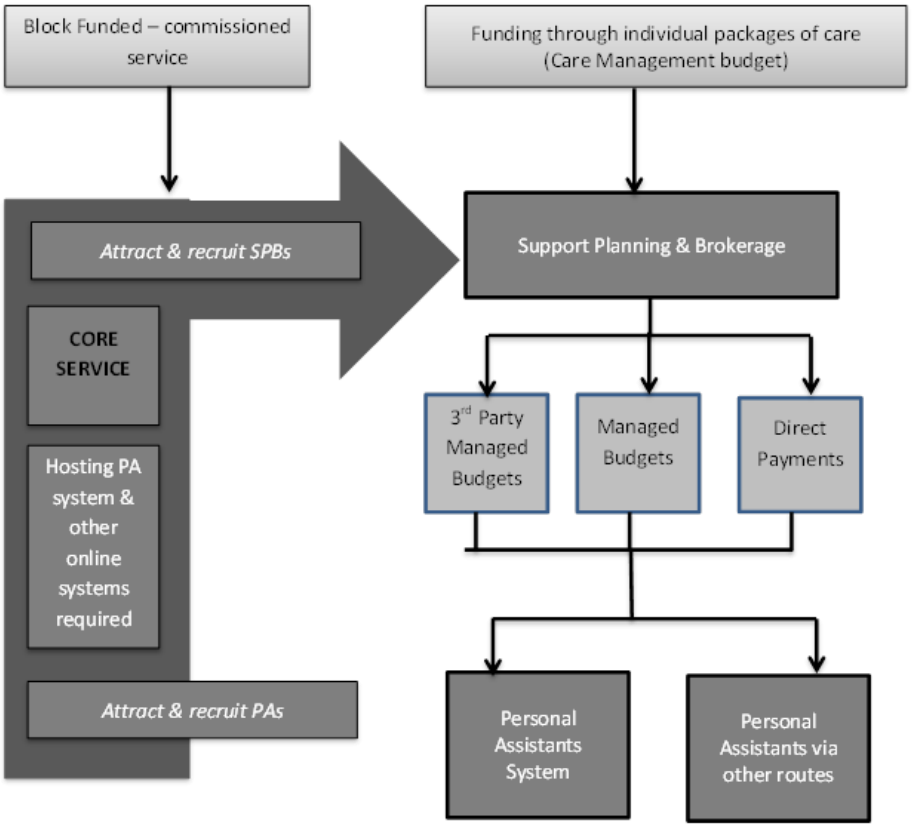


Diagram 2

The SPB online system will advertise individuals who are independent of any agency as well as staff working for agencies. It is envisaged the support planner and broker would be presented as a person in the first instance with reference to the following information easily and readily available

- Whether they are independent (self-employed) or working for an agency, with the agency named
- Whether they have lived experience of using a DP
- What areas of expertise they have experience of (e.g. mental health, physical disability)

Key attributes of all DP support services

The JTF identified a number of key attributes that need to feature in any services delivery model. This includes

- A workforce that has empathy and where possible draws on lived experience
- Works to a strength based approach
- Seeks to empower individuals and drive increased choice, control and levels of independence.
- To make the offer of direct payments a mandatory part of working approaches across all care groups.
- User involvement is sought and proactively pursued ideally through a local steering group involving service users from all areas of direct payments.
- People who have lived with direct payments are integral to a lot of the service delivery and development, giving authentic credence to the difference that a DP can make

Out of scope

The work of the JTF covered 4 key service areas that were identified as critical to helping support an increase take up of DPs. During the meetings there were many other issues raised about DPs but sat outside the remit of this work. This included

- Issues around client contribution
- Individual cases and the challenges they faced
- SCC communications and letters around DPs and changes
- The processes within SCC that enable the payment of a DP, often difficult to navigate when problems occur
- Difficulties with the All Pay approach.
- Absence of a DP offer to some areas of ASC, notably mental health clients.

Financial implications

The following table provides a summary of the funding information. More information is contained in the sections below.

Service area	Proposed funding source	Estimated cost per annum	Cost pressures	Additional information
AIG	ICU commissioning budget	£15,000	Yes, no identified budget.	Potential to build into existing contract or purchase separately
Training – developing the programme	SCC L&D resources	£3,000	Yes, no identified budget.,	To cover the cost of people with lived experience help design the training
Training – delivering the programme	SCC L&D resources	£3,200	Yes, no identified budget.	To cover the cost of people with lived experience providing training 2 people @ £400 per day for 4 days per annum (£800 per day)
SPB system	TBC	No information available	Yes, no identified budget.	To secure and develop an online SPB system

SPB services	Care Management budget (possibly Better Care Fund in 1st year)	£47,680 (£50,000)	Yes, no identified budget.	Costs estimated on 300 participants using SPB service, of which increased numbers will take a DP. Potential to release capacity within ASC staff teams
PA System	TBC	£10,000	Yes, no identified budget.	Annual cost to HCC
PA costs	Care Management budget	Variable	No	As set out in clients POC
PA employment support	ICU commissioning budget	N/A	No	Contained within Core service
Core service	ICU commissioning budget	£130,935	Yes, up to £36,000 over budget	Based on 3 WTE staff, 0.5 manager and other costs. Current ICU budget £95k.

Table 2

The cost pressure of implementing this service model is estimated to be around £127,200

A significant element of this is the SPB service (£50,000) which should be considered against the need to increase ASC capacity, which is likely to cost significantly more than the cost for the SPB service.

The table below summarises the estimated cost pressures

Service area	Estimated Cost pressure	Additional information
SPB service	£50,000	Supports capacity building in ASC workforce
Training costs (£6,200)	£6,200	
ICU shortfall (£35,000)	£36,000	
SPB online system (£10k)	£10,000	
PA Online System	£10,000	
Provision of AIG	£15,000	
Total	**£127,200**	

Detailed funding information

AIG

While any future plans need to wait for the AIG review to complete, it is envisaged any learning and feedback will be incorporated, where accepted, into current or new contracting arrangements. At this point the cost is unknown but it is expected that this area of work will need to be funded through the ICU commissioning budget and estimated at £15,000 based on comparable work/contracts.

Training

Existing resources deployed to the Learning and Development (L&D) team should be utilised to develop the Direct Payment training programme. Securing the services of those with lived experiences to help develop the DP training programme is estimated to be £3000, with an additional cost of £3,200 estimated to cover the cost of delivery.

There is a **risk** around the capacity of the SCC Learning and Development (L&D) team having sufficient time and resource to accommodate this training.

Support planning and brokerage

A three tiered cost model forms the basis of the SPB service. These figures have been checked by ASC and are representative of costs incurred through other comparable services.

Low	Up to 5 hours. Fixed fee £100	Simple planning for clients who know exactly what they want.
Medium	Up to 10 hours. Fixed fee £180	Default option
High	Up to 18 hours. Fixed fee £320	Communication issues result in additional time required for support planning.

Table 3

The proposed funding mechanism for the SPB approach would be through care management funding. However, as a pilot the cost of this service may attract funding from the Better Care Fund. When calculating the potential cost of the SPB service we have used the number of clients accessing a DP as guide. There were 308 clients accessing a DP at the time of the analysis so based our estimates on 300 clients using the SPB service. The table below shows the **weekly** POC costs against different client groups.

COST_CLASS	LEARNING DISABILITY SUPPORT	MEMORY & COGNITION SUPPORT	MENTAL HEALTH SUPPORT	PHY SUPPORT ACCESS & MOBILITY	PHYSICAL SUPPORT:PERSONAL CARE	SENSORY SUPPORT: VISUAL	SENSORY SUPPORT:DUAL	Grand Total
1) Under £ 100	13	1	4	3	28	6	1	56
2) £ 100-199	17		6	2	63	2		90
3) £ 200-299	13	3	4	3	47	2	1	73
4) £ 300-399	18	1	1	1	17	1		39
5) £ 400-499	6	1			6	1		14
6) £ 500-599	1		1		6			8
7) £ 600-999	8	1			14			23
8) £ 1000 +	2		1		2			5
Grand Total	78	7	17	9	183	12	2	308

Table 4

Using an average hourly cost for ASC staffing (£20 per hour) and assuming each of the cost categories align to one of the SPB levels (see table 5 below) there are potential efficiencies of over 7% available from the new SPB model; £47,680 compared to £51,480. These calculations can only be used as a guide.

Cost Category	SPB estimated band	Number (all client groups)	Cost per person	SPB estimated total cost	Avg hourly ASC cost	Hours	Cost per person	Variance SPB /ASC per person	ASC estimated total cost	Variance total cost SPB /ASC
1) Under £ 100	Low	56	£100	£5,600	£20	5	£100	£0	£5,600	£0
2) £ 100-199	Low	90	£100	£9,000	£20	5	£100	£0	£9,000	£0
3) £ 200-299	Medium	73	£180	£13,140	£20	10	£200	-£20	£14,600	-£1,460
4) £ 300-399	Medium	39	£180	£7,020	£20	10	£200	-£20	£7,800	-£780
5) £ 400-499	Medium	14	£180	£2,520	£20	10	£200	-£20	£2,800	-£280
6) £ 500-599	Medium	8	£180	£1,440	£20	10	£200	-£20	£1,600	-£160
7) £ 600-999	High	23	£320	£7,360	£20	18	£360	-£40	£8,280	-£920
8) £ 1000 +	High	5	£320	£1,600	£20	18	£360	-£40	£1,800	-£200
Totals		308	£1,560	£47,680					£51,480	-£3,800

Table 5: weekly cost categories

These costs would be in addition to any existing costs and do not propose a reduction in ASC staff. However, this approach would support and enable increased capacity within the ASC system in particular across assessment, support planning, sourcing services and reviews.

The final funding calculation was based on 300 clients accessing the new SPB service. It is unlikely there would be 300 new referrals in the first year, although not inconceivable if clients are referred from across ASC teams and includes some reviews.

The costs assign 50% (150) to the medium cost level (see groups 3,4,5,6, in table 5) and 25% to both low (groups 1 and 2) and high cost bands (groups 7 & 8). These calculations are based on assumptions and will be tested through a small SPB pilot.

A cost of £10,000 is the estimated cost to secure the SPB online system based on the cost of the PA system.

PA System

There are three elements to developing an improved PA offer in Southampton

4. the payment for PA hours of support
5. a PA online system where clients can search and source a PA and
6. Support to clients with any employment issues pertaining to a PA.

The payment for PA hours of support is currently funded through clients POC and would remain funded in this way. With improved take up of DPs it is expected there will be an increased use of PAs rather than commissioned services such as Home Care.

The PA online system would be funded through the ICU commissioning budget. This is expected to be an arrangement with Hampshire County Council and extend on any arrangements by ASC to secure their online service. HCC have indicated a cost in the region of £10,000 per annum.

Support for clients with any employment issues pertaining to a PA will be provided though the Core service. Costs for this service are included below.

Core Service

The cost to provide the Core service is based on 3 full time posts and other costs (to include management costs and overheads). The 3 posts would cover the following areas of work

- Recruitment of PA's and SPBs (1 WTE)
- Support to access PA and SPB system alongside management of systems (1WTE)
- Support with PA employment issues (1WTE)

The Core service would be commissioned. The value of the contract would be in the region of £130,000 drawing on the following calculation.

Estimate against existing staff costs (Spectrum)	
Core service costs	
Core service costs	
Staff (3 @ £28,500)	£85,500
0.5 management	£16,000
Other costs* @ 29%	£29,435
	£130,935

Table 6 * Other costs to include premises, travel, expenses, overheads etc.

This would provide capacity for the following

- one staff member to support an estimated 100 with PA employment support per annum

- one staff member to support 180 to access the PA /SPB system per annum
- one staff member to identify and recruit a minimum 100 PA's and 50 employers onto the system within the first year of operation.

5. Funding Recommendations

a) To allocate the necessary funding for the delivery of the proposed service model as set out in table 2
b) To note these costs are based on Adults and not inclusive of children or CHC clients.

Appendix A

The following information shows the number of DP clients in June 2019.

