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Joint Commissioning Board

Thursday, 20th February, 2020
at 9.30 am

PLEASE NOTE TIME OF MEETING

Conference Room, CCG HQ, Oakley Road, Southampton

This meeting is open to the public

Members

Dr Kelsey (Chair)
Councillor Hammond (Vice-Chair)
Councillor Fielker
Councillor Shields
Maggie MacIsaac
Matt Stevens

Please send apologies to:

Emily Chapman, Board Administrator,

Tel: 02380 296029

Email: emilychapman1@nhs.net

PUBLIC INFORMATION

Role of the Joint Commissioning Board

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

Public Representations

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

Benefits from Integrated Commissioning

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

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

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

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

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

Dates of Meetings: Municipal Year 2019/20

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

CONDUCT OF MEETING

Terms of Reference

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

Business to be discussed

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

Rules of Procedure

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

Quorum

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

Disclosure of Interests

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

AGENDA

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

1 WELCOME AND APOLOGIES

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

2 DECLARATIONS OF INTEREST

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

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

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

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

4 RESIDENTIAL AND NURSING HOMES – MARKET MANAGEMENT UPDATE AND COMMISSIONING STRATEGY (Pages 7 - 18)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Matthew Waters	Decision	Attached

5 PERFORMANCE REPORT (Pages 19 - 28)

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

	Information	
Stephanie Ramsey	Discussion	Attached

6 BETTER CARE HIGHLIGHTS REPORT (Pages 29 - 54)

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

7 BETTER CARE STEERING BOARD MINUTES (Pages 55 - 62)

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

8 ANY OTHER BUSINESS

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

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Meeting Minutes

Joint Commissioning Board - Public

The meeting was held on 19th December 2019, 09:30 – 11:00
CCG Conference Room, NHS Southampton HQ, Oakley Road, SO16 4GX

	NAME	INITIAL	TITLE	ORG
Present:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	Councillor Dave Shields	Cllr Shields	Cabinet Member - Health and Sustainable Living	SCC
	Councillor Lorna Fielker	Cllr Fielker	Cabinet Member – Adult Social Care	SCC
	Matt Stevens	MS	Lay Member for Patient and Public Involvement	SCCCG
In attendance:	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG / SCC
	James Rimmer	JR	Managing Director	SCCCG
	Sandy Hopkins	SH	Chief Executive	SCC
	Beccy Willis	BW	Head of Governance	SCCCG
	Keith Petty	KP	Finance Business Partner	SCC
	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Amanda Luker	AL	Senior Commissioning Manager	SCCCG/ SCC
	Chris Pelletier	CP	Associate Director	SCCCG/ SCC
	Emily Chapman (minutes)	EC	Business Manager	SCCCG
Apologies:	Maggie MacIsaac	MM	Chief Executive Officer	SCCCG
	Councillor Chris Hammond	Cllr Hammond	Leader of the Council	SCC

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted.	
2.	**Declarations of Interest**	
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or	

	relationship No declarations 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 17th October 2019 were agreed as an accurate reflection of the meeting. **Matters Arising** **ACTION: Primary Medical Care estates briefing to be brought to an informal meeting before March 2020** **Action Tracker** There action tracker was reviewed and updated.	**EC**
4.	**Integrated Advocacy Service**	
	AL attended the meeting to present the Integrated Advocacy Service procurement. Cllr Fielker introduced the paper to the Board. Cllr Shields queried why the contract is only set for two years. AL responded it is a 2 year contract with the option to extend for a further two years. This procurement is joint with Hampshire, and this is a jointly made decision for a 2 year contract. Cllr Fielker approved the following recommendations: (i) To delegate authority to the Director of Quality and Integration, following consultation with the Cabinet Member for Adult Care, to award the contract for the Integrated Advocacy Service to the preferred bidders as set out in the report and to enter contracts in accordance with the contract procedure. (ii) To delegate authority to the Director of Quality and Integration to progress contractual and financial close of commissioned services for Integrated Advocacy Services and exercise all further decision making in relation to this re-commissioning AL left the meeting.	
5.	**Establishing a regional consortium for the commissioning of independent foster care**	
	CP attended the meeting to present the establishing a regional consortium for the commissioning of independent foster care papers to the Board. CP outlined the highlights of the report. The number of Looked After Children (LAC) placed in Independent Foster Arrangements (IFA) is over profile, as opposed to what is planned for. The unit costs we have seen in IFA is in line with regional and national averages. One of the aims for the new contract is to maximise	

	incentive for providers to give their best cost. This contract doesn't solve the issue of demand, but does provide the solution for what we pay foe. To ensure via the contract value for money, with standardised terms and conditions. Cllr Fielker raised that it is positive to see an independent care charter to be introduced. SR highlighted that this work has been undertaken in conjunction with children's services. MK asked if the 16 Local Authorities are local to Southampton. CP responded the range is quite wide. CP clarified the finances to the Board. The Board thanked CP and his team for all the hard work that has taken place to get to this stage, and the ongoing work that will be needed. JCB agreed the following: (i) It is recommended that regional LAs are invited to join a Southampton-led consortium for the purpose of commissioning a replacement to the current IFA framework agreement. It should be further noted as detailed in Appendix 1 that the project budget is £92,277, that Southampton's estimated contribution to the cost of this project (based on proportional utilisation, and assuming all current consortium LA's join the new consortium) is £10,169, with the balance to be paid by participating authorities. Southampton will additionally receive income of £13,031 per annum from consortium members during the contract term as remuneration for undertaking the tasks and functions associated with consortium leadership, and Southampton's estimated contribution to the cost of centralised contract management will be £15,480 p.a. during the contract term. CP left the meeting.	
6.	**5 Year Health and Care Strategy**	
	SR provided a verbal update on the development of the Southampton 5 Year Health and Care Strategy as follows: - The full Strategy will be brought to a future meeting for approval - All the sub-groups leading on work streams are working on detailed plans, including road map of priorities for each year - Key Performance Indicators being developed - Work streams are being developed via the Better Care Steering Board, to align with work that is taking place in the clusters and Primary Care Networks (PCNs) Cllr Shields queried governance, scrutiny and ownership of this	

	document. It was clarified the endorsement of the Strategy would take place at JCB. Formal approval will be via Cabinet and Council, CCG Governing Body and Health Provider Boards. Better Care Steering Board will oversee the effective implementation, and will escalate any issues to this Board.	
7.	**Performance Report**	
	The Board received the performance report for review. SR outlined the highlights of the report. The Board discussed the issues regarding concerns on the wheelchair service. It was noted that the procurement for the wheelchair service is currently taking place. JR raised Delayed Transfers of Care (DTOC). **ACTION: to undertake a deep dive at this Board on DTOC**	**SR/DC**
8.	**Better Care Steering Board Minutes**	
	The Board received the Better Care Steering Board (BCSB) meeting minutes from the 25th September 2019 for information. MK provided a verbal update on the November BCSB meeting as follows: - The work continues on strengthening the three locality teams - The PCN Clinical Directors now attend the BCSB - There is a transition to move from localities to PCNs, however this is work in progress - The main focus of the meeting was to look at project ideas from locality leadership teams, and the Board approved this work to go forward. 12 projects were submitted covering a range of areas including social prescribing, mental health and integrated working	
9.	**Any Other Business**	
	None raised.	
10.	**Next Meeting Date**	
	20th February 2020 09:30 – 10:30, Conference Room, NHS Southampton HQ, Oakley Road, Millbrook, SO16 4GX	

Joint Commisioning Board - Action Tracker (Public)					
Date of meeting	**Subject**	**Action**	**Lead**	**Deadline**	**Progress**
17/10/2019	Quality Report	SR to provide a briefing at a future meeting on staffing / workforce within Mental Health / SHFT	Stephanie Ramsey	Apr-20	Scheduled for March 2020 meeting
17/10/2019	Quality Report	Deep dive session to take place on Mental Health.	Stephanie Ramsey	Apr-20	Scheduled for March 2020 meeting
17/10/2019	Performance Report	Deep dive session to take place at a future meeting for the Associate Directors to talk through each of their areas	Stephanie Ramsey	Apr-20	Scheduled for March 2020 meeting
17/10/2019	Highlight Report: Better Care Steering Board (BCSB)	MS to bring an update to this Board and Better Care Steering Board on the Primary Care Estates review	Matt Stevens	Mar-20	Complete - took place in January 2020
19/12/2019	Performance Report	To undertake a deep dive at this Board on DTOC	Stephanie Ramsey / Donna Chapman	May-20	Complete - DTOC update included in the papers for the February meeting as part of the Better Care Report.

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DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Residential and Nursing Homes – Market Management update and commissioning strategy**		
DATE OF DECISION:		**Thursday, 20th February 2020**		
REPORT OF:		**Stephanie Ramsey**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Matthew Waters	Tel:	023 8083 4849
	E-mail:	Matthew.waters@southampton.gov.uk		
Director	**Name:**	Stephanie Ramsey	Tel:	023 8029 6941
	E-mail:	Stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY

BRIEF SUMMARY
The Integrated Commissioning Unit (ICU) works on behalf of the council and CCG to meet the Care Act duties of facilitating a diverse market of personalised care and support services, to enable people with care needs to access the right care services they need. This includes: • Gathering market intelligence to identify the strengths of the market and where changed resources may be required in the future. • Detailing requirements for services, to enable providers to respond to needs. • Specific activities, including commissioning and procurement, and also responding to cost and other pressures the market is facing.
In these ways the ICU ensures the following: sufficiency of supply to meet needs; diversity promoting choice for individuals; the risk of market failure is managed; quality is promoted; and best value can be achieved.
This paper provides the Joint Commissioning Board with information on the approach being taken to the residential and nursing home market relating to the following key areas: • Cost pressures within the residential and nursing home sectors for older people in particular and the approach for future pricing and published rate levels. • Current work providing for a more formal approach to commissioning. This includes the development of a procurement strategy, working with the CCG and neighbours and identifying opportunities to increase capacity in the nursing home availability in the future.
RECOMMENDATIONS:
The Joint Commissioning Board's authority is sought to implement the proposals in this paper including:

	(i)	The increase in the current published rate levels of care homes costs from April 2020 based on the likely impacts of the National Minimum Wage increases and the current inflation rate. The recommended increases are Residential care – 5% increase; Nursing homes – 6% increase.
	(ii)	The strategy for responding to uplift requests from homes providing care at

		costs above the published rate levels.
	(iii)	The further reviews of the published rates to stratify these based on complexity of care.
REASONS FOR REPORT RECOMMENDATIONS		
1.	Failure to provide a clear approach to managing the local care and support market would produce significant risk in relation to: • Fulfilment of the Council's duties under the Care Act to shape and manage the local care market maintaining sustainability. • The frequency of care packages and contracts being 'handed back' to the Council, and provider failure or exits from the local care market. • The ability to routinely facilitate timely movement of patients through the local system of health and social care services (i.e. impacting on Delayed Transfers of Care).	
2.	The proposals are designed to bring a level of stability to the residential and nursing home markets accessible to the council, and to maintain the council's market position in 2020/21. This will enable a more comprehensive review for 2020/21. This will be informed both by market insight and our strategic intentions particularly in relation to an increased focus on community led support and embedding prevention within the Adults' commissioning intentions and the operational delivery model within Adults Social Care.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
3	To not increase the published rate levels – this will place the authority at risk of failing to meet its duties under the Care Act, by failing to adequately meet the needs of providers to ensure financial stability.	
4	A number of options for fee increases have been considered including increases based on Retail Price Index and Consumer Price Index. In addition, we considered modelling different rises on different breakdowns of estimated staff costs and other costs. Although this means that an alternative set of proposals could be justified, this would do no more than transfer funding between providers on a zero-sum basis. The challenge would be whether this would make better use of the funding that is available. Since the assessment in this report has taken market-related considerations into account, the alternatives would not lead to better outcomes than the recommendations in this report will produce. For example, there are options to consider lower increases to the published rate levels but these would fail to adequately address concerns within the market and would risk Southampton finding it more difficult to access much needed care home places.	
DETAIL (Including consultation carried out)		
5	Residential care homes and nursing homes both provide 24-hour care in an accommodation setting. Nursing homes also provide nursing staff, enabling them to provide a higher level of care to those individuals with the most complex needs.	
6	The market is not always well balanced. One such area is the over-supply of residential care for older people. Often this accommodation is small, within refurbished standard housing available on the open market, and is unsuitable to meet all needs. Elements of this market may therefore be at risk if CQC require considerable investment, as has been the case in a very small number of homes to date.	

7	Conversely, there is an under-supply in adult nursing care provision, despite the city having developed two long term contracts to guarantee supply. Although the numbers of council placements into nursing care have not changed significantly in recent years, the need levels have increased significantly, and too much of the provision in the city remains at too low a level to meet the more complex need requirements. As a result, around 40% of all placements in nursing homes are made outside of the city, even if the majority of these are made in homes within just five miles of the city boundary.
8	**The residential care home market in Southampton** There are 29 private residential care homes in the city providing accommodation and support for people aged 60 and above. A number of these support people aged 16-64 as well. This number does not include residential settings for people with Learning Disabilities nor those specifically aimed at people with mental health, substance misuse and other issues.
9	These 29 homes provide a total of 690 bed spaces. Of these, Southampton uses a total of approximately 270 at any one time (40% of the total). The rest of the placements are secured from the council's in-house provision and from outside of the city.
10	The sector is made up largely of small providers – mainly owning only one or two properties. There are few larger units, specifically built, and where available these are owned and managed by regional and national organisations. In this, Southampton is not an outlier in relation to other unitary authorities, nor in relation to the residential home market more generally.
11	There is an over-supply of this accommodation, with vacancy levels averaging 10%. This is of concern as it suggests a loss of potential revenue for those homes carrying vacancies. Two care homes in the city have closed in the past three years – one in 2017 and one in 2018. Both followed CQC inspections and requirements to invest in the homes to meet standards
12	**The nursing care home market in Southampton** There are eight nursing homes operating in Southampton, plus one rehabilitation centre. All are privately owned, and all bar two are owned and run by regional and national organisations. The nursing homes provide 566 places in total. All nursing homes in the city are purpose built, although the rehabilitation centre has been built as part of a large existing building. All properties meet CQC standards and expectations.
13	At any one time, the council commissions around one-third of these bed spaces. The CCG commissions further places, which means the public sector commissions up to 40% of the total nursing home places in the city. This includes 100 places within two nursing homes where the council has long-standing contracts.
14	**Quality** Quality within homes is improving, as shown by CQC ratings, with 95% of providers rated as Good or Outstanding. These ratings show the market locally has been well supported and is continuing to improve. This will make it easier to deliver the continuity of care required and puts providers in a good place to retain staff in the future. This provides a stable base for continuing discussions and moves to manage changes in care delivery to support increased complexity of care needs.
15	Driving up quality standards has limited the need for lengthy cautions or suspensions, and so significant placement capacity has been released following the improvements.

	For example, Southampton has seen 130% improvement in CQC ratings, and 95% of care home beds in Southampton are now rated Good by the Care Quality Commission following significant input from the ICU Quality team.
16	Managing access to and the costs of residential and nursing care Care home placements are increasingly required only for those with the most complex needs and challenging behaviour. Demand for nursing care that is suitable for those with cognitive impairments and complex needs in particular, is increasingly outstripping local supply and as a result, 40% of the Council's nursing home placements for this group are now made outside the city boundary.
17	The ICU Placement Service is successful in managing costs for spot purchase placements as effectively as possible. However, the demand for care exposes the city to competition for a limited supply with neighbouring authorities and self-funders whose usual rate of pay for such placements is significantly higher. This is affecting placements within the city and on its boundaries.
18	Increasing the supply of nursing home capacity accessible to the council and health is a priority. Work undertaken with the market suggests that the current nursing home market in the city is responding only slowly to the future demands and requirements of the city council and CCG. Even where placements are being made costs are rising. The reluctance to invest also reflects changes to the bank lending practices and the low returns this sector is providing.
19	In 2018 the council signed the Residential Care Charter, committing itself to work towards enabling the market to pay staff at Real Living Wage levels – a level the council pays its staff in its own homes. These rates are currently 12% higher than the National Minimum Wage level. There is a need to help the market to attain this level.
20	**Financial and demand pressures** The overriding priority when commissioning care is to ensure sufficiency of supply of quality care. Under the Care Act 2014 a local authority has a duty to ensure sustainability of the care market and to ensure that there is diversity and quality in supply. Providers are autonomous businesses responsible for employing, training and setting pay and terms and conditions for their own workforces. The council has to set fees that cover the legitimate costs of delivering the service and make a fair return to support the business to be sustainable.
21	Although the Council remains the single biggest purchaser of available beds in the market, self-funders purchase the majority of places - over 55% of available beds, with the balance bought by the CCG and a very small number bought by other local authorities (mainly within the rehabilitation centre). This puts additional pressure on the council when setting fees as, in essence, it is competing with self-funders who generally providers favour as they often have lower support needs and are in a position to pay fees at a higher rate.
22	In addition, the publication of the Competition and Markets Authority (CMA) report in 2017 showed that the market is able to cover its costs, but is finding it increasingly difficult to cover future capital requirements.
23	The ICU recently updated its financial analysis of the 10 homes in the city with the highest number of council placed residents. This showed that these providers were covering their operating costs but that the rate of return did not allow for any significant investment decisions to be made from capital. This is added to by the rate of returns being low, meaning that securing funding from the banking sector may also be difficult. This information matched the circumstances faced by the two homes to

	have closed in the city in recent years.
24	The cost of care and support services have been rising significantly due to year on year increases in the National Minimum Wage rates. As these have risen, the main pressures have been on the lowest cost placements and, within the residential sector, on those placements made at the council's published or expected rates. Initially, the highest cost placements have been largely kept stable. However, in the last two years even these placements costs have begun to rise as providers determine that cost differentials between staff have been denuded to a level below which they cannot drop further.
25	For the council to ensure both sufficiency and quality of supply it accepts that the rates at which it purchases care will need to rise. The core of its approach takes into account market insight about the relative proportions of provider spending which are accounted for by staffing costs and other types of expenditure. Since care is a relatively low-paid sector, the increase in the National Minimum Wage from 1st April (6.2% for over 25s and 6.5% for under 25s) is the largest individual impact. A further general inflationary increase is allowed for other costs, affecting homes. Other factors such as future commissioning intentions, market sustainability, training to meet current and future needs, and recruitment and retention, are the basis for the proposals that are the subject of this report.
26	The ICU is therefore responding on several fronts: • Agreeing increases to the published rate levels above the minimum level, including a higher increase for the nursing home rate. • Developing its understanding of a fair price for care in homes. • Developing specifications for care homes, reflective of needs. • Developing its third party workforce strategy to ensure the skills in the workforce to meet complex needs in the future. • Working with Southampton and West Hampshire CCGs, and Hampshire County Council, to determine a commissioning approach, particularly focused on the highest cost placements. • Considering procurement options for residential settings, to guarantee access and prices for specific care needs. • Continue to work with the sector to identify opportunities for new nursing homes, including on the RSH site.
27	These areas will be included within the ICU Business Plan for 2020/21. Reports on progress will be made to the Joint Commissioning Board as each element progresses.
28	**Published rate levels for 2020/21** The council's published rates reflect the price the council has determined it wishes to pay for care home placements. A review of published rates in the South East shows that Southampton's published rate levels are in the lowest quartile. They are low in relation to the neighbouring authority of Hampshire, whose published rates are between £60 and £100 per week higher.