Sum of PEOPLE								
Cost Category	LEARNING DISABILITY SUPPORT	MEMORY & COGNITION SUPPORT	MENTAL HEALTH SUPPORT	PHY SUPPORT ACCESS & MOBILITY	PHYSICAL SUPPORT:PERSONAL CARE	SENSORY SUPPORT: VISUAL	SENSORY SUPPORT:DUAL	Grand Total
1) Under £ 100	13	1	4	3	28	6	1	56
2) £ 100-199	17		6	2	63	2		90
3) £ 200-299	13	3	4	3	47	2	1	73
4) £ 300-399	18	1	1	1	17	1		39
5) £ 400-499	6	1			6	1		14
6) £ 500-599	1		1		6			8
7) £ 600-999	8	1			14			23
8) £ 1000 +	2		1		2			5
Grand Total	78	7	17	9	183	12	2	308

Of the 308 DP clients 41% are aged 40 – 64 years, 31% aged 18-39 years and 28% aged over 65, so a fairly even spread across the age groups.

Age	Number	Percentage of all DP clients
18-39	97	31%
40-64	125	41%
65+	86	28%
	308	

In each of the age groups the majority receive POC in cost groups 1 – 4 (see table above), so accessing POC up to £399 per week.

Analysis of information shows

- Cost category 2 (£100 - £199) is the largest group = 90 people
- Cost category 3 (£200-£299) is the next largest group = 73
- Cost category 1 (under £100) is the third largest group = 56
- Cost category 4 (£300-£399) is the fourth largest group =29

  Targeting groups 1 – 4 would yield the greatest volume

- Cost category 7 (£600-£999) is the highest volume where there is a higher personal budget
- Cost category 8 shows there are only 5 customers on direct payments with personal budget over £1000.

Age groups

- In the 18-39 age group, the total number of customers using direct payments is 97.
- In the 40-64 age group, total number of people using DP is 125.
- In the 65 plus group, total number of people using DP is 86.
- In each of these age categories the largest volume of personal budgets categories are 1-4 .
- In the 18-39 age group the largest group is the LD group using DPs.
- In the 40-64 age group and the 65 plus group the largest group of is those with physical support: personal care needs.

56 of the 308 customers who receive a direct payment have a DP as part of a mixed budget and other care and support services provided, of which 48 people are in Category 1 -4 of personal budget allocation amounts. Two within category 7.

AGE_GROUP	18-39

Sum of PEOPLE							
COST_CLASS	LEARNING DISABILITY SUPPORT	MENTAL HEALTH SUPPORT	PHY SUPPORT ACCESS & MOBILITY	PHYSICAL SUPPORT: PERSONAL CARE	SENSORY SUPPORT: VISUAL	SENSORY SUPPORT: DUAL	Grand Total
1) Under £ 100	12	1	1	3		1	18
2) £ 100-199	11	1	1	4			17
3) £ 200-299	10	1	1	8	2		22
4) £ 300-399	12	1		1	1		15
5) £ 400-499	5			4			9
6) £ 500-599	1						1
7) £ 600-999	8			5			13
8) £ 1000 +	1			1			2
Grand Total	60	4	3	26	3	1	97

AGE_GROUP	40-64

Sum of PEOPLE								
COST_CLASS	LEARNING DISABILITY SUPPORT	MEMORY & COGNITION SUPPORT	MENTAL HEALTH SUPPORT	PHY SUPPORT ACCESS & MOBILITY	PHYSICAL SUPPORT: PERSONAL CARE	SENSORY SUPPORT: VISUAL	SENSORY SUPPORT: DUAL	Grand Total
1) Under £ 100	1		2	1	15	3		22
2) £ 100-199	6		3	1	32	2		44
3) £ 200-299	3	1	3	1	25		1	34
4) £ 300-399	2				8			10
5) £ 400-499	1				1	1		3
6) £ 500-599			1		3			4
7) £ 600-999					5			5
8) £ 1000 +	1		1		1			3
Grand Total	14	1	10	3	90	6	1	125

AGE_GROUP	65 +

Sum of PEOPLE							
COST_CLASS	LEARNING DISABILITY SUPPORT	MEMORY & COGNITION SUPPORT	MENTAL HEALTH SUPPORT	PHY SUPPORT ACCESS & MOBILITY	PHYSICAL SUPPORT: PERSONAL CARE	SENSORY SUPPORT: VISUAL	Grand Total
1) Under £ 100		1	1	1	10	3	16
2) £ 100-199			2		27		29
3) £ 200-299		2		1	14		17
4) £ 300-399	4	1		1	8		14
5) £ 400-499		1			1		2
6) £ 500-599					3		3
7) £ 600-999		1			4		5
Grand Total	4	6	3	3	67	3	86

DECISION-MAKER:		**CABINET MEMBER FOR ADULT SOCIAL CARE FOLLOWING CONSULTATION WITH THE JOINT COMMISSIONING BOARD**		
SUBJECT:		**PROPOSAL FOR THE MAINSTREAMING OF HOSPITAL DISCHARGE PATHWAY 3 FOR PATIENTS/CLIENTS WITH COMPLEX NEEDS.**		
DATE OF DECISION:		**17 OCTOBER 2019**		
REPORT OF:		**DIRECTOR OF QUALITY AND INTEGRATION**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Jamie Schofield**	**Tel:**	**023 80296004**
	E-mail:	**Jamie.schofield1@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 seeks approval to proceed with a proposal to mainstream hospital discharge Pathway 3 for patients/clients with complex needs. This follows a substantial pilot period and a further subsequent redevelopment of the model based on the learning from the pilot which was outlined in a report presented to the Joint Commissioning Board (JCB) in February 2019. See Appendix 1 for brief summary of the pilot.

RECOMMENDATIONS:

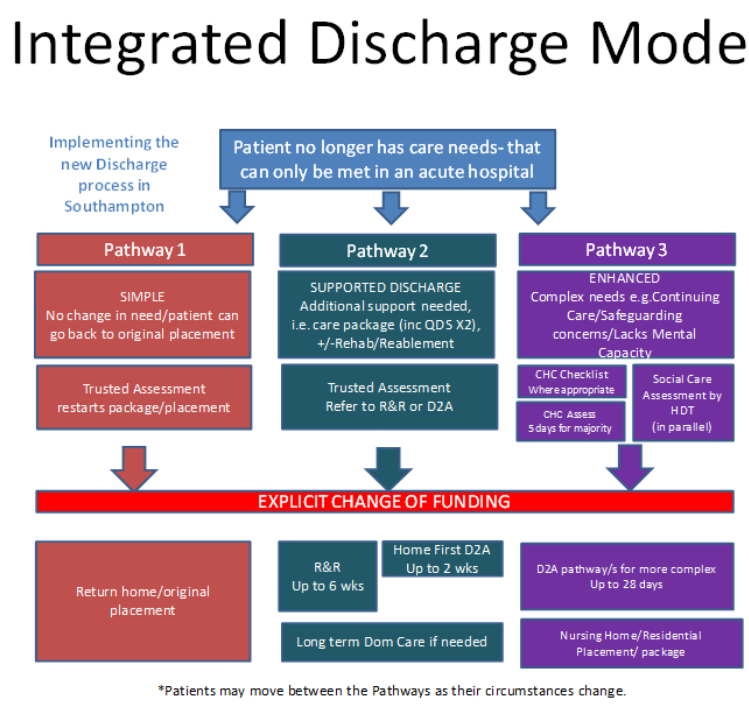
	(i)	To give approval to proceed with the preferred future Pathway 3 Discharge to Assess option for potential Continuing Health Care (CHC) patients/clients and those with complex social care needs leaving hospital who require a period of assessment.
	(ii)	To approve establishment of a pooled fund under S75 partnership arrangements of the Health Act with contributions of £229,183 per annum from Southampton City Council and £421,041 per annum from Southampton City Clinical Commissioning Group to fund the assessment placements required for the operation of the Discharge to Assess scheme.

REASONS FOR REPORT RECOMMENDATIONS

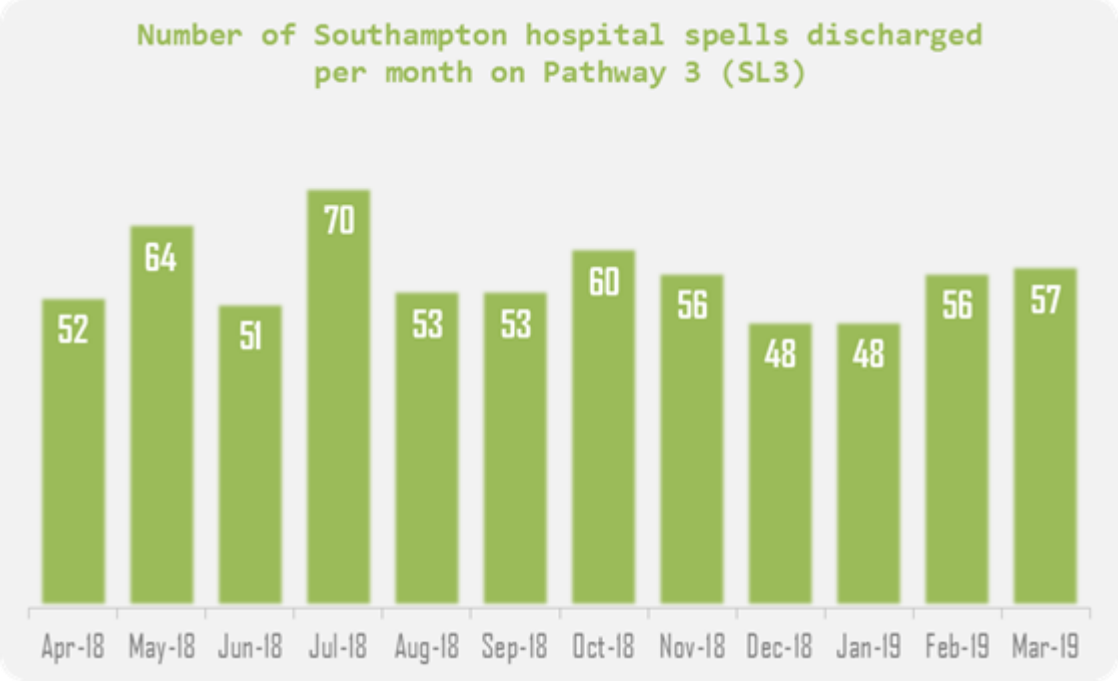
1.	The consistent delivery of safe, appropriate and timely discharge from the acute hospital setting continues to challenge the majority of health and social care systems, particularly where the needs involved are complex.
2.	This report concerns the mainstreaming of Discharge to Assess (D2A) as a core part of Pathway 3 for those complex patients/clients requiring a period of assessment, following the original Discharge to Assess (D2A) pilot which commenced in November 2017 and subsequent amendments to the pilot to

	respond to the learning. 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 Local Government Association (LGA), Department of Health (DH), Monitor, NHS England and Association of Directors of Adult Social Services (ADASS) in 2015. Southampton has a significant challenge to achieve the nationally set target for reducing DTOC and is currently under national scrutiny for having one of the highest rates in the country. Ceasing this approach that the pilot has evidenced as being effective, could negatively impact DToC further. Assessment of long term health and social care needs outside of the acute setting is better for our population and the health and care 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	
4.	In the report presented to JCB in February 2019, five options were considered in relation to D2A for Pathway 3 as follows: • Option One – Continue as is with the current Pathway 3 D2A model • Option Two – Abandon D2A for Pathway 3 • Option Three – Separate D2A pathways for health and social care clients • Option Four – Use of Transitional Care Unit for D2A on the University Hospital Southampton (UHS) site • Option Five – CHC only D2A scheme
5.	A detailed options appraisal was undertaken and the preferred option in February 2019 was Option 3: Two separate D2A pathways – one for CHC patients and one for Social Care clients, with a pooled budget to cover the placement costs for the period of assessment for those clients/patients where it is difficult to predict whether they will be health or social care responsibility. The other options were rejected for the following reasons: • Option One – the costs of this were considered too high and are artificially inflated above the Council's average placement costs owing to the assessment placement attracting CHC rates, given the potential the client could meet CHC eligibility criteria. There had also been a high rate of families refusing D2A because they are not happy for their relative to be moved twice. • Option Two – this would increase the DTOC rate and length of hospital stay. It is also not in line with national policy which promotes assessment taking place outside the hospital setting and does not comply with the 8 High Impact Change Model for improving hospital discharge. • Option Four – this is likely to be high cost and does not comply with the general principle of assessing people in their own home or at least a setting which replicates a homely environment. • Option Five – this option would have little impact for the majority of patients/clients as CHC patients account for a very small proportion of Pathway 3 overall numbers (less than 2%).
6.	Since February 2019 and following further work at the request of the JCB to

	develop the preferred option and how it could be implemented, Option 3 has been discounted on the basis that it was found from a live audit of Pathway 3 patients/clients conducted by the Integrated Discharge Bureau (IDB) that very few are clearly CHC or social care clients prior to assessment and that the majority require a period of assessment to determine this. In addition the tool being proposed to determine this (which other areas had adopted to determine if a client was likely to meet CHC eligibility or not without a full assessment) has been discredited nationally because it is not felt to be accurate enough to determine likely future need.
7.	Option one (Continue as is with the current model) - with some modifications to make this affordable to the Council (reflective of average council rates) and include an element of spot purchasing to enable clients to go straight to their final placement where possible - is now the preferred model.
DETAIL (Including consultation carried out)	
8.	**Background** Three pathways for discharge have been developed to provide a standardised approach, which is now recognised across the whole South West Hampshire System. • **Pathway 1 Simple discharges** – these are managed by the hospital 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/clients 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 or reablement. Ward staff are responsible for identifying and directing these patients/clients 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/clients 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/clients to the IDB which will then facilitate discharge.
9.	These 3 pathways are illustrated in the diagram below.