<table>
<tr><td>29</td><td>Southampton is able to commission care from the residential and nursing home sector at a cost that is below the south east average, although significantly higher than its published rate levels:
<table>
<tr><th></th><th>Residential care (average cost)</th><th>Nursing Care (average cost)</th></tr>
<tr><td>Southampton</td><td>£738.27</td><td>£730.37</td></tr>
<tr><td>South East</td><td>£767.93</td><td>£741.77</td></tr>
</table></td></tr>
<tr><td>30</td><td>Annually, commissioners undertake a review of the rates, fees and charges it pays to independent providers of care homes in Southampton. In addition to statutory and market considerations, commissioners have also considered other factors that include:
Contract clauses on price revision and annual inflation.
Pressures on providers including (but not limited to) statutory obligations, paying the National Minimum Wage.
Auto enrolment of pensions and increased regulatory costs, with CQC costs rising by 60% over three years (CQC).
Intelligence from the market gained through provider forums, meetings with individual providers, representations from providers and market reports that inform the commissioning at current rates and the impact of uplifts on the market.
Private rates paid and what is a fair ‘public’ rate/fee to pay, taking account of guides (for example) on minimum rates.
Representations from providers on pressures and expectations of the market, difficulties in recruiting and increasingly the difficulty in retaining staff against a backdrop of increased regulation and complexity of need.</td></tr>
<tr><td>31</td><td>This report excludes the two contracts with BUPA, since changes in their costs are governed by the indexation provisions specified in those agreements.</td></tr>
<tr><td>32</td><td>The formula used to calculate the appropriate uplift to the published rates uses a split of 50% wages and 50% other costs. For this year the impacts are:
NMW (6.3%) + Inflation (1.9%) = 8.2% / 2 = 4.1%</td></tr>
<tr><td>33</td><td>There is a need to ensure council rates are reflective of the current market, to sustain that market for the longer term. It is also continuing to be difficult to secure care at the council’s published rate levels. This is particularly the case within the nursing home sector, even allowing for the two BUPA contracts. As complexity rises, so the gap between the published rate levels and the costs to meet needs is growing. Indeed, despite the best efforts of the Placement Service, once the council has to negotiate prices above the published rate levels it is subject to the market setting those rates, making increases in costs more likely.</td></tr>
<tr><td>34</td><td>Proposed action – Published rate uplifts 2020/21
While the published rates need to increase by 4.1% just to keep pace with costs, the need to secure access for more complex needs is continuing to grow. There is the particular need to address the pressures within the nursing home market. The fact that Hampshire’s rates are so significantly higher that Southampton’s is not lost on the market further increasing pressures. Indeed, residential care secured outside of the city in Hampshire now commences from the Hampshire published rate level as a minimum. The current rates for comparison:</td></tr>
</table>

Code	Client Groups	Southampton Published Rate	Hampshire Published Rate
	RESIDENTIAL CARE HOMES		
2	Very Dependent Social Care Rate	£417.76	£516
2A	Very Dependent Social Care with Dementia	£493.15	£616
	NURSING CARE HOMES		
4	Social Care Rate (includes very dependent nursing for people with dementia)	£551.11	£684

35 In order to show the market that Southampton is responding to concerns about sustainability, to promote access to spaces, and to encourage higher increases in wages for staff on the National Minimum Wage, it is recommended the council pays a higher increase than the minimum identified above of 4.1%. Indeed, a 5% increase to residential care and a 6% increase for nursing care minimum rates will give clearer indications to the market of the council's intentions to begin to address their concerns, and to recognise the greater difficulty in securing access particularly to nursing home places.

36 Uplifts to the published rate levels at 5% for residential care placements and 6% for nursing care placements would see the following changes in rates:

Code	Client Groups	2019/20	2020/21 – Per week and (daily rate)	Total cost
	RESIDENTIAL CARE HOMES			
2	Very Dependent Social Care Rate	£417.76	£438.69 (£62.57)	£19,569
2A	Very Dependent Social Care with Dementia	£493.15	£517.86 (£73.98)	£147,411
	NURSING CARE HOMES			
4	Social Care Rate (includes very dependent nursing for people with dementia)	£551.11	£584.22 (£83.46)	£125,519

Total cost of proposals - £292,499 above current council spend

37 The ICU will manage the communication with the sector to explain the differentials in increases.

38 This will impact on the council budget. The budget for adult social care has increased for 2020/21 to take account of what was the expected National Minimum Wage increase. The actual increase is however higher than originally expected by 0.6% (with a 0.3% impact on the market itself). This issue has already been raised by the Finance Team.

39 Despite this, we propose to manage the budget by limiting increases for care at above the published rate levels, as providers approach the council.

40 **Proposed action - Responding to other uplift requests**

For care home placements purchased at above the published rates, it is proposed

	that the ICU follow the usual process of confirming the legitimacy of uplift requests on a case by case basis through analysis of financial checks, accounting processes and provider negotiations, including individual cost checks. However, a maximum increase of 2% is to be set. Any requests resulting in a higher increase will need to follow agreement with the Executive Director for Health and Wellbeing (Health & Adults).
41	It is further recommended that this 2% level becomes the aim for Southampton CCG for Continuing Healthcare increases. It is expected that some increases above this level may be required, depending upon the individual circumstances of each case.
42	**Proposed action - Fair price for care in the residential sector** In 2015/16, Southampton joined with Hampshire and Portsmouth councils in commissioning Laing and Buisson to undertake a cost of care exercise with the sector. This failed however, to provide adequate data for any of the areas (too few responses within the timescale allowed) upon which to base recommendations.
43	In 2016, the ICU undertook a simplified cost of care exercise, considering care levels required in homes to meet needs and adding hotel costs. We updated this recently, and the results are similar in that the actual cost for a care home placement is at a minimum 10% higher than the published rates set for 2020/21. The ICU will now test this with the market itself. The intention is to focus both on the basic costs of providing care in residential settings, and to develop a pricing model for more complex care packages. This will include the care home sector and Hampshire Care Association. It is expected this modelling will help in updating the published rates.
44	**Developing specifications for care homes, reflective of needs** The work on the cost model will lead to the development of new specifications and expectations for care delivery. In this way, placements can be matched with expectations of delivery standards and prices rather than being an open negotiation for each placement. These specifications and prices would be suitable to share with the CCG and will promote joint commissioning.
45	**Developing the third party workforce strategy** The ICU is working with the sector to understand the workforce requirements for the longer term. Currently, a mapping exercise is being undertaken and this will lead to training and recruitment practices for the future. The sector is helping to produce this work.
46	**Working with Southampton and West Hampshire CCGs, and Hampshire County Council** The ICU has been meeting with Hampshire County Council commissioners during the last year. This mapped out some opportunities for joint working. The main area for continued discussions is on the highest cost placements the agencies make. These are almost exclusively in homes outside the city boundaries in Hampshire. It is clear that Southampton, Hampshire, and the two CCGs are attempting to access the same homes, often to the detriment of each other as the limited number of bedspaces available allow homes to have greater power over both access and price. The next stage of the discussions is to share information on placements and costs.
47	This could involve a commissioning approach specifically around these homes and placements. The current work is focused on defining the homes and understanding the competition elements. Consideration will then be given to defining the most appropriate approach.
48	**Considering procurement options for residential settings**

	The ICU is currently gathering information on procurement options. This includes a review of how other areas have approached their local markets to see if there are lessons to be learnt in a formal approach to the market. The work on costs, specifications and joint working with others all suggest we will be in able to develop an approach beyond the current 'framework' established by the signing of the current Residential Contract. The risk for Southampton is that with so many placements occurring outside of the city any procurement approach has to be mindful of the needs of other local authorities.
49	Discussions with Hampshire have included the possibility of a Dynamic Purchasing System being adopted. This has not progressed further, but would present one option for consideration.
50	The procurement specialists now based in the ICU will provide appropriate support, skills and knowledge to enable this area to progress.
51	**Continue to work with the sector to identify opportunities for new nursing homes** The need for more nursing home capacity in the city, particularly for more complex needs has been shared with the market.
52	A Land Options paper was developed in 2019, with limited sites showing availability. The ICU, on behalf of the council and CCG, is involved in discussions with NHS Property Services regarding the future use of approximately half of the RSH hospital site near the city centre. This is entering the stage where NHSPS are to commission a partner to advise on ways to take forward the plans and ideas. These will continue to be taken forward this year.
RESOURCE IMPLICATIONS	
Capital/Revenue	
53	The costs of the changes to the published rates is of the order of: **Code** | **Impact of 5% and 6% increase** Code 2 | £19,569 Code 2A | £147,411 Code 4 | £125,519 **Total cost** | **£292,499**
54	For cost comparison purposes, the effect of a 4.1% increase on prices is included below: **RESIDENTIAL CARE HOMES** | **2019/20** | **2020/21 – 5% & 6% increase** | **4.1% increase** | **£ increase** | **Revised cost** | **£ increase (daily rate)** **2** | **Very Dependent Social Care Rate** | **£417.76** | **£438.69 (£62.57)** | **0.041** | **17.1282** | **434.888** | **62.1269** **2A** | **Very Dependent Social Care with Dementia** | **£493.15** | **£517.86 (£73.98)** | **0.041** | **20.2192** | **513.369** | **73.3385** **NURSING CARE HOMES** **4** | **Social Care Rate (includes very dependent nursing for people with dementia)** | **£551.11** | **£584.22 (£83.46)** | **0.041** | **22.5955** | **573.706** | **81.9579**
55	The council has already transferred £1.6million into the adult social care budget to account for increases to the National Minimum Wage (NMW). A further £172K is to be transferred into the budget to account for the higher than expected increase in the NMW level. Similar increases are already built into the budgets for the following two

	years. This is equivalent to 4.1% for care home increases and 5.02% for other services (utilising the formula for calculating the impact of NMW and inflation and different settings).
Property/Other	
	There are no property implications from this report.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	The Care Act requires local authorities to promote the diversity, quality and sustainability of local adult care services. This duty includes a requirement to promote the efficient and effective operation of local care services and ensure that people wishing to access them have a variety of high quality services to choose from.
Other Legal Implications:	
CONFLICT OF INTEREST IMPLICATIOINS	
	None
RISK MANAGEMENT IMPLICATIONS	
	The risk with awarding only a 4.1% increase for the Published Rate levels is that this merely creates a standstill position for homes and fails to begin to address the issues regarding the low published rate levels in the city. It will fail to begin to address the concerns of the market, the low rates of return for homes, and will not address the low level of new placements being made at the council's published rates.
	The 2% limit on other requests for increases is likely to be tested by applications from providers. However, while there will be some cases of higher increases being required, the process of managing the requests, with dedicated resources of the ICU, will limit most requests. The council has made a financial commitment to adult social care for 2020/21 including covering additional costs, and the ICU will work to manage inflationary increases within these budgetary constraints, as has been the case in recent years.
POLICY FRAMEWORK IMPLICATIONS	
	The proposals are in line with the council's policy framework plans and meet the council's financial procedure rules and scheme of officer delegations.

KEY DECISION?	**Yes**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	

1.	
2.	

Documents In Members' Rooms

1.	
2.	

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.		
2.		

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1. Integrated Commissioning Unit (ICU) Summary Performance Report — M10 (Jan) 2019/20

Achieving Transformation Change

↑	95% Target ≥ 92%	% CAMHS routine assessments within 12 weeks
↑	186 Target ≤ 153	Number of Permanent admissions to residential & nursing homes (65+)
↓	45.5 Target ≤ 27	Average Daily Delayed Transfers of Care (DTOC) beds
↓	21,258 Target ≤ 20,272	Number of Non-Elective Admissions
	2,607 Prev Yr = 2,224	Falls & Fraity (65+) Admissions <24hr

Quality

↓	50% Target ≥ 80%	% Full Continuing Healthcare Assessments completed ≤28 days
↑	100% Target ≥ 85%	% Continuing Healthcare Assessments taking place in community
↑	86% Target ≥ 90%	% of placements that are sourced through the Care Placement Team
↑	5.5% Target ≥ 5.3%	% people with common mental health conditions accessing IAPT
↑	30.0% Prev 12 mths = 29.1%	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

Supporting work to further develop integrated team model

Section 75 review of Mental services now complete, recommendations reviewed and accepted by SCC and SHFT. Recommendations have been used to develop an action plan with delivery oversight at future s75 partnership board meetings. CAMHS - Multiagency Single Point of Access with No Limits and Yellow Door in place. The Lighthouse Crisis lounge now open in Shirley High St.

Roll out of SoLinked (community solutions) including development of Southampton fund. New city wide navigation service in place that includes navigation for people living with mental health challenges and dementia.

Consultation underway on deregistration of 3 Dimensions residential homes, will impact 17 clients (estimated saving £150k).

Development of Sufficiency strategy with children's services. CAMHS Local Transformation Plan refreshed. MH Support Teams in Schools commenced Jan 2020 to support schools in managing MH/emotional/behavioural difficulties. Work commenced to develop a more integrated model of pre-school provision for children with complex disabilities.

LD market position statement currently being reviewed.

Ageing Well Framework finalised with wide stakeholder engagement - Peoples Panel Survey completed to inform messaging approach and identify potential priorities.

b. Procurement & Market Mananagement

Number of procurements in train including:

• Joint Equipment Store (max £11,260k for Southampton City) - procuring for both PCC and SCC. Stand still period now completed and contracts with Nottingham Rehab for signing, work has started work on the transition between providers. Service due to commence 01.07.20.

• Direct payment support (£512k) – complete, service to commence April 2020

• Weston Court respite service progressing through tender process

• Southampton Peer support services (£480k) – awarded. To commence April 2020

• Wheelchairs procurement – joint across all CCG's in Hampshire and Isle of Wight. Procurement closed 27 January and now in evaluation phase.

• Home care framework call off– additional hours confirmed following a mini competition off the Framework ,using winter pressures

• 1st anniversary of the reopening Children's residential framework has now concluded and also working with consortium on evaluation of the reopening event for the Independent Fostering Agency framework

• Work commenced on development of a community transport offer – model to be presented to JCB in June.

• Development of vision for making best use of Kentish Road site and agreement to proceed to undertake a feasibility study

• Palliative care – formal notice given to Solent NHS Trust and care will move to Countess Mountbatten from August 2020.

• LD day external service review in progress, to align with internal review.

c. Quality

Overall quality of social care providers in Southampton continues to be good, a recently held provider event, focused on supporting care homes in avoiding admissions to hospital was attended by over 40 providers.

Continued work with the current wheelchair service provider to ensure that challenges are being addressed.

Monitoring the quality of care at UHS continues with a particular focus on cancer pathways, ophthalmology and the emergency department.

Workforce concerns continue in mental health services in Southampton, particularly at Antelope House (Adult Mental Health) and the Western Hospital (Older Persons Mental Health)

Improvements in infection prevention and control at Countess Mountbatten Hospice have been seen, with 97.5% compliance with the required standards.

Southern Health NHS Foundation Trust have been rated good by the CQC, a clear demonstration of the progress they have made over the last few years.

d. Strengthening Commissioning Integration

To Promote strengthening Integrated Commissioning there have been eleven proposals developed with leads identified from across the Integrated Commissioning Unit, Clinical Commissioning Unit and the Council. These include - Maximising the potential of our existing arrangements and benefits; shift in approach so that joint projects are centred around key issues; promoting joint working of teams/services working on areas of common interest; development of best practice standards for citizen and staff engagemen; JCB practices and best possible uses of insight; innovation in procurement to promote the best use of the Southampton '£'; contribution from health organisations to the Council's priorities and vision; and the role of Southampton 'place' within the wider ICS development.

Each of these schemes are progressing with project plans outlined and work initiated in a number of areas: Clear process for taking forward the functions and benefits of pooled fund arrangements; engagement resource developed with partners and service users and undergoing testing; planned joint ways of working group; and desk top exercise to highlight opportunity for joint working in addition to those already in place. Some areas will progress at a later date in order to reflect the context surrounding them, including the contribution of health organsiations to the Council Priorities and vision, making the best use of insight and the role of Southampton 'place' within the wider ICS development. Each of these are seeking to ensure that they compliment other key developments existing timelines e.g. setting of the Council priorities and vision and the ICS plan.

3. Key Performance Indicators

a. Integrated Care (Better Care)

	RAG Summary	
	Last Yr	Target
Green	3	4
Amber	4	1
Red	5	6
n/a	6	7

			Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M8	Average Daily DTOC beds	46	37	8	22%	27	19	70%
M8	Average Daily DTOC beds rate (per 100,000)	23	19	4	22%	13	9	70%
M1-8	Total Non-Elective Admissions	21,258	20142	1116	6%	20,272	986	5%
M1-8	NEL Admissions (under 18s) - UHS only	2,190	2224	-34	-2%			
M1-8	NEL Admissions (18 - 64 yrs old) - UHS only	9,899	8775	1124	13%			
M1-8	NEL Admissions (65+ yrs old) - UHS only	7,832	6760	1072	16%			
M8	Long Stay Admissions - Number of Patients 21+ days	66	0			77	-11	-14%
M8	Long Stay Admissions - Number of Patients 50+ days	12	0					
M8	Long Stay Admissions - Number of Patients 100+ days	2	0					
M1-8	Permanent admissions to residential homes aged 65+	186	198	-12	-6%	153	33	22%
Q3	% of People with Learning Disabilities receiving a Physical Health Check	36	38	-2	-4%	45	-9	-20%
Q3	Childrens Wheelchairs - 92% seen within 18 weeks by Q4	40	46	-6	-13%	79	-39	-49%
M1-8	CAMHS - 92% of routine assessments within 12 weeks (YTD)	95	0			92	3	3%
Q3	60% of people with an SMI receiving a full annual physical check	26	0			46	-20	-43%
M7	% of people experiencing psychosis will be treated within 2 weeks of referral (YTD)	95	100	-5	-5%	57	37	65%
M9	% of adults open to LD social care team who have had a Care Act assessment/review in the past 12 mths.	40	31	9	29%			
M8	Number of new Enhanced Health in Care Homes	18	0			18	0	0%
M9	% of clients in rehab/reablement who do not need ongoing care	70	70	0	0%			

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. Pathway 1 more established, Pathway 2 increased investment in home care to support “bridging” care.
- 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
- Delays attributed to care and nursing home acceptance assessments is a constant challenge – we have invested in a hospital based Trusted Assessor pilot designed to work alongside homes in the first instance with a long term view to undertaking the assessments on behalf of the homes (the homes would still make the final decision). The expectation is that this will be a slow piece of work as the homes need to build trusting relationships with the assessor.
- 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 primary care team will be promoting the importance of health checks throughout Quarter 4 and Becky is working with those practices that require support to increase their %. 16 out of 26 practices are reporting below 50% and therefore the focus will be on supporting these practices.
Under Enhanced Care in Care Homes SPCL have contract to undertake assessments and will be completing AHC if patients have LD – commencing in Quarter 4; already done 17 to date; Primary Care have reminded then that this needs to be coded to pull through into our figures.