	
10	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 or if not possible a setting as homely as possible”.
11.	The benefits of assessing people's long term care needs outside of 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 a less acute setting leading to a more informed and accurate assessment of their needs. This can reduce ongoing requirements and care costs.
12.	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 embed 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.
13.	**Pathway 3** Pathway 3 involves those patients/clients requiring complex assessment and/or or those that have complex long term care needs. Within Pathway 3 there are currently a number of patient/client sub-groups:- • End Of Life (EOL) – These are patients identified as close to end of life where the sourcing of care and the discharge process is sped up (i.e. “Fast tracked”) to support them to die in the place of their choosing

	wherever possible. A fast track pathway exists for this group of patients. • Specialist Rehabilitation – Patients requiring bed based care in a specialist environment for example following a stroke. These patients are easily identified and follow a health pathway into specialist rehab care. • **Clients with complex needs including those who are potentially Continuing Health Care (CHC) patients– These are patients/clients that are medically fit enough to be discharged from hospital but need further assessment in the community to determine their long term needs. This is the group for whom D2A has been piloted and that this proposal relates to.** • "Bespoke Care" – Patients/clients requiring case by case funding arrangements between agencies for a specific need or intervention e.g. bariatric/non-weight bearing care, specialist support for people with mental health needs or learning disabilities and patients/clients with delirium with the potential for resolution. These arrangements would effectively be time limited "bridging" arrangements (which could be for a lengthier period than standard D2A arrangements which tend to be 28 days) giving the opportunity for longer term planning once community based stabilisation is achieved. This group of patients/clients can experience delays whilst needs and funding arrangements are clarified as it is sometimes unclear as to whether their needs are the responsibility of health, social or both. This group could potentially benefit from a pooled budget arrangement in future with the appropriate level of contributions from each agency. ❖ There are patients/clients that start out on Pathway 3 because they need further hospital based specialist assessment before they can safely be discharged e.g. "safeguarding" concerns, mental capacity assessment, best interest meetings however they then may be discharged on a different pathway once these issues are resolved.
14.	The End of Life and Specialist Rehabilitation Pathways work effectively as patients have clearly identified health needs; however patients/clients with complex needs/potential CHC eligibility and patients/clients requiring time-limited "bespoke care" require complex specialist assessment in the community and are more likely to require negotiated interagency funding arrangements. As described below these last two groups account for approximately 40 patients/clients a month on average.
15.	The average number of patients/clients discharged overall across the whole of Pathway 3 between April 2018 and March 2019 was 14 a week.

	
16.	Based on data produced from the first quarter 2019/20, these numbers breakdown into the patient/client subgroups as follows:- • End of Life - 24% (14 per month av.) • Specialist rehabilitation - 5% (3 per month av.) • Complex needs including potentially CHC eligible clients - 13% (8 per month av.) • "Bespoke Care" - 58% (35 per month av.)
17.	This paper is proposing to continue with D2A supported by a pooled fund for the group of clients who have complex needs, including those who are potentially CHC eligible (13% of the Pathway 3 patients/clients – approximately 8 a month) with the funding contributions adjusted to ensure that the Council only pays the equivalent of its average care home rates (as opposed to CHC rates) for the placement during the period of assessment.
18.	In future there may be benefits in expanding the pooled budget to also include the group of clients described above with "bespoke" care needs (58% of Pathway 3 patients/clients – approx 35 a month); however further work would need to be done to model the costs and contributions of this and so this is currently not included in this proposal.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
19.	This paper is proposing to continue with the current D2A model for CHC and Complex Care client groups in Pathway 3 to enable assessment of their long term care needs to take place in a more homely setting outside of hospital. In order to facilitate this, it is estimated that up to 10 nursing home beds will be required at any one time for the period during which clients are assessed, based on 2 clients a week and an average assessment period of 5 weeks. It is proposed that the assessment beds comprise a mix of block contracted beds

(6 beds) and spot purchased beds (4 beds), thereby enabling some clients to go straight to their long term destination where possible whilst also maintaining the positive relationship that has been developed with the current contracted nursing home provider for this scheme.

20. It is proposed that a pooled budget with contributions from the CCG and Council is established to cover the costs of the 10 assessment beds (6 contracted beds and 4 spot purchased beds). The pilot has been funded via iBCF monies but this funding route will be ending. These are clients/patients that the council/CCG would be paying packages for if not included as part of the pooled budget. This model has been agreed with University Hospital Southampton NHS Trust as SCC investment to reduce DToC in lieu of a fines approach.In recognition of the Council's concern that the potential for patients/clients to be CHC artificially raises the rates paid, it is proposed that the Council's contribution to the pooled fund is set at the level at which it would be if the Council were paying its own average rates for adult nursing home care (i.e. £879.06 per week).

21. This has been modelled as follows:

PROVIDER	UNITS	UNIT PRICE PER WEEK	NO OF WEEKS	TOTAL 2020-2021 COST
The Hawthorns	6	1,145.00	52.143	358,222
Spot Purchased - estimated cost	4	1,400.00	52.143	292,001
TOTAL COST				**650,223**
TOTAL NUMBER OF DAYS AVAILABLE	3,650			
AVERAGE STAY PER CLIENT IN DAYS	35			
POTENTIAL NUMBER OF PATHWAY 3 CLIENTS	104			
AVERAGE NUMBER OF PATHWAY 3 CLIENTS PER WEEK	2			

22. Based on the Council paying its average adult nursing home rate of £879.06 per week, the contributions would therefore be:

CCG CONTRIBUTION	SCC CONTRIBUTION
421,041	**229,183**

Property/Other

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

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

24. This paper includes a proposed pooled fund the statutory powers for which are described in Section 75 of the National Health Service Act 2006.

Other Legal Implications:

25..	None
CONFLICT OF INTEREST IMPLICATIOINS	
26..	None
POLICY FRAMEWORK IMPLICATIONS	
27..	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?	**Yes**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Summary of learning from pilot
2.	Implementation Plan for mainstreaming Discharge to Assess for Pathway 3
3.	ESIA
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.	**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.	**None**	
2.		

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Summary of Key Learning From The D2A Pilot

This report provides a summary of the key learning points and future recommendations associated with the pilot of the Discharge to Assess (D2A) scheme for complex patients/clients on Pathway 3 over the period 1 November 2017 – 31 December 2018.

The Joint Commissioning Board 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 costs of long term care package for this cohort of patients/clients, i.e. the extent to which assessment outside the hospital setting, and in particular in a person's home, can reduce their long term care package
- to evaluate the impact on DTOC overall in terms of both numbers and costs

The target group for the pilot were Pathway 3 patients/clients who are medically fit and able to leave hospital (UHS) but due to the complexity of their long term care needs, require further assessment and support in the community setting. Demand was estimated to be around 4 patients/clients a week (although the numbers that went onto the scheme were much less).

A nurse (1wte) and a social worker (1 WTE) were recruited fixed term to support hospital staff in identifying suitable patients, undertake the assessment in the community setting and ensure timely move on to long term care. A budget of £1,021,860 per annum was agreed for the pilot, funded 50:50 by the CCG and the Council (using improved Better Care Fund money) to cover the cost of these two staff members and a mixture of 13 assessment placements (nursing home beds, residential care beds and live in home care) which were initially commissioned using block contracts.

Following the initial evaluation which covered the period November 2017 - June 2018 a number of changes were made which have reduced the costs of the pilot:

- The budget for the assessment placements was reduced from £832,000 per annum to £421,200 and only one of the block contracts which was for 3 beds from one of the nursing homes was maintained, with the remainder of the budget held for spot purchasing (up to 3 placements at any one time). This decision was taken on the following grounds:
    - The original estimate of 4 patients/clients a week being discharged onto the D2A scheme proved to be an over-estimate and in reality there were only 1-2 discharges a week. This led to a high number of voids in the contracted beds. It was however acknowledged that to a certain extent this was down

to hospital processes not identifying suitable candidates early enough for D2A and some patients/families opting out of the scheme (primarily because they did not want to move twice) which would need to be addressed in any permanent scheme.

- A key reason for some patients/families opting out of the scheme was that they did not want to move twice and therefore by spot purchasing some of the assessment placements it allows for the possibility of assessing some people in their final destination. There is a risk however that the time it takes to source and spot purchase a bed will compromise any reduction in hospital length of stay.
- A positive relationship had been established with one of the nursing homes and therefore it was felt beneficial to continue to block purchase this resource. There have been very few voids in these beds.
- Owing to the complexity of the client group, the residential care beds were rarely able to meet client need and remained empty.

- The dedicated social worker for the scheme was removed and this function was absorbed by the Hospital Discharge Team with some additional hours funded. This decision was taken partly because the member of staff left but primarily with a view to the long term when it was felt that the Hospital Discharge Team should be managing D2A for Pathway 3 clients as part of their day to day operations. Having a separate team managing D2A over-complicates processes and risks duplication. The view was that in the long term the Hospital Discharge Team would manage the scheme exclusively from within its existing resources, drawing in support from CHC only when the patient requires a CHC assessment. However for this to happen a number of functions relating to Discharge Pathways 1 and 2 will need to be transferred back to the hospital and Rehab and Reablement Team and so a small budget was maintained to cover additional hours in HDT. Work is progressing to fully embed pathways 1 and 2 with a view that these functions will be handed over by end of the year 2019/20.

Summary of Pilot Activity

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

This shows that during the 12 month period there were:

- 60 patients/clients who went onto the pilot (an average of 5 a month) of whom the vast majority went into the standard nursing home placements (53 out of 60)
- 18 patients/clients who declined the pathway on the grounds of patient/client choice

- About one fifth of assessments took longer than the scheduled 28 days
- There were 7 readmissions and 12 deaths which were reviewed and reflected the complexity of the client group
- It should be noted that less than 2% of patients/clients who went onto the scheme turned out to be CHC eligible.

Learning from the Pilot

Impact on Hospital Length of Stay

One of the key aims of the D2A scheme was to reduce hospital length of stay by undertaking the assessment of the client's needs for long term care outside of the hospital setting.

In order to measure the extent to which the pilot achieved a reduction, the length of stay in hospital for two groups with similar levels of need was compared:

- those patients/clients who were offered D2A and accepted (55 client records were available to review)
- those patients/clients who were offered D2A and declined. (18 clients)

The table below shows the length of stay in terms of the total average length of time in hospital, from admission to discharge. Those patients/clients who went onto the D2A scheme had shorter lengths of stay on average:

- by an average of 27 days from admission to discharge

Admission to Discharge

	Total LOS		Average LOS	
MMM YY	Declined	Accepted	Declined	Accepted
Dec-17	156	87	52	29
Jan-18	200	172	67	25
Feb-18	23	149	23	37
Mar-18	106	253	106	51
Apr-18	201	65	67	22
May-18	156	23	78	23
Jun-18	29	225	29	56
Jul-18		534		59
Aug-18		118		39
Sep-18	76	315	76	79
Oct-18	117	120	117	60
Nov-18		228		46
Dec-18	103	217	103	43
Jan-19	149		149	
Grand Total	**1,316**	**2,506**	**73**	**46**

Based on an estimate of three Pathway 3 clients a week (156 a year), this reduction in length of stay would equate to:

4,212 bed days per annum or 11.5 hospital beds (based on average reduction of 27 days between admission and discharge for clients on D2A)

Impact on national targets

In addition to impact on length of hospital stay, the pilot was shown to have also had a positive impact on achieving 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 14% (December 2018 position). The pilot was only one factor in this reduction, but the overall additional focus it gave to assessing long term care needs in a non-acute (outside of hospital) setting was a major positive.