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 - Q3 the overall performance increased from 18% to 26%. Enhanced service contract with primary care in place, although not all practices have signed up to the offer. Pilot developed for Q4 implementation, community wellbeing team/health facilitator role to increase take up of physical health assessments for individuals who have historically not engaged/less likely to present for their health check appointment. Support requested from NHSI/E to provide standard ‘queries’ to ensure all areas measuring the same data from GP clinical systems

Wheelchairs - In January 2020 a refreshed Improvement plan has been established with the provider. This will be monitored monthly with 2 weekly telephone conference calls with the Regional manager and CCG Associate Director. The plan focuses on Pathway improvements for low need, specialist seating and MND, Clinical Productivity - triage, adherence to criteria, DNA policy, increased allocated clinical time to 60% and MECC, Community Provision - integration into OT networks, identification of existing wheelchair trained staff in community, engagement with care homes, Communication and Engagement, Workforce - explore joint post opportunities, Digital - connect local service with national spine and support automated triage process, explore options for satellite clinic, development of mini equipment store and Care Home Project - in development

In response to the workforce challenges, Millbrook are introducing a new staffing model, exploring whether therapy support can be brought in from other contracts, approaching suppliers for additional capacity, targeting locums outside the area with an agreed pay package to cover travel and accommodation costs, recruiting into apprenticeships and implemeting an improved recruitment system

b. Prevention and Early Intervention

	RAG Summary	
	Last Yr	Target
Green	4	4
Amber	2	0
Red	3	0
n/a	0	5

			Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M1-7	Falls and Frailty (65+)	2,607				2,224	383	17%
Q3	IAPT - % with common mental health conditions accessing IAPT	5.5	5.3	0.2	4%	5.3	0.2	3%
Q3	IAPT - % who complete IAPT moving to recovery	50	51	-1	-2%	50	0	0%
M8	% LARC (all 4 methods) at Integrated Sexual Health Service (YTD)	43	42	1	2%	35	8	23%
M8	% of HIV tests completed as part of an STI screen (YTD)	84	85	-1	-1%	75	9	12%
Q3	% of pregnant women who cease smoking time of delivery (YTD)	17.5	18.4	-0.9	-5%			
M8	Alcohol - % of all clients completing and not re-presenting	30.0	29.1	0.9	3%			
M8	Opiates - % of all clients completing and not re-presenting	3.3	6.7	-3.4	-51%			
M8	Non-opiates - % of all clients completing and not re-presenting	27.8	30.7	-2.9	-9%			

Summary

Falls – work is ongoing to reduce the numebr of admissions for falls and fraility. This includes:
• UHS has appointed a therapist to lead the Fracture Liaison Service/pathway. Work will commence to implement the agreed standard operating procedure.
• The Pilot Community Alarm (Gold) and Telecare service commenced on 1 May offering a 6 month to patients with a falls risk and socially isolated. 90 people signed up and have accessed the pilot to date. Analysis is taking place to evaluate the impact on ED attendances & NEL admissions.
• To improve the identification and management of patients who have a falls risk, 4 practices piloted the use of Keele University Tool. A number of appraoiches where trialled. The Wellbeing Team have agreed to work with practices/PCN's across the City to roll out the adoption, working with the Saints Foundation to promote access to the falls prevention exercise offer.
• With additional investment into Community Independence Team (5WTE) waiting times for assessment have reduced and the number of assessments completed have significantly increased.
• The Saints Foundation will be working with a Public Health registrar to evaluate take up and maintaining falls prevention exercise participation. This will involve evaluating national best practice and gathering local qualative information from users and people referred to the service.
• SCiA have since September 2019 been providing a Community Transport offer to patients being discharged from ED, CDU, AMU and SDEC. Approximately 50/60 patients are supported home every month. Work is underway to increase the numbers accessing service by providing UHS volunteers to escort people home.
• The pilot scheme of a Urgent Response Service clinician in SCAS call desk to support call handlers in diverting to more appropriate community pathways that avoid hospital conveyance has been viewed as a success. A new QIPP plan has been developed as a result of the pilot to expand the service from the current Mon- Friday (8.00- 1.00pm) to 7 days (8am – 6.00pm), with enhance support available via the URS Team and access to the good neighbours network being developed by Communicare. Funding for this scheme needs to be approved by the CCG.

Substance Misuse -The new Substance Use Disorder Service contracts commenced on 1st of July 2019. This data reports the proportion of all people in treatment, who successfully completed treatment and did not re-present within 6 months. The figures presented in this table evidence activity from our previous contracts / system i.e. Successful completions that took place between the beginning of April 2018 until the end of March 2019 and Re-presentations up to the end of September 2019.
It is positive to note the improvement in performance for people with a primary alcohol use disorder, particularly, as this improvement has been made in line with a significant (87%) increase in the number of people with an alcohol concern accessing treatment and support over the same period. Commissioners are aware of the poorer performance for other cohorts and have been working jointly with the provider, an improvement plan is in place and this work is being overseen by Commissioners and CGL Directors. CGL are working on their improvement plans and delivering the service during a time of change. The service is working towards an improvement trajectory that will take some time to see performance fully recover to historical levels and matching our LA comparator performance levels.

c. Commissioning Safe & High Quality Services

RAG Summary	Last Yr	Target
Green	3	2
Amber	0	0
Red	2	2
n/a	0	0

				Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M8	≥85% of CHC assessments taking place in an out of a hospital setting	100	88	12	14%	85	15	18%
M8	≥80% of Full CHC assessments completed within 28 days	50	80	-30	-38%	80	-30	-38%
M1-8	<44 cases of Healthcare Associated Infections (Community): Cdiff (cumulative)	16	21	-5	-24%	18	-2	-11%
M1-8	Zero cases of Healthcare Associated Infections (community): MRSA (cumulative)	1	2	-1	-50%	0	1	-
M9	% of Providers with a CQC Rating of good or above published in month (cumulative)	71	81	-10	-13%			

Summary

CHC Assessments within 28 days - this target remains challenging to achieve. As we have moved through the year, the use of Care Track as our new record keeping and reporting tool is ensuring that our reported figures are more accurate than with the previous system. Data quality continues to be refined and we are meeting with Care Track in February 2020 to ensure that we are using the tools to effectively and accurately. The CHC team have also begun an evaluation and refinement process to ensure that all decision making is compliant with the National Framework for CHC. Framework compliant decision making challenges the 28 day compliance target particularly with regards the completion of DST's for FNC patients where social work capacity with the Local Authority challenges the ability to complete assessments in 28 days. This is a national challenge with regards CHC and the CHC team are working with Local authority partners to try and mitigate the issues.

Care Home Beds - Overall quality of social care providers in Southampton continues to be good, a recently held provider event, focused on supporting care homes in avoiding admissions to hospital was attended by over 40 providers.

d. Managing and Developing the Market

RAG Summary	Target	Last Yr
Green	5	4
Amber	0	1
Red	1	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%
M9	Care Placement - ≥90% placements are sourced via Team	86	83	4	4%	90	-4	-4%
M9	Avg days from referral received to placement start date (Home Care)	10	13	-3	-24%	14	-4	-31%
M9	Avg days from referral received to placement start date (Res/Nursing)	5	5	0	-2%	14	5	-68%
M9	Total number of home care hours purchased per week	22,942	21,953	989	5%			
M9	% Home Care clients using a non framework provider	19	22	-3	-14%	20	-1	0%

Summary

Care Placement: 'We continue to work with stakeholders to improve the use of the Placement Service however please note that this target does not take into account emergency placements sourced outside office hours. The number of these placements would have been higher towards the end of November and beginning of December due to the winter/ Christmas pressure period. This is the likely reason for the reduction from 92% - 86% for this period. We will continue to monitor this closely.

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 access to specialist rehab beds, in particular Snowden but also specialist spinal rehab beds commissioned by NHSE - Mental Health delays at SHFT 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 - commissioning additional dom care capacity over the winter period, including Live In Care placements - commissioning additional reablement bed over the winter period - increasing bed based capacity within the Pathway 3 D2A scheme - Roll out of low level health needs care (with the exception of diabetic care) from Dec - extension of rehab/reablement inreach to 7 day service - recruitment of 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 - where's best next campaign - launched 20 Jan Other schemes currently being scoped/mobilised include: - voluntary sector support within the IDB and brokerage service to help families make timely decisions - deep dive review and process mapping of key pathways - particularly pathway 3 CHC/Fast-track - Trusted Assessment to care homes - Review of specialist rehab provision - joint with West Hampshire

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
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 for first contact showing consistent improvement, but secondary waits still a challenge for some specialities. Waits for services for ADHD and Autism, as nationally, remain long. Solent NHS Trust CAMHS have recruitment challenges Southern Health have significant workforce challenges which is impacting on bed availability and opening of the Crisis lounge and S136 suites. Detailed recruitment and retention plan being implemented. Higher use of bank and agency staff who do not have direct access to recording systems - new leadership team are addressing this. Serious incident on Saxon Ward. External thematic review of whole of Antelope House Transfer of Eastleigh Southern Parish patients from the East Community Mental Health Team taken forward. Evidence that caseloads are now starting to reduce Autism Services waiting list improvement now slowing due to increased referrals; further investigation underway The risk in relation to staffing continues at Antelope House, impacting on bed availability and opening of Crisis Lounge, and recent leadership changes have led to a further period of instability. Higher use of bank and agency staff, improvement in direct access to recording systems . Older Persons Mental Health service has recruitment challenges which may impact on bed capacity SHFT Contract Review meeting in July 2019 changed to a focused meeting on Antelope House staffing concerns ,to review again and ascertain the impact of actions being taken. Specific Workforce Clinical Quality Review Meeting (CQRM) was held with SHFT in September 2019. Overall assurance was provided around the strategic activity being undertaken across the Trust. Serious incident on Saxon Ward, external thematic review ongoing. Southern have CQC unannounced visit in November Most providers have elements of challenge with recruitment of specialist roles. Retention and recruitment plans are being implemented and monitored for impact

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	Despite ongoing efforts to improve performance, including a waiting list initiative specifically targeted at children, the service continues to be challenged and as at Nov 19 the average waiting times (from ref to case closed) for Children was 24 weeks and for Adults 34 weeks. The main reason for performance remains workforce challenges associated with recruiting and retaining experienced clinical staff. In response to the workforce challenges, Millbrook are undertaking the following: - introducing a new staffing model - approaching suppliers for additional clinical capacity - targeting locums outside the area with an agreed pay package to cover travel and accommodation costs - recruiting into apprenticeships - improved recruitment system In January a refreshed Improvement plan has also been established with the provider. This will be monitored monthly with 2 weekly telephone conference calls with the MB Regional manager. The improvement plan focuses on: - Pathway improvements for low level need, specialist seating and MND - Maximising Clinical Productivity - triage, adherence to criteria, DNA policy, increased allocated clinical time and MECC - Building stronger relationships with community therapists including networking and exploring the potential for joint posts - Engagement with care homes to ensure recycling opportunities are maximised - Communication and Engagement - establish local strategy for identified key areas to improve communication - Digital - connect local service with national spine and support automated triage process - Identifying key hotspots where provision could be localised to improve access e.g. via satelite clinic, development of mini equipment store

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Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Home 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. The new framework has increased capacity and additional hours are purchased from a 'retainer service' which provides rapid access and responds to peak need. 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. The new framework allows an annual re-opening to encourage new entrants to the market and ensure any potential loss in capacity is mitigated. 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. . The establishment of 'lead provider' roles across the 5 areas in the city and provides a platform for further developmental work and sustainability in the city.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 we need to be always alert to seasonal peaks and trends. At this time one winter pressures project has been implemented and a further project is being scoped - both aiming to stimulate additional capacity development during the winter period and into the spring.

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

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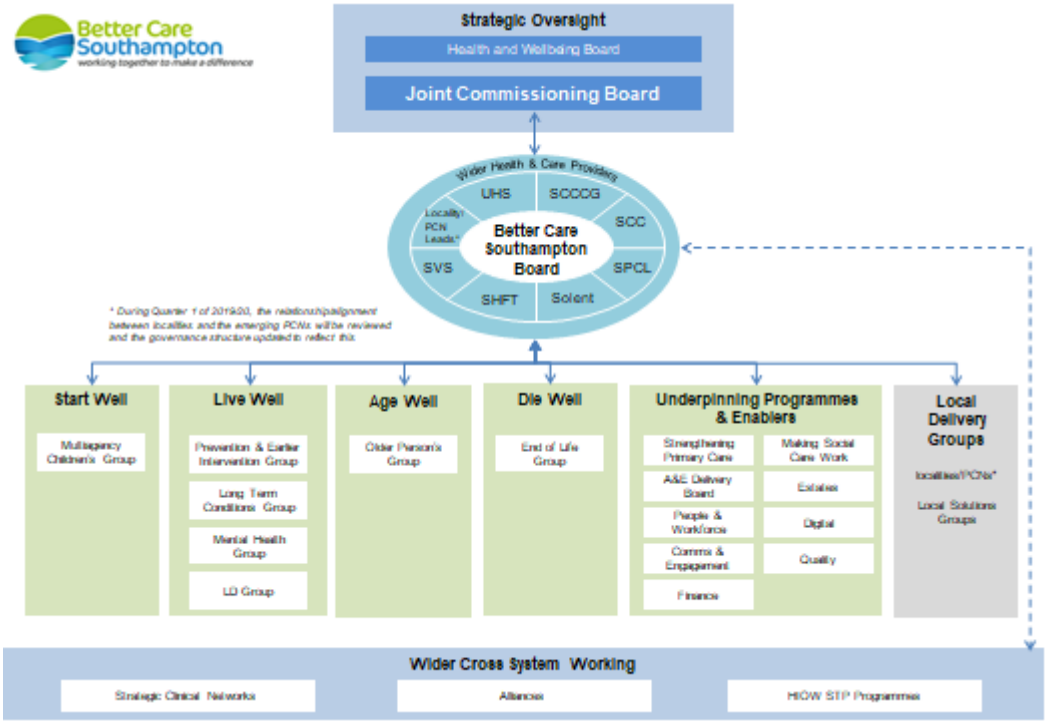
DECISION-MAKER:		**Joint Commissioning Board**		
SUBJECT:		**Better Care Highlight and End of Year Report**		
DATE OF DECISION:		**20 February 2019**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman**	Tel:	023 80296004
	E-mail:	**d.chapman1@nhs.net**		
Director	**Name:**	**Stephanie Ramsey**	Tel:	023 80296941
	E-mail:	**Stephanie.Ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
NOT APPLICABLE		
BRIEF SUMMARY		
This report provides an overview of performance and progress in 2019/20 against Southampton's Better Care programme and highlights the priorities for 2020/21.		
RECOMMENDATIONS:		
1.	**(i)**	To note 2019/20 performance against Southampton's Better Care programme and spend against the pooled budget, including the iBCF.
2.	**(ii)**	To note the priorities going forward for 2020/21.
3.	**(iii)**	To note the iBCF programme of spend for 2020/21.
REASONS FOR REPORT RECOMMENDATIONS		
4.	The Joint Commissioning Board (JCB) is responsible for oversight of the Better Care pooled fund. This responsibility has been delegated to JCB from the Health and Wellbeing Board (HWBB).	
5.	National Better Care Fund Operating guidance was last published on 18 July 2019 for 2019/20. The Policy framework for 2020/21 is expected to be published in mid-late February. It is expected that 2020/21 will be a further transition year for the Better Care Fund with the potential for a 3 year plan for 2021/22 – 2023/24, subject to outcome of the Comprehensive Spending Review. It is also expected that the national conditions and metrics for 2020/21 will remain the same as they were for 2019/20.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
6.	**NOT APPLICABLE**	
DETAIL (Including consultation carried out)		
7.	**Overview** Southampton's Better Care Plan aims to achieve the following vision: • To put **individuals and families at the centre of their care and support**, meeting needs in a holistic way • To provide the **right care and support, in the right place, at the right time** • To make **optimum use of the health and care resources** available in the community • To **intervene earlier** and build resilience in order to secure better outcomes by providing more coordinated, proactive services.	

	• To **focus on prevention and early intervention** to support people to retain and regain their independence It is a programme of whole system transformational change which is based around 3 key building blocks: • **Implementing person centred, local, integrated health and social care**. This includes harnessing the assets within communities and the power of individuals in improving their own health and wellbeing. It also includes health, social care, housing and voluntary sector teams in each locality coming together to proactively identify those people most in need in the local area and plan and deliver care and support in a more joined up and personalised way. • **Joining up Rehabilitation and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams** that in turn link with each locality. • **Building capacity** across the system to promote and support people to maintain their independence for as long as possible. This includes promoting self management approaches and supporting the role of carers. It also includes developing the capacity of the voluntary and community sector to meet lower level needs in local communities, as well as investing in the home care sector to enable more people to continue living in their own homes.
8.	During 2019/20, Southampton's Better Care programme has been refreshed to align with the city's new **5 Year Health and Care Strategy (2020 – 2025)** which in turn aligns to the Council Strategy, CCG operating plan, NHS Long Term Plan and Sustainability and Transformation Partnership/Integrated Care System plans and is a subset of the wider 10 year strategy for health and wellbeing led by the Health and Wellbeing Board. The 5 Year Health and Care Strategy sets out the following goals to be achieved across the full life course (Start Well, Live Well, Age Well, Die Well): • Reducing inequalities and confronting deprivation • Tackling the city's biggest killers : Cancer, Circulatory diseases and Respiratory diseases • Improving earlier help, care and support • Improving mental and emotional wellbeing • Working with people to build resilient communities and live independently • Improving joined up, whole person care

9.	Better Care is seen as central to delivery of the 5 year strategy and the Better Care governance structure (as shown below) has been updated to reflect the core elements.  Membership of the Better Care Southampton Board includes the CCG, the GP Federation (Southampton Primary Care Ltd), the Council (Director of Adult Social Care), the acute Trust (University Hospital Southampton), the community Trust (Solent NHS Trust), the mental health and learning disability community provider (Southern Health), the Voluntary and Community Sector (Southampton Voluntary Services), the clinical leads from each of the 3 Better Care localities and the Clinical Directors from each of the 6 PCNs. The Board reports to the Health and Wellbeing Board. Reporting into the Better Care Southampton board there are working groups for each of the work programmes in the 5 Year Health and Care Plan. The working groups report into the Better Care Board on a thrice yearly basis highlighting progress and any issues for escalation. The locality structure on which our Better Care model is based enables needs and gaps to be analysed at a very local level and specific plans to be developed in response. We have specifically invested in locality leadership teams for this purpose which comprise dedicated input from professional leads, including Primary Care Networks (PCNs), social care and the two community trusts (Solent and Southern Health). We have also invested in data analyst time to develop detailed information packs on health and care need and resource utilisation at a locality level.
10.	The **Better Care Fund** pools resources from both the CCG and Local Authority to support the delivery of the Better Care Programme. In 2019/20 this totals approx. £126.50M (approx £79.00M from the CCG and £47.00M from the Council, making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which is £16.177M, demonstrating its commitment to integrating health and social care at scale. Southampton's Better Care Fund is made up of the following schemes: 1. Supporting Carers 2. Integrated locality teams 3. Integrated Rehabilitation and Reablement and Hospital Discharge 4. Aids to Independence 5. Prevention and Early Intervention

6. Adult Learning Disability Joint Commissioning
7. Promoting uptake of Direct Payments
8. Transforming Long Term Care
9. Integrated provision for children with SEND
10. Integrated health and social care provision for children with complex behavioural & emotional needs

11. Performance as at Q3 2019/20

The table below provides a summary of performance against the key Better Care national indicators. Owing to monthly reporting timescales, it is only possible to provide activity data up to Month 8, i.e. 30 November 2019.

Metric	YTD Performance versus Plan	YTD Performance versus last year	Comments
NEL Admissions	5% above plan (21,258 versus 20,272)	6% above last year (21,258 versus 20,142)	There has been an increase in NEL admissions this year compared to last year. The majority of this increase has been in very short stay admissions (0 day admissions have increased by 9% whilst admissions of more than one day have increased by 4%). There has been significant growth in ED attendances (12% compared to last year) When considering the different age ranges, the increase in admissions is similar for both working age adults and older people. The reduction in child admissions is purely as a result in changes to the pathway and coding of activity.
- **Children** - **Working Age Adults** - **Older People**		7% lower 7% higher 8% higher	
DTOC	Rate of Lost bed days as % of overall bed availability: 6.6% as at Nov 19compared to 3.5% target YTD average is 5.6% Average daily number of delays: 45.5 for Nov 2019 against target of 26.7 (70% over target) YTD average = 38.1 average daily delays	Rate of Lost bed days as % of overall bed availability: 6.6% compared to 5.5% Nov 2018 YTD average is 5.6% compared to 6% for Apr – Nov 2018 Average daily number of delays: 45.5 for Nov 2019 compared to 37.3 for Nov 2018 YTD average = 38.1 average daily delays compared to 40.9 last year	The DTOC rate has been increasing since April As at Nov 2019, DTOC rate at an individual Trust level was: • UHS: 6.5% in Nov 19 vs 7% in Nov 18 and 5.5% for YTD vs 6.8% last year • Solent: 4.6% in Nov 19 vs 3.5% in Nov 18 and 3.2% for YTD vs 2.8% last year • Southern Health: 11.1% in Nov 19 vs 4.9% in Nov 18 and 8.9% YTD vs 3.7% last year Further detail on DTOC can be found at Appendix 1.
Permanent Admissions to residential homes	8% above plan (186 admissions versus 173)	6% lower than last year (186 admissions versus 198)	Whilst we are not on track to achieve the reduction we planned for this year, permanent admissions are 6% lower than this time last year.