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
% CHC Assessments in acute setting	86%	56%	50%	29%	23%	19%	15%	15%	10%	20%	17%	20%	17%	15%	14%

Financial Impact

The table below compares the average inpatient tariff of those patients/clients who went onto the D2A scheme with those patients/clients who were offered the scheme and declined. Similar to the length of stay data, this shows that those patients/clients who went onto the D2A scheme went on to have a lower average tariff compared to those who declined the scheme:

- by an average of £4,220 less for total hospital length of stay

PbR Final Tariff

* Tariff based on PbR Final Tariff (does include XBD costs)

Total LOS Tariff

			Average Tariff	
MMM YY	**Declined**	**Accepted**	**Declined**	**Accepted**
Dec-17	£24,247	£18,021	£8,082	£6,007
Jan-18	£32,447	£41,316	£10,816	£5,902
Feb-18	£6,483	£3,046	£6,483	£762
Mar-18	£21,889	£36,881	£21,889	£7,376
Apr-18	£25,704	£18,398	£8,568	£6,133
May-18	£44,254	£0	£22,127	£0
Jun-18	£5,852	£44,740	£5,852	£11,185
Jul-18		£61,222		£6,802
Aug-18		£21,334		£7,111
Sep-18	£12,755	£57,750	£12,755	£14,438
Oct-18	£22,442	£27,443	£22,442	£13,722
Nov-18		£38,056		£7,611
Dec-18	£13,634	£40,491	£13,634	£8,098
Jan-19	£0		£0	
Grand Total	**£209,707**	**£408,698**	**£11,650**	**£7,431**

Impact on reducing long term care 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 (based on evidence from elsewhere). 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 may 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.

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 generally 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 generally 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 related to those contracted homes at the beginning of the pilot 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)

18 clients/families declined the D2A scheme for these reasons which will need to be taken into account for future implementation. Placement moves would be reduced by placing a client wherever possible in their long term placement directly from hospital and carrying out the assessment there.

D2A Pathway 3 - High Level Mainstreaming Timeline

Key Actions	Responsibility	Status	November 2019	Dec 2019	Jan 2020	Feb 2020	March 2020	April 2020	May 2020
1. WORKFORCE									
Implement a rolling training program for UHS Ward and IDB staff re - early identification of D2A eligible patients.	UHS/CCG	Partially Established							
Implement training for Nursing Home staff involved in the D2A assessments – and roll out	CCG (Q&S – EHCH)	Partially Established							
D2A Assessment Staff in place.	SCC/CCG	Established							
2. Communication									
Establish communication protocols to ensure that staff, patients and their families are fully engaged in the process.	UHS/ICU/SCC	Partially Established							
Develop and roll out accessible information for each stage of the process.	UHS/CCG/SCC	Established							
Feedback loop - Develop Patient, Family and Staff Experience protocols	UHS/CCG/SCC	Established							
3. Procurement/Contractual arrangements for Assessment placements									
Develop Service Specification for Assessment placement	CCG	Established							
Seek expressions of interest from Nursing Homes	CCG	Not Started							
Undertake a procurement process	CCG	Not Started							
Award Contract		Not Started							
4. Operational Processes									
Ensure clear process is in place for	CCG/UHS/SCC	Partially							

D2A Pathway 3 - High Level Mainstreaming Timeline

Key Actions	Responsibility	Status	November 2019	Dec 2019	Jan 2020	Feb 2020	March 2020	April 2020	May 2020
Identification of eligible patients at UHS.		Implemented							
Sourcing D2A Assessment Beds	CPS/CCG/UHS/SCC	Established							
Assessment process and timescales.	SCC/CCG	Established							
5. Second phase (Complex Patients with "Bespoke" Care Needs)									
Establish Project Group to look at opportunities for further use of pooled funding for complex patients	ICU	Not Started							
Report initial Findings to JCB	ICU	Not Started							
Agree next Steps	ICU	Not started							

SOUTHAMPTON CITY COUNCIL

Equality and Safety Impact Assessment

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

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

Name or Brief Description of Proposal	Re-Procurement of the Joint Equipment Store

Brief Service Profile (including number of customers)

This report seeks Joint Commissioning Board (JCB) approval to proceed with a proposal to mainstream a hospital discharge pilot for patients/clients on Pathway 3 with complex needs. This follows a substantial pilot period and a further subsequent redevelopment of the model based on the learning from the pilot which was outlined in a report presented to JCB in February 2019.

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 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.

Discharge to Assess (D2A) is recognised nationally as best practice for ensuring timely hospital 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 or if not possible a setting as homely as possible".

The benefits of assessing people's long term care needs outside of 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 a less acute setting leading to a more informed and accurate assessment of their needs. This can reduce ongoing requirements and care costs.

The focus of this paper is a subgroup of patients on Pathway 3 who have complex needs some of whom will potentially be entitled to Continuous Healthcare funding. This cohort of patients is relatively small (averaging 8 a month) however they are likely to require specialist assessment and potentially will have long term high cost needs.

The proposal is to mainstream the model that has been piloted.

In order to facilitate this, it is estimated that up to 10 nursing home beds will be required at any one time for the period during which clients are assessed, based on 2 clients a week and an average assessment period of 5 weeks. It is proposed that the assessment beds comprise a mix of block contracted beds (6 beds) and spot purchased beds (4 beds), thereby enabling some clients to go straight to their long term destination where possible whilst also maintaining the positive relationship that has been developed with the current contracted nursing home provider for this scheme.

The proposal is for a pooled budget with contributions from the CCG and Council to be established to cover the costs of the 10 assessment beds (6 contracted beds and 4 spot purchased beds).

Summary of Impact and Issues

The main issue, based on the pilot phase, was that some patients that were eligible for D2A refused to enter on to the scheme, the primary reasons being:-

- The location of the proposed interim placement wasn't close to their home or family,
- That they would be "forgotten" once out of a hospital bed and would be stuck in a placement that they hadn't chosen.

These issues have been mitigated against as part of the pilot through the use of spot purchasing arrangements to allow for placements to be as close to people's homes as possible. One of the principles of the scheme is to also try to place people in nursing homes which are likely to be their final destination (nearly all Pathway 3 D2A patients are assessed as requiring a nursing home placement). Ward based awareness and confidence in the scheme has also supported patient discussion at an earlier stage which also helps manage any concerns they or their families might have about the pathway.
Potential Positive Impacts
The benefits of assessing people's long term care needs outside of 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 a less acute setting leading to a more informed and accurate assessment of their needs. Risks of prolonged stays in hospital after a person is well enough for discharge also include hospital acquired infection and deconditioning. This proposal addresses this by ensuring that people can leave hospital as soon as they are fit for discharge.

Responsible Service Manager	Jamie Schofield
Date	23/09/2019
Approved by Senior Manager	Donna Chapman
Date	23/09/2019

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	The model supports primarily older people to have their needs assessed in a community setting reducing the inherent risks associated with unnecessary hospitalisation e.g. reduced mobility, hospital acquired infection.	Not applicable – this proposal would be a positive impact by enabling people to leave hospital sooner and therefore reduce the risks associated with prolonged hospital stays.
Disability	As above this group of patients require assessment in an environment that reflects, as best as possible, their long term surroundings particularly in relation to mobility, equipment, personal needs etc.	Not applicable – this proposal would enable a person's long term needs to be better assessed and therefore met by enabling the assessment to take place in an environment which is more homely.
Gender Reassignment	No specific impact	
Marriage and Civil Partnership	No specific impact	

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Pregnancy and Maternity	No specific impact	
Race	There is a potential impact in terms of being fully informed/involved and understanding the pathway and assessment process. There is also a need to ensure that people are confident that any home they might move on to is able to support their cultural needs.	The wards and discharge teams are much more aware of the D2A pathway and are encouraged to discuss these potential options with patients and their families at the earliest opportunity. This would when necessary include use of interpreters. The eligibility assessment for D2A includes the requirement to identify individual needs that support the Care Placement Service in identifying a suitable placement. The assessment undertaken in the community is vigorous and holistic incorporating an individual's cultural and religious needs.
Religion or Belief	As above it is important that patients religious beliefs form part of the assessment process both in terms of eligibility for D2A and the assessment process undertaken in the community.	The wards and discharge teams are much more aware of the D2A pathway and are encouraged to discuss these potential options with patients and their families at the earliest opportunity. This would when necessary include use of interpreters. The eligibility assessment for D2A includes the requirement to identify individual needs that support the Care Placement Service in identifying a suitable placement. The assessment undertaken in the community is vigorous and holistic incorporating an individual's cultural and religious needs.
Sex	No specific impact	

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Sexual Orientation	No specific impact	
Community Safety	No specific impact	
Poverty	No impact specifically related to this proposal. The D2A pathway is free to all patients. The outcome of the assessment will determine whether they are entitled to CHC or social care funding, or potentially self-funding if they are above social care financial eligibility thresholds. This is no different should the person be assessed in hospital or through the D2A pathway.	Not applicable
Health & Wellbeing	The D2A assessment process will reflect the wider health and social care system to ensure that service provision is joined up and person centred.	Staff undertaking the D2A assessments are highly experienced and have a broad knowledge of the wider system. The Enhanced Health in Care Homes programme is partially established in all Southampton nursing homes with further roll out over the next year with the primary care element.
Other Significant Impacts	No specific impact	

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DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Quality Update**		
DATE OF DECISION:		**17th October 2019**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Carol Alstrom	Tel:	023 80296956
	E-mail:	carol.alstrom@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	023 80296914
	E-mail:	stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY
This paper provides an update on quality in health and social care services in Southampton, including the latest Care Quality Commission ratings for social care providers following inspections.

RECOMMENDATIONS:		
1.	(i)	Note the quality report
	(ii)	Endorse the Disputes Procedure

REASONS FOR REPORT RECOMMENDATIONS	
2.	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

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
3.	Not applicable this is an update report only

DETAIL (Including consultation carried out)	
4.	**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
5.	**Good Practice** Currently across Southampton social care providers in the care home and home care market are considered overall to be providing good care. One service is currently under review by the Care Quality Commission (CQC) and it is anticipated that this service will receive a rating of either requires improvement or inadequate. The Quality Team is currently reviewing this provider to understand what has changed since the last review and the provider will be assisted with the development of an action plan to ensure any breaches of the regulations are addressed.

<table>
<tr><td></td><td>The current profile of CQC ratings across Southampton is

<table>
<tr><td></td><td>Outstanding</td><td>Good</td><td>Requires Improvement</td><td>Inadequate</td></tr>
<tr><td>Nursing Homes</td><td>0</td><td>9 (7)</td><td>0 (2)</td><td>0</td></tr>
<tr><td>Residential Homes</td><td>1</td><td>41 (43)</td><td>7 (6)</td><td>1 (0)</td></tr>
<tr><td>Home care providers</td><td>2</td><td>36</td><td>5</td><td>0</td></tr>
</table>