12. Performance Commentary

- **Permanent admissions to residential and nursing homes:** We have seen a steady reduction in rates of admission to residential and nursing homes for people over 65 since 2015/16. Particular action to reduce residential and nursing home admissions has included:

- Continued expansion of Extra Care housing to provide an alternative to residential admission, supporting people to stay independent for longer. We are currently preparing for the opening of Potters Court in 2020 which will offer 80 additional units of Extra Care.
- Development of community activities and support including the roll out of the Community Solutions Service (So:Linked). The service seeks to promote an approach for the city which results in an increase in the breadth and depth of community based activity available and being accessed, that supports people to live well and independently in the community, promotes self-help and a culture where people help others in their community. The new Community Solutions Service also includes community navigators to help people identify and access the help they might need. In addition the ongoing development of Southampton Living Well Service offering day time activity and care.
- Implementation of the falls prevention strategy, acknowledging that falls (particularly when they result in a hospital admission) are a major cause of loss of confidence and independence which can lead to residential admission. During 2019/20 we have re-procured the Falls exercise offer; piloted a scheme which enables health professionals to refer people at risk of falls to the City's Telecare Service where they can receive equipment to detect a fall and a fast response to prevent a long lie; and increased capacity in our Community Independence Service to provide assessment and support for those who have suffered a fall. We are currently in the process of evaluating all these schemes.
- Ongoing work to assess and provide support to carers, enabling them to care for longer. The ICU commissions a Carers in Southampton service that delivers universal identification, advice and support as well as delegated carer assessments. Engagement with carers has grown significantly with numbers contacting the service increasing from 200 in 2014/15 to 2,712 by the end of Q3 2019/20. The numbers accessing information via the website has increased from 990 in 2014/15 to 75,906. The number of carers reached during 2018 to Q3 of 20/19/20 is 118,111.

- **Delayed transfers of care (DTOC)**: Whilst our DTOC rate has been reducing over the last 2 years, DTOC still remains significantly above where it should be, above our comparator authorities, the main pressures being at UHS, but also Southern Health. When reviewing the main reasons for delay, home care placement is the most prominent followed by awaiting assessment (which relates to social care providers coming into hospital to assess), nursing home placement and then awaiting further non acute NHS care. Delays particularly increase at the weekend. Further analysis of these delays shows that the main reasons are associated with increasing levels of complexity requiring more "double up" care or harder to source nursing home placements. **A detailed report on our DTOC position and the action being taken to address it can be found at Appendix 1**.
- **Non Elective (NEL) admissions:** Since November 2018, an increased volume of A&E attendances has led to an increased number of non elective admissions. This step-change has been seen across the country and is not specific to Southampton. The majority of the increase has been in short stay admissions (less than one day), with the most notable increase being in the elderly population. Changes to the A&E pathway, such as the introduction of the Frailty Unit/Same Day Emergency Care (SDEC) which are coded as NEL admission could be artificially contributing to some of this increase. Our overall plan for 2019/20 was to hold NEL admissions at 2018/19 levels and prevent any further growth, by implementing a number of initiatives to reduce urgent care activity. Working with Hampshire (West Hampshire CCG and Hampshire County Council), Southampton has developed a Whole System Urgent & Emergency Care Recovery Plan. Particular actions which Southampton is taking forward jointly with Hampshire include:
  - Targeted choose well campaign focused on geographical areas with high A&E attendances which could be managed in the community.
  - Ensuring newly commissioned models within the Extended Access Hubs and Urgent

	Treatment Centres are fully embedded and utilised to reduce attendances at A&E for minor illnesses and injury o Identifying the top 200 high intensity users (HIU) presenting to A&E and ensuring there are individual care plans in place for each o Implementation of urgent community response services at the Same Day Emergency Care (SDEC) Service for those aged over 80 at UHS with the aim to optimise same day or next day turnaround of appropriate patients, including establishing a same day transport facility to ensure timely and safe transfer home with support from the voluntary sector. As a result, SDEC is seeing and discharging more people on the same day (the same day discharge rate increasing from approx. 15% to 30%) o Introduction of a clinician from the Urgent Response Service into the South Central Ambulance Service call centre with knowledge of the local pathways and services in order to support the call handlers with identifying alternatives to hospital. This scheme is currently being evaluated but early data is showing that it is having success in reducing hospital conveyance and subsequently admission (of 53 patients over a 4 month period, 43 went on to have no hospital admission). o Roll out of the Enhanced Health in Care Homes service to all residential homes across the city and consideration of additional support to be provided to nursing homes – this has resulted in a further 6% reduction this year in hospital admissions from these homes. o Improvements to mental health crisis care - working in partnership with Southern Health and Solent Mind to develop "The Lighthouse" a new community based facility that will support individuals in a recovery-focused way to manage their mental health crisis. Local residents using the facility receive interventions in a therapeutic environment, with the facility being staffed by mental health nurses, as well as peer supporters provided by Solent Mind who bring their lived experience to the service. In addition, we have secured NHS transformation funding to increase the capacity of the Crisis Resolution Home Treatment Team to allow more home treatment to be provided, giving people a real alternative to a hospital admission. o Mental health support in NHS 111 – working with other commissioners, South Central Ambulance Service and Southern Health, we have secured NHS transformation funding to expand the current 'alternative to crisis' service with the introduction of an open access urgent referral. This means that if someone calls 111 with a mental health concern, they will be directed to specialist mental health nurses who can provide specialist support. o Alcohol InReach service. We have been working with our hospital specialist alcohol nurse service, the Alcohol Care Team (ACT-UHS) and our community drug and alcohol support service, Change, Grow, Live (CGL Southampton) to increase the capacity of ACT-UHS and further develop the InReach programme to support people identified with an alcohol concern into treatment. This means that more people will have access to our specialised alcohol support to help reduce alcohol related harm.
13.	**Key Developments during 2019/20** Below is a brief summary of some of the key developments in 2019/20 against each of the Better Care programme priorities. • **Priority 1: Integrated care based around localities and Primary Care Networks (PCNs)** ➢ During 2019/20 the leadership teams in each of the 3 localities have been strengthened with dedicated time from clinicians, operational management from Southern Health and Solent and professionals in Adult Social Care to review the needs of the locality and develop priorities for improving outcomes. • **Priority 2: A much stronger focus on prevention and early intervention** ➢ Continued development of the Southampton Living Well Service which commenced in

	April 2018 and is transforming the way we provide older people's day care into a more person centred, community focussed model. The provider of this service is co-producing an activity offer with service users and will establish an affiliate scheme with local activity groups/organisations which will significantly increase the number and range of activities being offered outside of the traditional day care setting. ➢ Re-procurement of the Falls Exercise offer which is now operating across the whole city ➢ Further development of the Welcome Home scheme which is now in its second year and is a volunteer based programme which supports people following discharge to get back on their feet and regain their independence. 95 requests for help have been received to date, 83 (88%) of which received support. 61 (64%) received support in their homes and 22 (23%) received telephone support only. Since January 2019 the number of volunteers ("Communiteers") available to help with Hospital Homecoming requests has increased from 28 to 47 • **Priority 3: A shift in the balance of care away from bed based provisions and into the community** ➢ Continued development of the integrated rehabilitation and reablement service to support more people in the community, in their own homes. ➢ Development of a pathway in rehab and reablement for delivering community based intravenous medication, enabling patients with higher levels of acuity to be supported outside hospital. ➢ Sensory services have been restructured resulting in a significant reduction in the waiting list and a move from reactive to proactive care in the community, with sensory services being seen as everyone's business. ➢ Home care procurement. Commissioners have worked with providers to develop a new model for Home Care delivery in Southampton. The procurement process was completed early 2019 and the new Framework started on 1 April 2019. The framework includes a new role of Lead provider which makes it possible for agencies to be involved in system wide work and has already made possible a reduction in the waits experienced for a care package from referral to start date. • **Priority 4: Significant growth in the community and voluntary sector** ➢ Procurement of the So:Linked Service as referenced above has led to a new Community Navigation and Community Development service. This service was procured in 2018/19 and started in October of 2019. The service seeks to promote an approach for the city which results in an increase in the breadth and depth of community based activity available, and being accessed, that supports people to live well and independently in the community, promotes self-help and a culture where people help others in their community. • **Priority 5: Develop new models of care** ➢ Continued development of an integrated team for adults with learning disabilities, which brings together Council, Southern Health and CCG staff under a single management structure. ➢ The Improving Access to Psychological Therapies (IAPT) Steps to Wellbeing Service has continued to develop integrated physical and mental health pathways adding Atypical Respiratory Disease, Chronic Pain and Persistent Physical Symptoms for people experiencing low mood/depression, anxiety, stress or other common mental health problems to the pathways previously developed for Diabetes and Chronic Obstructive Pulmonary Disease (COPD).
14.	**Priorities for the Better Care Programme going forward** Moving forward, Better Care will be central to the delivery of the 5 Year Health and Care Strategy by developing the new models of place based person centred integrated care which will form the foundations for implementing the Strategy's priorities. Key Better Care priorities for 2020/21 will be:

- Development of **integrated care teams** across health and social care, physical and mental health in each of the localities, aligning with Primary Care Networks.
- Focused work to reduce **DTOC** with a critical review of the city's implementation of the High Impact Change Model for Hospital Discharge and operation of each of the 3 discharge pathways
- Fully embedding the **Enhanced Health in Care Homes** model with roll out to Nursing Homes and in future the city's Extra Care schemes
- Further expansion of **Extra Care Housing** with the development of 80 new bed spaces at Potters Court which will open in 2020 at the same time as reviewing the need for further developments in the East and Centre of the city
- Continued development of responsive **Mental health** services
- Implementation of **Southampton's Frailty model**, to manage higher levels of acuity in the community, e.g. intravenous medication and strengthen multidisciplinary working at the hospital front door to ensure that people are directed in a timely way to the best setting for supporting their needs, wherever possible in their own homes
- Working with the new So:Linked Service to continue to build capacity within the **community and voluntary sector** to provide earlier more preventative support, including taking forward development of a place based giving scheme
- Development of an integrated **community transport** model to enable people to better access support and activities across the city
- Taking forward opportunities for **integrating equipment, aids, care technology and home adaptation services** to provide more person centred support as well as maximizing the use of the DFG to better support people's independence

RESOURCE IMPLICATIONS

Revenue

15. Financial performance against each Scheme is monitored on a monthly basis by the Better Care Finance and Performance Group.