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 (CQC) and locally expected requirements. These providers are subject to regular monitoring visits and intelligence review with early intervention when concerns are identified. No specific themes or trends are emerging from quality concerns at this time, workforce challenges continue in the market as a whole in terms of recruitment and retention of staff. The one provider rated inadequate has addressed the issues identified by CQC and the ICU Quality Team will be reviewing their progress with the actions in October, it is anticipated that all the actions will have been completed by this time.</td></tr>
<tr><td>5</td><td>The Quality Assurance meetings held monthly have also focused on the quality of services being provided by adult social care and children’s social care core teams. Areas reviewed at the meeting include Children’s social care and readiness for Ofsted, Adult safeguarding practice, and the outcomes of the recent peer reviews in adult social care. The meeting will receive elements from the action plan arising from the peer reviews relating to quality from August onwards.</td></tr>
<tr><td>6</td><td>Other areas of focus across health and social care in Southampton for the ICU quality team include workforce issues in Adult Mental Health services, which have resulted in temporary closures of ward beds and the section 136 suite at Antelope House. The Quality Team are in regular contact with the management team at Antelope House, will continue to monitor the situation and provide support as needed.
Work is ongoing with University Hospital Southampton NHS Foundation Trust (UHS) to improve communication and working relationships with the nursing home sector in the city. This work is to help support early discharge from hospital. UHS have been working on improved discharge summaries and improving processes related to discharge including supply of discharge medication.
The Continuing Healthcare (CHC) team continue to work with partners to ensure that CHC assessments are completed in the community in line with national requirements. Completing a CHC assessment in hospital can result in a distorted view of an individuals care needs, so using the Discharge to Assess pathway 3, individuals who are eligible for a CHC assessment are moved into a community setting to allow this to be completed in a more ‘normal’ environment. Work is currently underway between the CCG and SCC to review the processes supporting packages of care for individuals entitled to section 117 aftercare, part of the Mental Health Act requirements. Work is underway to develop a joint protocol for management of this client group. A presentation to the Health Overview and Scrutiny Panel took place in September, this was well received and it is anticipated that a further request to attend will be issued next year due to the complexity of this funding source.</td></tr>
<tr><td>7</td><td>Disputes Procedure– The disputes protocol is a requirement of the NHS Continuing Healthcare framework and over the last few months, the CCG and Local Authority teams have been working to agree this key document. Whilst it is aimed at CHC it can also be used for other individual funding processes such as section 117 aftercare or jointly funded packages of care. The Joint Commissioning Board is asked to endorse this</td></tr>
</table>

	procedure which has been developed in conjunction with legal advice from the CCG and the City Council.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8	There are no specific resource implications of this paper.
Property/Other	
9	None noted
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10	The Council has a statutory power and responsibility to safeguard individuals receiving services within the Southampton City boundary
Other Legal Implications:	
11	None noted
CONFLICT OF INTEREST IMPLICATIOINS	
12	No conflicts of interest are noted
RISK MANAGEMENT IMPLICATIONS	
13	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.
14	**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. Work continues across the City, and the Hampshire and Isle of Wight STP, with key partners to explore options on how this situation can be improved.
POLICY FRAMEWORK IMPLICATIONS	
15	The information contained within this report are in accordance with the Councils Policy Framework plans

KEY DECISION?	**N/A**
WARDS/COMMUNITIES AFFECTED:	
SUPPORTING DOCUMENTATION	
Appendices	
1.	Disputes procedure

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.		**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.	Not applicable	

1 Introduction

1.1 This Procedure is the mechanism to be applied by NHS Southampton Clinical Commissioning Group ("CCG") and the Local Authority for the purposes of resolving disputes regarding the eligibility of a Service User for NHS Continuing Health Care ("CHC").

1.2 While this Procedure is intended for use between the CCG and the Local Authority, its terms can also govern any disputes arising from time to time between the CCG and other local authorities, who agree to use it. The Partner Organisations recognise that whilst this procedure is intended to resolve disputes regarding eligibility for CHC, it could be adapted for use to resolve related issues such as disputes regarding individual packages of care, such as, but not exclusively, section 117 funded care and joint packages of care. This procedure has been developed with legal advice from legal advisers to Southampton City CCG and Southampton City Council

1.3 There are four stages to the resolution of disagreements between the Partner Organisations in this Procedure:

1.3.1 Stage One: an informal dispute resolution procedure at operational level (Part I) and Clinical Lead level (Part II) as described in Paragraph 5.

1.3.2 Stage Two: A formal dispute resolution procedure through the Disputes Panel, as described in Paragraph 6.

1.3.3 Stage Three: Resolution by the Chief Executives, or equivalent levels, of each Partner Organisation as described in Paragraph 11.

1.3.4 Stage Four: Arbitration as described in Paragraph 12.

Every effort will be made to comply with the time limits set out in this Procedure. The Partner Organisations may, by agreement, extend any of the time limits provided that this is in accordance with the National Framework.

2 Service User Complaints and Appeals

2.1 Complaints made by the Service User about a Partner Organisation, their performance and provision (or non-provision of services) should be responded to in accordance with that Partner Organisation's complaints handling process. All such complaints should be addressed to the complaints officer of the relevant organisation in the first instance. In addition, Patients Advice and Liaison Service (PALS) will assist in dealing with specific concerns raised by NHS patients.

2.2 For the avoidance of doubt, this Procedure is not to be used to manage disputes between a Service User and the CCG regarding that individual's eligibility for CHC. An individual can appeal against a CCG decision relating to their eligibility for CHC in accordance with the National Framework and NHS complaints procedures.

3 Funding During Disputes

3.1 Pending resolution of a Dispute, the Partner Organisations shall at all times act in the best interest of the Service User and, in the spirit of partnership and co-operation, will ensure that the Service User is being cared for in an appropriate environment and that their assessed needs are being met at all times. the CCG will ensure that Service Users are informed in writing as soon as possible about their eligibility (or not) for CHC once a final decision is made and in any event not more than 28 calendar days from the date of receiving the positive Checklist, in accordance with paragraphs 159 and 162 of the National Framework.

3.2 Pending resolution of a Dispute, there should be no delay to the provision of appropriate care for the individual Service User. At no point during the process may either the CCG or the Local Authority unilaterally withdraw from an existing funding agreement.

3.3 Where a Dispute arises, the Partner Organisations funding the arrangements in place at the time that the Service User is assessed by the Multi-Disciplinary Team (MDT) will continue with the funding on an interim basis (and without prejudice to their position) until the Final Resolution Date.

3.4 If no funding arrangements are in place at the time that the Service User is assessed by the MDT, the Partner Organisations will agree in writing responsibility for interim funding of the care required (without prejudice to their position) until the dispute is resolved.

3.5 Unless otherwise agreed, costs incurred by either Partner Organisation ("Paying Partner") pursuant to interim funding arrangements being made in accordance with Paragraph 3.3 or 3.4 will be reimbursed by the other Partner Organisation no later than 28 days from the Final Resolution Date where that Dispute is resolved in favour of the Paying Partner.

4 Preventing Disputes

4.1 Formal dispute is a last resort, which should seldom if ever be necessary. Most disagreements can be resolved through discussion and negotiation. Partner Organisations agree to stay focused on the key objective, which is to ensure that an individual's eligibility for CHC is correctly determined in a timely fashion.

4.2 Resources should be directed at that aim rather than being directed into the management of disputes. It is therefore crucial that strategic managers take steps to strengthen joint activity that focuses on agreement and aims to prevent conflict.

4.3 Partner Organisations will need to work through the following issues:

- **Partnership culture**—the Partner Organisations should ensure there is a clear and consistent message about the joint responsibility to solve problems and resolve disagreements purposefully and constructively before they develop into disputes.

- **Assessment procedures**—accurate needs assessment is fundamental to the process of determining eligibility for NHS CHC. The Partner Organisations should ensure there is a robust and comprehensive joint assessment process in place and that this is adequately resourced to enable a timely and proportionate assessment to be undertaken in accordance with the Continuing Healthcare National Framework (2018)

- **Decisions on eligibility** – should be agreed based on the assessed level of need and the multi-disciplinary recommendation arising from the assessment and recorded on the Decision Support Tool. As per paragraph 153 of the Continuing Healthcare National Framework, the multi-disciplinary team's recommendation should be followed except in exceptional circumstances, and for clearly articulated reasons. It should not normally be necessary to challenge either the multi-disciplinary team's recommendation or the local CHC eligibility panel decision if both health and social care staff have been fully included in the assessment and agree the overall recommendation.

5 Stage One: Informal Disputes Procedure

Part I: Attempts to resolve the Dispute at operational level

5.1 If the CHC Panel do not agree with the MDT's recommendation in the first instance, the CHC Panel will refer the matter back to the MDT and if required, seek further information from the MDT and defer its decision to the next CHC Panel meeting, or to such CHC Panel meeting as it shall specify, providing that it is no longer than 21 days from the date the case is first considered by the CHC Panel. In line with para 154 of the Continuing Healthcare National Framework the CHC Panel should not refer a case back, or decide not to accept a recommendation, simply because the multidisciplinary team has made a recommendation that differs from the one that those who are involved in making the final decision would have made, based on the same evidence. The CHC Panel's reason for deferral must be recorded and the Service User whose case is being considered should be informed of the likely timescale before the CHC Panel's decision is communicated.

5.2 If the Local Authority disputes the recommendation of the MDT and notifies the CCG before a decision of the CHC Panel is made, the CCG will direct the CHC Panel to defer their decision until the next CHC Panel meeting in accordance with Paragraph 5.1 and the Local Authority will be entitled to make representations for the CHC Panel to consider at this meeting.

5.3 The final decision of the CHC Panel, together with the reasons behind it, will be recorded by a clerk appointed by the CHC Panel's chair and communicated to the Local Authority, the Service User and their carers within 5 working days of the decision.

5.4 If the Local Authority disputes a decision of the CHC Panel (whether that decision was made with or without referral to a second meeting) then they will notify the CCG in writing within 5 working days of the decision being made. This should be done by way of an email, identifying their concern(s) and sent to *SOCCG.continuinghealthcare@nhs.net*.

5.5 On receipt of the email, CCG will allocate the matter to an operational manager for consideration and in order to liaise with the Local Authority within 7 days. If a solution cannot be reached within 7 working days, then Paragraph 5.7 will apply.

5.6 To ensure robustness, the process needs to involve operational staff with a good understanding of the National Framework (and its application). To ensure fairness, this should be a balance between CCG and the Local Authority perspectives.

Part II: Attempts to resolve the Dispute at Clinical Lead level

5.7 If, despite following Stage One, Part I of this Procedure, the Local Authority continues to dispute the decision made by the CHC Panel, the dispute will be referred by the allocated operational manager to the Clinical Lead for NHS Continuing Healthcare (or their nominated deputy) for the CCG and a nominated service manager for the Local Authority. Such referral should take place within 5 working days of the decision being made. A joint decision will be reached within 10 working days of the case being referred and a request for extension should be agreed and recorded between the parties.

5.8 If the dispute cannot be resolved by negotiations within the 10 working day period and the Local Authority still disagrees with the decision made, the Local Authority service manager will submit a formal letter of dispute to the CCG. This letter will be submitted by email to *SOCCG.continuinghealthcare@nhs.net* within 10 working days of the expiration of the period of negotiation set out in paragraph 5.7 and should set out the grounds for the Dispute clearly and concisely.

6 Stage Two: Formal Dispute Procedure

6.1 Stage Two of the disputes procedure involves the convening of a Disputes Panel.

6.2 A meeting of the Disputes Panel will be set up by the CHC Department within 15 working days of receiving confirmation that Stage One could not resolve the Dispute.

6.3 The CHC Department will provide all Disputes Panel members with the documents to be considered by the Disputes Panel at least one week prior to the panel meeting. Input will be sought from the Local Authority as to what documents should be provided, including the supporting evidence that the Local Authority is relying on to dispute the decision.

6.4 Stage One of the disputes procedure should encourage resolution of disputes at the earliest opportunity and, where a formal Dispute is declared, it is important that all attempts to resolve the Dispute informally continue where possible and that the Disputes Panel is kept informed of any progress.

6.5 It is in the interests of the Partner Organisations to resolve Disputes whether informal or formal as quickly and effectively as possible.

7 The Role of the Disputes Panel

7.1 The Dispute Panel role is advisory, as the Partner Organisations cannot be compelled to accept its recommendations. Any recommendations should however be made available to the Chief Executive Officers, or their nominated officers, in the CCG and the Local Authority where they are unable to locally resolve a dispute (Stage 3) and prior to referral to Arbitration in accordance with Stage 4 of the disputes procedure.

7.2 The purpose of the Dispute Panel is to advise whether, based on all available evidence given by the MDT, the Service User is eligible for CHC funding, whether it should be a joint package of health and social care or whether it should be the Local Authority's sole responsibility. If it is the view of the Disputes Panel that the Service User is not eligible for CHC funding, they must advise on the extent to

which the CCG should contribute or not (either in funding or in service provision) to a Service User's care package in order to meet their assessed health needs. The Dispute Panel should also advise on the reimbursement of the costs incurred by the Partner Organisations if it is determined they do have a primary health need or health needs identified under a joint package agreement during the Dispute as appropriate (see Paragraphs 3.3 and 3.4)

7.3 To ensure fairness, there should be a balance between health and social care perspectives. Members of the Dispute Panel should act in a professional manner. They should interpret the eligibility of a Service User according to the Continuing Healthcare National Framework. They should not be representing the "position" taken by their own Partner Organisation and should ensure at all times that the Service User's needs and best interests are at the heart of the decision. In accordance with the National Framework, a review panel of a neighbouring CCG may be called upon to review the case which provides greater patient confidence in the impartiality in decision making. Provided that review does not put unnecessary delays in the process of the decision making.

8 Membership of the Disputes Panel

8.1 To ensure robustness, the process needs to involve individuals with a good understanding of the National Framework. For each case, decisions must be based on a high quality assessment.

8.2 The Disputes Panel must be composed of individuals with no previous involvement in the decision i.e. they must not have formed part of the original CHC Panel.

8.3 The Disputes Panel will have three members as follows:

- An independent chair (from Southampton Voluntary Services or such third sector or independent body acceptable to both parties. the costs i.e. fees and expenses approved by the Partner Organisations will be shared equally between the Partner Organisations);
- Associate Director or their nominated deputy for the CCG; and
- Decision making representative from the Local Authority at the equivalent level.

8.4 The following individuals may be present in an advisory capacity:

- Independent NHS CHC Manager/advisor;
- Case lead/presenter;
- Clinical advisor; and
- Co-opted specialists as required.

If the Dispute involves more than one Clinical Commissioning Group, the CCG will invite representatives of the other Clinical Commissioning Group(s) to attend.

9 Attendance and Procedure at the Dispute Panel Meeting

9.1 The CCG will co-ordinate dates, venues and minute taking for the Panel meeting.

9.2 Attendance at meetings is expected of all participants notified of the requirement to attend. Practitioners unable to attend will take responsibility for informing the Chair and sending another appropriate representative with delegated authority.

9.3 An independent person with CHC management experience from an organisation not a party to the Dispute should be invited to attend as a process advisor. This individual will attend Dispute Panel meetings as an advisor only (i.e. not as a member) and will have no right to vote.

9.4 The Disputes Panel members will endeavour to reach a unanimous decision. In the event of a majority decision the voting will be recorded together with the reasons for the decision and the recommendation made.

9.5 The Chair will take responsibility for appointing a clerk to take minutes of the meeting and record and issue the recommendations in writing to the Partner Organisations within 5 working days of the meeting.

10 Information sharing/documentation for the Disputes Panel

10.1 The Decision Support Tool and a copy of the CHC Panel minutes, together with all relevant supporting documentation, will be required.

10.2 The meeting attendees will need a basic understanding of the circumstances of the case under discussion and copies of documents to be referred to must be made available to all of those attending at least 5 working days before the Disputes Panel sits. Other specialist assessments may also be used if it would be helpful or appropriate to do so.

10.3 The data sharing agreement between the Partner Organisations will apply to any information shared throughout this process.

11 Stage Three: Referral of the Dispute to the Chief Executives of Partner Organisations

11.1 In the event that the Dispute cannot be resolved by the panel, the Dispute will be referred by both Partner Organisations to the Chief Executive of the CCG and the Chief Executive of the Local Authority, or their nominated Executive/Board level officers. Details of the Dispute should be provided in writing, by way of a joint letter agreed between them and sent to both officers within five working days of the letter being submitted as specified in Paragraph 5.8. In the event that a joint letter cannot be agreed, each Partner Organisation will write a separate letter to both Chief Executives.

11.2 The respective Chief Executives, or their nominated officers, will meet to discuss the decision of the Disputes Panel and, within 15 working days of referral to them, will make recommendations to the Partner Organisations. An independent CHC advisor should be present to provide advice to the Chief Executives on the Continuing Healthcare National Framework. An appointed clinical advisor, agreed by both parties, may also be necessary to provide advice.

11.3 The Partner Organisations will accept the recommendation made by the Chief Executives.. However, in the event that the Chief Executives fail to reach agreement, the matter shall be referred to Arbitration in accordance with Stage Four of this Disputes Resolution Procedure.

12 Stage Four: Arbitration

12.1 In the event that the Dispute cannot be resolved through Stage Three of the Disputes Procedure, the Partner Organisation that wishes to dispute the recommendation of the Dispute Panel must refer the matter for arbitration in accordance with this Paragraph 12. Such referral shall be made no later than 15 working days following confirmation of the Dispute Panel's recommendation. If no such referral for arbitration is made, the Partner Organisations agree that they will both be bound by the recommendation of the Chief Executive Officers at Stage 3.

12.2 Any Dispute referred to Stage Four of this Procedure shall be determined by arbitration governed by both the Arbitration Act 1996 and such rules as are agreed between the Partner Organisations ("Rules"). If, within 2 working days of receiving confirmation of the ongoing dispute as set out in Paragraph 12.1, the Partner Organisations are unable to agree on an arbitrator or arbitrators, or are unable to agree on the Rules, either Partner Organisation may, upon giving written notice to the other Partner Organisation, apply to the President or the Vice President, for the time being, of the Chartered Institute of Arbitrators for the appointment of an Arbitrator or Arbitrators and for any decision on Rules as may be necessary. The seat of the arbitration shall be England and Wales. The arbitration shall be governed by the Arbitration Act 1996.

12.3 It is agreed that the costs of the Arbitrator appointed in accordance with Paragraph 12.2 (and the costs, if any) of the Chartered Institute of Arbitrators in the appointment of that Arbitrator) will be shared equally between the Partner Organisations.

13 Review

13.1 The Partner Organisations agree that this Procedure will be reviewed annually to ensure that it meets the needs of both partners. If any amendments are required, then they will be agreed by the Partner Organisations and this Procedure will be updated accordingly.

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1. Integrated Commissioning Unit (ICU) Summary Performance Report M6 2019/20

Achieving Transformation Change

	95% Target ≥ 92%	% CAMHS routine assessments within 12 weeks
↑	54 Target ≤ 59	Number of Permanent admissions to residential & nursing homes (65+)
↑	37 Target ≤ 27	Average Daily Delayed Transfers of Care (DTOC) beds
↓	10,617 Target ≤ 10,136	Number of Non-Elective Admissions
↓	796 Target ≤ 605	Falls & Fraity Very Short Stay Admissions (over 65s) <6hr

Quality

↑	78% Target ≥ 80%	% Continuing Healthcare Assessments completed ≤28 days
↑	100% Target ≥ 85%	% Continuing Healthcare Assessments taking place in community
↑	90% Target ≥ 90%	% of placements that are sourced through the Care Placement Team
↑	4.98% Target ≥ 4.94%	% people with common mental health conditions accessing IAPT (YTD - local reporting)
↑	30.5% Prev 12 mths = 26.4%	Alcohol - % of clients completing treatment and not re-presenting

KEY

Compared to Previous Year

↑ Better than previous year

↓ Worse than previous year

→ Same as previous year

Compared to Target

Within 10% of Target

Target Achieved

<10% below target

2. ICU Workstream Progress

a. Achieving Transformation Change

Enhanced health support in care homes rolled out to all care homes, evidence of impact on both admissions and Emergency Department attendances from the homes.

CAMHS changes : Local Transformation Plan refresh on track. Successful application made for two MH Support Teams in Schools – new service commencing Jan 2020 – this will specifically support schools in managing MH/emotional/behavioural difficulties, thereby supporting the inclusion agenda – ultimately enabling more children to remain in their local school . No Limits Counselling model in place for 5-25 year olds. Funding has been secured from Health Education England and Solent and No Limits staff to roll out restorative practice training now attending sessions.

Model developed for more integrated, person centred support in the early years focussed on there being a key worker role for all children at the complex level of disability – proposal that this specialist health visitors. Work commenced to develop a more integrated model of pre-school provision for children with complex disabilities.

Ageing Well Framework finalised with wide stakeholder engagement -work now underway to develop social movement approach to promoting ageing well messages. Keele Risk Stratification tool for falls being piloted in several practices.

b. Procurement & Market Mananagement

- Joint adults and children and young people Peer Support service to be tendered October 2019.
- ADHD diagnosis and support service to commence Nov 19
- Weston Court respite service review completed and re-commissioning due to start in September.
- Southampton Living Well Service formally launched in July. The service is continuing to work with community partners to develop an affiliate scheme in order to broaden the activity offer available in communities.
- Eat Well Procurement to be completed by end Aug 19
- Community Solutions Service including Community navigation has now been procured and is currently mobilising.
- New falls exercise service goes live in October. Proposal for PH Registrar to develop plan to improve take up and continuation of exercise
- Short break offer went live in April
- Joint Equipment store tender went live in August

c. Quality

Focus of Antidepressant work for 19/20 is improving the management of depression in the over 65yrs.

S Monitoring the quality of care for patients in the Emergency Department, Cancer pathways and ophthalmology services at UHSFT continues, some improvements in waiting times have been noted but this remains an area of concern for the quality team.
Solent NHS Trust continues to work with NHS Property services to address security issues on the RSH site following break in's earlier this year.
Workforce concerns continue at Antelope House, contingency plans are in place to support the section 136 suite.

3. Key Performance Indicators

a. Integrated Care (Better Care)

RAG Summary	Last Yr	Target
Green	6	4
Amber	6	0
Red	1	5
n/a	2	6

			Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M4	Average Daily DTOC beds	37	43	-6	-14%	27	10	38%
M4	Average Daily DTOC beds rate (per 100,000)	18	21	-3	-14%	13	5	39%
M1-4	Total Non-Elective Admissions	10,617	9,971	646	6%	7,561	3056	40%
M1-3	NEL Admissions (under 18s) - UHS only	868	832	36	4%			
M1-3	NEL Admissions (18 - 64 yrs old) - UHS only	4,166	4,081	85	2%			
M1-3	NEL Admissions (65+ yrs old) - UHS only	2,840	2,666	174	7%			
M1-3	Permanent admissions to residential homes aged 65+	54	74	-20	-27%	59	-5	-8%
Q1	% of People with Learning Disabilities receiving a Physical Health Check	11	12	-1	-8%	14	-3	-23%
Q1	Childrens Wheelchairs - 92% seen within 18 weeks by Q4	53	73	-19	-27%	52	1	2%
M1-5	CAMHS - 92% of routine assessments within 12 weeks (YTD)	95						
Q1	60% of people with an SMI receiving a full annual physical check	22				27	-5	-19%
M4	% of people experiencing psychosis will be treated within 2 weeks of referral	100	82	18	22%	57	43	74%
M5	% of adults open to LD social care team who have had a Care Act assessment/review in the past 12 mths.	30	31	0	-1%			
M5	Number of new Enhanced Health in Care Homes	18	0	0	0%	18	0	0%
M5	% of clients in rehab/reablement who do not need ongoing care	56	48	9	18%			

Summary

DTOC - main issues affecting performance are:
- Overall increased complexity of patients: Actions to resolve include Bespoke work is carried out to support complexity and secure complex care, community OT in-reach to hospital to joint assess patients and greater consideration of how equipment and care technology could support people in the community to reduce levels of dependencies
- Discharge and community provision: trusted assessors are ongoing training to support Pathway 1, more investment in pathway 2 to increase reablement and invested in home care to increase capacity
- Hospital processes: UHS is developing an action plan to create greater consistency in hospital and CCG quality team are working with UHS to develop reporting to encourage grater transparency
- Community resource pre admissions - commissioners are working with Providers to become more preventative, community clusters are working with voluntary sector to develop 'social prescribing'

% with LD receiving a Physical Health Check - the annual target is 75% and the majority of checks are usually carried out in Q4 (>40% of checks carried out last year)

NEL Admissions -Unprecedented demand is continuing into 2019. Commissioners and UHS are currently investigating the causes of the increased activity, with a view to developing actions and mitigations. There is no one area or issue that is driving the increases. Investigation will continue through the Finance and Information Group, which reports to the UHS Performance Board. Additional activity is being experienced across a number of systems and indeed nationally. Over 65 year old admissions are particularly high - there is some concern that new SDEC pathways are resulting in more people now being coded as inpatient admissions

SMI full annual physical check - this is going to be an extremely challenging indicator to hit and partly reliant on practices signing up to the enhanced service, a number declined this year. We have seen an increase in 18/19 from 10.9% to 25.8%, we will be reviewing the offer to practices as well as exploring development of new HCA role to engage those not attending annual health check with possible point of care testing kits.

% of adults open to LD social care team who have had a Care Act assessment/review in the past 12 mth - The M4 performance is 27%, this is 5 percentage points lower than 36% as at M2 last year – The LD adult social care team have used iBCF funds to employ social workers and an independence advisor to work on reviews within the team. A review process has been established and has senior practitioner oversight.

b. Prevention and Early Intervention

RAG Summary	Last Yr	Target
Green	5	4
Amber	3	0
Red	1	1
n/a	0	4

				Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M1-3	Falls & Fraity Very Short Stay Admissions (over 65s) <6hr	796	704	92	13%	605	191	32%
Q1	IAPT - % with common mental health conditions accessing IAPT	4.98	4.27	0.71	17%	4.94	0.04	1%
Q1	IAPT - % who complete IAPT moving to recovery	50	52	-2	-3%	50	0	1%
M5	% LARC (all 4 methods) at Integrated Sexual Health Service (YTD)	47	51	-4	-9%	35	12	34%
M5	% of HIV tests completed as part of an STI screen (YTD)	85	84	1	1%	75	10	14%
Q1	% of pregnant women who cease smoking time of delivery	19.4	15.3	4	27%			
M3	Alcohol - % of all clients completing and not re-presenting	30.5	26.4	4	16%			
M3	Opiates - % of all clients completing and not re-presenting	6.3	4.6	2	37%			
M3	Non-opiates - % of all clients completing and not re-presenting	29.4	30.5	-1	-4%			

Summary

Falls – M4 YTD is 13% above the previous year and 32% above target. Work is ongoing to improve this including work with UHS & Solent to further integrate Fracture Liaison Service with Community Independence Team. Opportunities have been identified to increase efficiency in pathway and a business case for investment has been approved to take forward service development in the following areas.

- Pilot commenced on 1 May offering a 6 month Community Alarm (Gold) and Telecare service to patients with a falls risk and socially isolated. Approx 40 referrals by July
- To improve the identification and management of patients who have a falls risk, 3 practices have piloted the Keele University Tool with aim to roll out to city in Autumn
- Additional Investment into Community Independence Team (5WTE) to reduce waiting times to meet service specification targets
- Procurement of new exercise provider. Saints Foundation to commence new contract from 1st October
- Development of providing Community Transport SCiA) from ED, discharging to care of charity with follow up visits from Homecoming Service (Commnicare) to commence in Sep
- URS clinician in SCAS call desk to support call handlers in diverting to more appropriate community pathways that avoid hospital converyance - went live beginning August

c. Commissioning Safe & High Quality Services

RAG Summary	Last Yr	Target
Green	3	3
Amber	1	1
Red	1	0
n/a	0	1

				Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M5	≥85% of CHC assessments taking place in an out of a hospital setting	100	80	20	25%	85	15	18%
M5	≥80% of CHC assessments completed within 28 days	78	80	-2	-3%	80	-2	-3%
M1-5	<44 cases of Healthcare Associated Infections (Community): Cdiff (cumulative)	8	14	-6	-43%	18	-10	-56%
M1-5	Zero cases of Healthcare Associated Infections (community): MRSA (cumulative)	0	2	-2	0%	0	0	0%
M1-4	% of Providers with a CQC Rating of good or above published in month (cumulative position)	73	82	-8	-10%			

Summary

d. Managing and Developing the Market

	RAG Summary	
	Target	Last Yr
Green	6	5
Amber	0	0
Red	0	0
n/a	0	1

				Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
Q1	≥90% contract reviews on schedule	95	92	3	3%	90	5	6%
M4	Care Placement - ≥90% placements are sourced via Team	90	84	6	7%	90	0	0%
M4	Avg days from referral received to placement start date (Home Care)	11	12	-1	-10%	14	-3	-22%
M4	Avg days from referral received to placement start date (Res/Nursing)	4	6	-2	-27%	14	-10	-71%
M5	Total number of home care hours purchased per week	22,577	22,551	26	0%			
M4	% Home Care clients using a non framework provider	19	22	-4	-17%	20	-2	-8%

Summary

4. High Level Risks/Issues to achieving project/programme delivery

Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Delayed transfers of care	Increasing complexity of clients will increase DTOC resulting in failure of plans, BCF targets and QIPP savings and this could compromise quality of care and outcomes for clients	V High	DC	DTOC remains a high priority and is closely monitored. Main challenges remain: o increasing levels of complexity amongst patients being discharged. There has been a strong push within the hospital to discharge patients earlier with higher levels of need which are more difficult to meet. o workforce capacity in the domiciliary care market particularly to support higher levels of need e.g. requiring calls at specific times or double up calls 3 or 4 times a day. o nursing home capacity to take more complex clients o increased requirement for housing adaptations and equipment to enable people to return home, which is resulting in increased spend on the Joint Equipment Service budget o people with low level health needs which are not specialist but require care staff to administer basic clinical tasks e.g. PEG feeds, collar care, eye drops. DTOC Peer Review organised by LGA took place on 30 April and has identified the following key actions which have been implemented: - Strengthening senior oversight and leadership by ensuring that there is a regular focus on DTOC performance at the monthly Better Care Steering Board meetings - there are now weekly Exec calls in place as well - Strengthening reporting processes and accountability so that on any one day performance can be tracked against each of the 3 discharge pathways ("simple" which is the responsibility of the hospital; "supported" which is the responsibility of Rehab and Reablement and "enhanced/complex" which is the responsibility of the IDB) - Organisation of a system wide workshop for 21 June with Hampshire colleagues to take a fresh look at the 8 High Impact Change Model for improving discharge and flow and identify key improvement areas for focus - following this a revised action plan is now in place Recent actions include: - further extension of the dom care retainer with a specific focus on facilitating timely discharge and working with URS to reduce extensions and thereby free up capacity in reablement - Roll out of low level health needs care (with the exception of diabetic care) which will start from Sept - plans to recruit an OT to review double up care with a view to freeing up capacity - budget issued to IDB to provide dedicated transport and other support to facilitate discharge e.g. deep cleans, handyman
Make Care Safer	There is a risk that the sustainability of high quality Mental Health services in the City via Southern Health Foundation Trust (SHFT) and Solent NHS Trust will not be maintained	High	CA	CAMHS waiting times showing significant improvement as a consequence of recruitment due to investment. Southern Health have significant workforce challenges which is impacting on bed availability. Higher use of bank and agency staff who do not have direct access to recording systems. Autism Services waiting list improvement now slowing due to increased referrals; further investigation underway Eastleigh Southern parish transfer of patients has not occurred in line with plan. escalated to contract review meeting. Quality team attending Antelope House Steering Group
Capability and sufficiency in councils procurement service	Staff turnover, lack of HASC category knowledge, skills, and experience within the SCC procurement function, and changes to the contract for procurement services provided by Capita may cause delays/ reduced quality and/or savings to projects in the ICU business plan that are dependent on procurement as an enabling function.	High	CP	The category procurement team has transferred to the ICU, but ¾ of posts are vacant. New team structure expected to be in place in Oct-19, but in the meantime there is significant risk to ICU business plan projects with a procurement-related dependency. An interim has been secured for 3 months starting 19/08, and ICUMT considering procurements that may need to be deprioritised due to service capacity issues.

KEY: SR - Stephanie Ramsey, DC - Donna Chapman, CB - Carole Binns, CA - Carol Alstrom, CP - Chris Pelletier

Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Wheel Chair Service	Waiting lists - financial, clinical and reputational risk. Risk of long waiting lists - leading to individuals at risk of harm in delay in service and reputation	V High	DC	This remains a key area of concern. Actions that Millbrook are taking to improve performance include: - Increased operating hours of the customer service team (8-8) to improve appointment booking - Utilising equipment reps and additional clinic resource to improve & increase handover in clinic numbers - Collaboratively reviewed the service's eligibility criteria with clarified criteria went live in December 2018 - Undertaken a review of school clinic provision which has included engagement with children, parents, schools and school therapists. Recommendations arising from this review have been implemented and the first school clinic was held on 22nd January. -Wheelchair assessment & prescriber training for community therapists to increase the number of direct issue chairs and reduce unnecessary assessments for service users. Both Southern and Solent have taken up this offer and training took place in May. In addition Southampton City CCG and West Hampshire CCG have made additional funding available for a 6 month waiting list reduction initiative focussed on children - which went live w/c 15 March. The aim is to ensure that 70% children are consistently seen within 18 weeks with a view to 18 weeks for all new referrals by the end of the initiative. Performance management of the current contract has also been strengthened through revised KPIs to (a) allow the full review of the patient pathway to improve understanding and identify improvement areas in a more responsive manner, and (b) set clear and achievable targets to enable commissioners to accurately hold the provider to account for any performance issues. Commissioners are now also exploring with Millbrook scope for delivering higher level training to enable community therapists to assess for and prescribe more chairs, following the basic training delivered in May which enables them to directly request direct issue chairs.
Dom Care	Risk that dom care market is unable to keep pace with increasing demand resulting from growing complexity (e.g. more QDS double up clients) and strategic drive to keep people independent. Risk of provider exits from the market adding to challenge around capacity. This is key system enabler and where there are sustainability, capacity and quality issues this impacts on patient choice, quality of care to clients, DTOC, use of residential care and ability to support other priority work areas such as the expansion of extra care housing	Moderate	CB	Action plan developed to address both short-term and long-term requirements has been implemented and has resulted in improvement. In excess of 700 additional hours per week have been sourced from existing provider on framework and additional capacity being sought through the Urgent Response Service. The potential for short-term exits is a constant risk but the process for dealing with this is now well established and we also continue to see strong interest from new providers in entering the care market in Southampton, either through joining the framework or acting as a spot provider. A quality assessment is in place to enable quick take-up of any additional capacity. Whilst there remains high risk due to this market fragility and increasing complexity/demand , this is well managed through the action plan which is updated as the situation changes. New framework design has elements which build on the success of the additional capacity which has been sought through the retainer process over the last two years, NB through lead provider role. Procurement exercise was and a new framework has been in place since 1/4/19. This established 'lead provider' roles across the 5 areas in the city and establishes a platform for further developmental work. These lead organisations are in strong position with both capacity and recruitment and are able to take on additional packages of care, reflected in the placements waiting list numbers being lower. However, we are mindful that although we are in a stronger position currently we have just entered the school holidays which has historically been challenging for capacity.

KEY: SR - Stephanie Ramsey, DC - Donna Chapman, CB - Carole Binns, CA - Carol Alstrom, CP - Chris Pelletier

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Highlight Report: Better Care Steering Board (BCSB)
October 2019

Vision
Providing system wide leadership, setting and driving the programmes of work required to achieve the city's vision and goals as set out in the city's 5 year plan (2020-25) through an integrated city wide system of person centred, strengths based, joined up care and support across health and social care, physical and mental health, primary and secondary care.
Purpose
• Overseeing new system wide models of pro-active care that ensure financial sustainability of health and social care services which promote collaboration and integration. • Holding all stakeholders/organisations to account to operate as a single Southampton "system". This will be underpinned through a Partnership Agreement. • Delivering the agreed plans for Better Care in Southampton, mitigating risks and removing blocks to progress. • Ensuring resources within organisations are prioritised and organised in a joined up way to maximise outcomes and that clusters/PCNs are resourced and empowered to deliver real change on the ground. • Utilising and encouraging the use of outcome based system wide specifications/contracts etc. to incentivise providers to work together. • Holding organisations to account to ensure the continual ongoing engagement of all stakeholders in co-designing, informing and delivering Better Care Southampton plans. • Representing their own organisations whilst prioritising the needs to operate in a collaborative partnership manner for the benefit of Better Care Southampton. • Ensuring that work programmes are aligned across the Local Delivery System and making connections with wider system planning and development (e.g. at a SW system or STP wide level) to ensure achievement of Southampton's Better Care and 5 Year Health and Care Plan.

Key issues considered:

1. Southampton City Five Year Health and Care Strategy programmes and work streams agreed and planning model and timescales approved. See Appendix 1. Highlight reports being developed and will be combined for formal reporting to Joint Commissioning Board.

2. Development of Integrated Locality Teams discussed and what this could look like in the longer term. Faster development required and David Noyes, from Solent NHS Trust, and Sarah Olley, from Southern Health Foundation Trust, now leading work to prioritise integrating teams and to develop a process as to how this builds and integrates with PCNs and localities.

3. Consideration of system Frailty model developed by Ageing Well sub group. Aim to delay the onset and progression of frailty and to enable more people to continue enjoying life independently in their own homes. Other benefits: to reduce pressure on both emergency and social care through better planning and proactive care and support. Approach supported by BCSB, along with agreement on description of levels of input at community, integrated teams and city wide.

4. Oversight of Urgent and Emergency care plans and achievement of Southampton focused actions. Session on improving services to High Intensity Users of services. Cross system working group in place – focus on top 100 without a plan in place already. Challenges with information sharing were identified. Mark Kelsey is progressing with this.

5. Update on workforce – initial collection of workforce data from all agencies by locality to provide a baseline of shape and distribution of capacity and capabilities. This will be undertaken by a workforce subgroup to support planning and achievability of future service models, for example showed that 36% of current workforce will be over 55 years of age by 2024. Further analysis is underway.

6. Q1 Performance reviewed – BCSB requested that report is widened by locality to include key performance indicators relevant to each sub group.

7. Developing Better Care Programme: In order to deliver the programme all parties have identified the need to establish an agreed level of resource to facilitate/ lead on delivery of a system wide work agenda which will support new models of care in the city. Memorandum of understanding being developed to underpin this work.

8. Communications: time limited appointment to support communications leads to develop a Communications and Engagement Strategy and develop website / web content.

Key Risks

Potential risk	Mitigations
Failure to achieve commitment from all organisations on resources for locality and Better Care leadership.	• Development of Memorandum of Understanding with formal sign off and agreement on how to hold each other to account
Failure to adapt and develop to Integrated Care System changes	• Monitor STP direction of travel. Ensure there are strong links into all STP work streams from the BCSB. • Ensure regular feedback at BCSB meetings on STP work streams**.**
Risk that front line staff, wider partners, service users and members of the public are unaware of, do not understand or do not own Better Care vision and nothing changes on the ground.	• All BCSB partners to identify a lead communications person to support Better Care communications and engagement. • Additional communications resource to be funded to work with communications leads on producing and implementing a Better Care communications strategy.
Risk that there is no progress in sharing care plans, improving consistency and quality of care plans thereby promoting silo working and duplication	

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

MINUTES

Meeting: **Better Care Southampton Steering Board on 28 August 2019**
In the Seminar Room, Oakley Road, Ground Floor

Present:

Dr Mark Kelsey (Chair)	SCCG Chair	SCCCG
Jo Pinhorne (JP)	Operations Director – Adults Southampton	Solent
Sarah Turner (ST)	BCS Programme Lead	BCS
Dr Sara Sealey (SS)	Locality Lead / GP	East Locality
Jo Ash (JA)	Chief Executive	SVS
Stephanie Ramsey (SR)	Director of Quality and Integration / Interim Director of Adult Social Services	SCCCG / SCC
Jane Hayward (JH)	Director of Transformation	UHS
Dr Nigel Jones (NJ)	Locality Lead / GP	East Locality
Dr Fraser Malloch (FM)	PCN Clinical Director / GP	Central PCN
Dr Samantha Davies (SD)	PCN Clinical Director / GP	LWP PCN
Matt Stevens (MS)	Lay Member	SCCCG
Dial In: Sarah Olley (SO)	Divisional Director of Operations	SHFT

In attendance:

Clare Young (CY)	PMO Manager	SCCCG

Apologies:

Donna Chapman	Associate Director System Redesign	SCCCG/SCC
David Noyes	Chief Operating Officer	Solent
Dr Nicola Robinson	Locality Lead / GP	Central
Julia Watts	Locality Lead	East Locality
Naz Jones	Locality Lead	East Locality
Dr Sanjeet Kumar	Cluster Lead	West Cluster

Item	Subject	Action
1.	**Welcome and apologies**	
	MK welcomed everyone to the meeting. Introductions were made and apologies for absence were noted, as above.	
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*	
	Action: All members are asked to complete the conflict of interest and	**ALL**

	declaration of interest forms as per the attachments. These are to be completed by everyone even if they do not have any conflicts of interest to note. Members of the Board made it known they had not received papers for the meeting. **Action:** The distribution list for the BCS steering board to be reviewed to ensure all members' names are included.	**ST**
3.	**Minutes of the Previous Meeting (31.7.19), Matters Arising and Action Tracker**	
	Corrections: 4. <u>Workforce subgroup</u> *Add: JA proposed that there should be shared modules for induction and training. All key agencies should be included in workforce.* 5. <u>Update on localities and roles</u> • *The East locality has come together Sara, Julia, Naz and Nigel are the locality leads.* Subject to the above amendments being made the minutes of the Better Care Southampton Steering Board on 31.7.2019 were approved. **Action Tracker actions:** 1. Close 9. Place on agenda for next meeting and close 13. Invite Dan King to next meeting and close 14. Close 16. Close 17. Close 18. In progress, close 19. Close 20. Close	**ST**
4.	**Better Care Performance Report: to review Q1**	
	CY talked board members through the performance report highlighting the following: • Largest challenge is on A&E attendances which then impacts on Non Elective Admissions (NEL) admissions • P6, largest increase in A&E activity is in the working age range of 18-64 years • P7, NEL admissions are seeing the largest area of impact in the older people age range of 65+years • P8, the significant increase in emergency hospital	

	admissions in falls and frailty is in the Length of Stay (LOS) <6hrs, >65+yrs The aforementioned comments are also reflective of the national position and further deep dive into the information has not shown any specific reasons as to why these outputs have arisen. The Board asked CY if the pack could be broken down into localities. **Action:** CY to investigate this option. The Board discussed at length the actions currently being taken by the A&E Delivery Board (AEDB), such as communications plan, working with champions, cross referencing the top 200 High Intensity Users (HIUs). **Action:** SR to circulate the AEDB comms plan. FM asked how widely e-consult is used across primary care as it had been found to be useful within St Mary's Practice and Primary Care Networks (PCNs) in London were using e-consult in an innovative way on behalf of all practices. MK explained usage was variable across the city. **Action:** MK to share data of usage of e-consult with primary care to share within PCNs for discussion. • P11, Delayed Transfers of Care (DTOC) continue to increase above target • P12, Southampton is benchmarked nationally as the 7th worst in the country for DTOC. West Hampshire is 9th. Reasons for DTOC patients are, waiting for care packages, assessments and Nursing Home (NH) places predominantly. SR explained actions being taken to address DTOC challenges are: • Visit to Cornwall to learn from their actions • Recruitment to previous gaps in assessment posts • Complexity of double-up of home care appointments, implementing hoist training to reduce the need for manual handling to free up double up requirements • Long term plan for extra NH capacity • Prevention of admissions – re-ablement in the community, get contact with individuals earlier and connect with social care for re-ablement to increase mobility. Aim to get this in place before Jan/Feb. JH explained to the Board how DTOCs were measured nationally and the impact this had on the outcome for UHS. Currently UHS has the equivalent of 3 full wards full of patients who do not need acute beds. Ideally the equivalent of two of these wards should	**CY** **SR** **MK**

	be elsewhere in the system with one ward of patients requiring other processes to take place within the Trust. The largest problem is placing patients with dementia and mental health needs. Two cohorts of patients are being admitted into hospital that generally should not be there, these individuals with social issues and those who are dying. The Board discussed patients who were accessing tertiary level services and their impact on UHS. SS raised the fact that all the issues relate to secondary care. Were there any reflections on primary care issues? The Board agreed there needed to be a primary care dashboard to be developed and this needed to be designed in consultation with primary care colleagues and for the data to be as correct as much as possible. **Action:** MS to raise dashboard development at the Primary Care Committee. **Action:** SR to meet with DC and CY to discuss the performance report, impact metrics and patient experience and bring back to the next meeting.	**MS** **SR**
5.	**Primary Care networks** • **Feedback from PCN Clinical Directors (CDs) on how they see the future** • **Alignment with Better Care**	
	NJ, FM and SD updated the Board on their reflections of PCNs describing all PCNS being at different stages in their development, building on relationships and understanding the different cultures which exist across practices. Central and North expressed concerns about recruitment and the impact this is/will have on them currently and in the future. Discussions have been taking place as to how to make the "day job" more achievable and the environment manageable and safe. Living Well Partnership (LWP) PCN has recruited a pharmacist who will start at the end of Sept and reflected that this was only one person with a large activity task to undertake. Recruitment is of a concern as this has driven up the costs of locums and impacted on continuity of care for patients. Concern has been highlighted about the future funding and costs to PCNs and that the management fund would not grow with them. The Board discussed these issues at length and how Better Care Southampton (BCS) may help/support the PCNs in their development, the relationship with PCNs and the interaction	

	between the community organisations and localities and what integrated teams across the system and localities might look like. It was reflected upon that DN/SO were meeting to discuss integration of teams. **Action:** JP to meet up with DN/SO to understand what action has been taken in relation to organisations integrating teams and to develop a process as to how this builds, integrates etc with PCNs and localities. Further confirmation of the need for a primary care dashboard to be co-produced was raised. **Action:** ST to invite locality and PCN leads to the workforce workshop on 23 September with explanatory information to engage and share the issues of attraction, recruitment, retention and new ways of working The Board raised the relationship with the STP and the requirements of NHSE in relation to PCNs. The PCN leads shared they had been invited to a PCN network breakfast at the LMC conference in Basingstoke. MK suggested that if there was any feedback which they felt would be helpful to relay, or needed further support then this could be relayed directly to him for any appropriate action.	**JP** **ST**
6.	**High Intensity Users (HIUs)**	
	A further discussion of HIUs followed on from the Performance report conversation earlier in the meeting. JH talked through the paper shared with members regarding the top 200 HIUs at UHS, 150 were Southampton City, 50 West Hampshire. It was acknowledged that generally the information related to geography and deprivation factors, but JH asked if there were any gaps in the work currently being undertaken which were not being addressed and how care plans could be unified. UHS send their data to the CSU to identify where individuals and families are to help understand where the resources are being taken up across secondary, primary and the local authority. The issue of data sharing was raised by members of the Board and gaining access to data from the CSU. **Action:** MK to raise the issue of data sharing with the CSU and find solution to share. SR shared with the Board a workshop of the HIU group on 23 September, 9.30-11.30 at Oakley Road, which will discuss the impact of the pilot undertaken to date and further possible options. The group would like to invite locality/PCN representation to the meeting. **Action:** ST to co-ordinate with SR and GC on sending out invitations to colleagues as soon as	**MK** **ST**

	possible. **Action:** The Board requested GC be invited to the next Steering Board and with DC share the outcomes of the workshop	**ST**
7.	**Integrated locality teams: What could this look like?**	
	This had been discussed within agenda item 5.	
8.	**Partnership agreement** • **Update on current position and agreement of next steps**	
	ST provided a summary of the feedback received to date, which addressed what the real purpose of the paper was; in its current form whether it was fit for purpose; differences over ability to pay for posts versus provision of staff and whether all organisations were party to the agreement even if they were not directly involved in the payment or provision of staff. SR informed the Board the CCG would fund a time limited communications post. Who would employ the individual and where they would be sited had yet to be agreed. **Action:** SR to follow up the appointment of this post with TS. ST shared with the Board that the post of project manager had not been successfully recruited to and a further attempt would be tried in September. MK and JP asked for the job description to share with potential individuals for the role. **Action:** ST to send job description details to MK and JP. JA stated the partnership agreement was not just about financial intent but also the commitment for all organisations to work together for a common purpose. The question as to whether PCNs should be signatories to the agreement was raised but as they are not legal entities it was felt this was not appropriate. If the document had been an MOU then the situation would have been different. SR explained she had an opportunity to use the legal team within the council and could take the feedback from the Board and ask the legal team to reframe the document accordingly. **Decision:** The Board agreed the document should be produced from a legal standpoint addressing issues raised as well addressing those not known by the Board. **Action:** SR to take the partnership agreement to the legal team at the council for completion.	**SR** **ST** **SR**
9.	**Standing Items** • **DTOC Update**	

	• **AEDB Urgent & Emergency Care Plan**	
	DTOC had been discussed in agenda item 4. SR updated the Board on AEDB plan with JH. An explanation of the impact of a breach of licence by UHS for not meeting the A&E target and cancer targets in a timely manner was shared. UHS have written a plan for NHS England/NHS Improvement however a system plan has also been requested. This has been written with colleagues and the plan aims for a trajectory recovery by 31.10.2019. Weekly phone calls from both an operational perspective and Chief Executive Officers (CEO's) are in place. The plan is likely to morph into the winter plan. UHS need to demonstrate consistent improvement with system help. **Action:** ST to resend the AEDB plan out to Board members for awareness. UHS have placed 9 additional junior medics in Emergency Department (ED). The organisation is working with highly regarded external ED consultants to help them improve their current situation to a sustainable place.	**ST**
10.	**RAID Log** • **To note risks and issues**	
	The following actions to **risks** were agreed: Risk 9. To be closed.	
11.	**Any Other Business**	
	None were raised.	
12.	**Close**	
	Meeting closed at 11:10	
Date of next meeting: Wednesday 25 September 2019, CCG Conference Room, NHS Southampton City CCG, Oakley Road, Millbrook, Southampton, SO16 4GX		

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