The total value of the pooled fund for 2019/20 (including the iBCF and DFG) is approx. £126.50M (approx £79.00M from the CCG and £47.00M from the Council).

As at Month 9, overall performance against the pooled fund was a projected year end under-spend of £0.31M, which represents a percentage variance against budget of 0.24%. This is made up of a £0.10M under-spend for the CCG and a £0.20M under-spend for the Council.

The main areas of under-spend contributing to this position are the Prevention and Early Intervention scheme (where there is an under-spend of £0.13M relating partly to planned contract savings and partly to vacancies) and Rehabilitation and Reablement (where there is an under-spend of £0.24M which relates to vacancies that the service has not been able to recruit to).

16. The value of the BCF pooled fund for 2020/21 is expected to be a roll-over of the funds from 2019/20 with inflation, growth and investment added to the NHS contribution in line with local agreement and Operational Planning Guidance (details still to be finalised).

17. The iBCF is part of the BCF pooled fund and comprises two tranches as follows:

	Improved Better Care Fund (Tranche 1)	**Additional Improved Better Care Fund (Tranche 2)**	Total Improved Better Care Fund
2019/20 Grant	£7,713,111	£1,567,547	£9,280,658

The first tranche is allocated directly to Adult Social Care and used for care packages and placements. This tranche has been increasing year on year.

	The second tranche is used for service transformation and time-limited projects linked to Better Care priorities (e.g. integration of services, prevention and early intervention, supporting independence and reducing reliance on bed based care, reducing DTOC). This tranche has been reducing year on year. During 2019/20 the total value of the second tranche of IBCF is £2.67m, which includes a carry forward from 2018/19 of £1.1m. A summary of how this has been allocated is included in Appendix 2.
18.	For 2020/21, both tranches of the iBCF will be a roll over from 2019/20. A summary of the 2020/21 plan for using the second tranche IBCF, including the carry forward of £0.33m, is also included in Appendix 2.
Capital	
19.	There is a £3.6M carry forward against the DFG grant that has built up over the years as a result of top up grants received at the end of each year. Use of this funding is being considered as part of a review of the DFG which is being taken forward by the Integrated Commissioning Unit and will be presented as a separate report to the Joint Commissioning Board.
Property/Other	
20.	There are no specific property implications arising from the Better Care pooled fund. However as part of the 5 Year Health and Care Strategy there is an enabling workstream specifically looking at the use of our collective estate across the Council, the CCG, primary care and NHS providers with a view to supporting the further development of integrated working.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
21.	The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006, which requires that in each Local Authority area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2017-19, NHS England set the following conditions: • Agreement of a joint plan between the CCG and Local Authority • NHS contribution to social care is maintained in line with inflation • Agreement to invest in NHS-commissioned out-of-hospital services • Implementation of the High Impact Change Model for Managing Transfers of Care. Southampton is compliant with all four of these conditions.
Other Legal Implications:	
22.	None
CONFLICT OF INTEREST IMPLICATIOINS	
23.	None
RISK MANAGEMENT IMPLICATIONS	
24.	Risks on specific Better Care Fund Schemes are monitored on a monthly basis. Key risks and issues for the Better Care Programme overall are summarised below: • **Capacity of the care market** to meet increasing needs and support additional schemes to improve discharge - To mitigate this, the ICU is working proactively with the care market and utilising alternative mechanisms such as retainers and block contracts to provide increased stability. • **Resilience in the voluntary sector** and ability to respond to new ways of working - A number of mitigating actions are being taken including: various procurement options being considered

	to make best use of local market and encourage innovation; support to local agencies also being considered as part of the developments; proactive review of any bidding opportunities.
POLICY FRAMEWORK IMPLICATIONS	
25.	Southampton's Better Care Programme supports the delivery of outcomes in the Council Strategy (particularly the priority outcomes that "People in Southampton live safe, healthy and independent lives" and "Children get a good start in life") and CCG Operating Plan 2017-19, which in turn complement the delivery of the local HIOW Sustainability and Transformation Partnership, NHS 5 Year Forward View, Care Act 2014 and Local System Plan.
26.	Southampton's Better Care Plan also supports the delivery of Southampton's Health and Wellbeing Strategy 2017 - 2025 which sets out the following 4 priorities: • People in Southampton live active, safe and independent lives and manage their own health and wellbeing • Inequalities in health outcomes and access to health and care services are reduced. • Southampton is a healthy place to live and work with strong, active communities • People in Southampton have improved health experiences as a result of high quality, integrated services

KEY DECISION?	**Not Applicable - No decision required**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Delayed Transfers of Care Report
2.	IBCF Expenditure

Documents In Members' Rooms

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

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

MEETING:		**Joint Commissioning Board**		
SUBJECT:		**Delayed Transfers of Care (DTOC) Briefing**		
DATE:		**19 February 2019**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman**	Tel:	023 80296004
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1. Background & Introduction

1.1 Reducing Delayed Transfers of Care (DTOC) is a key focus of Southampton City's Better Care plan and has always been seen as a joint priority and collective effort between the Council and Southampton City CCG and the city's health and social care providers. The city measures its performance against two targets:

- the NHS England (NHSE) national target of 3.5% for hospital Trusts (i.e. DTOC to be no more than 3.5 % of all available beds)
- the Health and Wellbeing Board (HWBB) target of no more than 26.7 average daily delays in acute and community hospitals (which gives a rate of 13.2 per 100,000 population), which we have broken down locally as follows:
    - University Hospital Southampton (UHS) (acute) – 20 average daily delays
    - Solent NHS Trust (community hospitals) – 2.7 average daily delays
    - Southern Health Foundation Trust (Adult Mental Health and Older Person's Mental health wards) – 4.0 average daily delays

1.2 Clear plans are in place for reducing DTOC. Because of the joint focus on University Southampton Hospital NHS Trust (which accounts for approx. 75% of discharges for Southampton), Southampton works very closely with Hampshire County Council and West Hampshire CCG and joint DTOC action plans across the Southampton and South West Hampshire System have been in place for some time, overseen by the A&E Delivery Board and more specifically the Southampton and SW System Integrated Discharge Bureau (IDB) Leaders Group.

1.3 The IDB leaders group meets on a monthly basis and includes senior representation from Southampton City CCG, Southampton City Council, West Hampshire CCG, Hampshire County Council, University Hospital Southampton Foundation Trust (UHS), Solent NHS Trust and Southern Health Foundation Trust (SHFT). Together the partners have appointed a single IDB operational manager (in post since 2015) who provides operational oversight across the system on a day to day basis (employed and based in UHS).

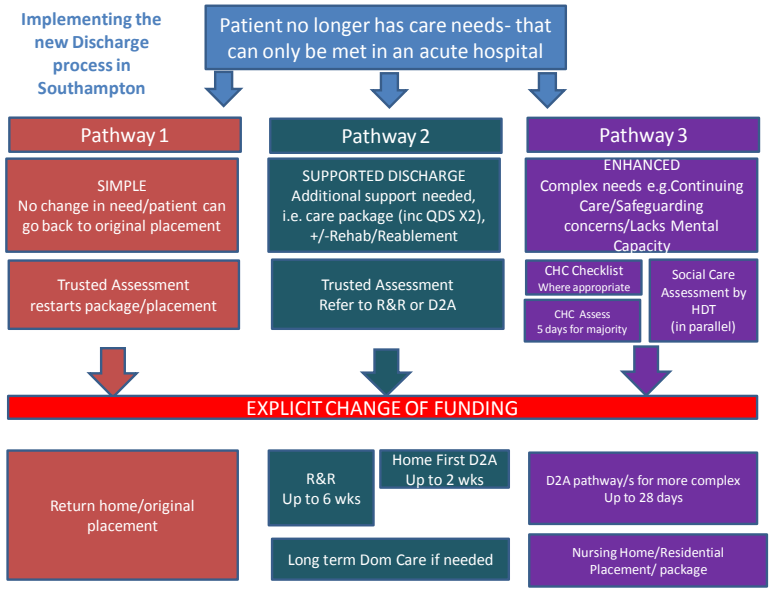
1.4 Three standardised discharge pathways have been adopted across the whole of the Southampton and South West System in order to simplify and streamline discharge processes, as follows:

- Pathway 1 Simple discharges - managed by the wards through trusted assessment with support as necessary from the IDB and strong links back to the

patient's community care team. Primarily this includes package re-starts and return to home or previous placement. Ward staff are responsible for identifying and assessing these patients.

- Pathway 2 Supported discharges - managed by the Rehabilitation (rehab) and Reablement teams, which in Southampton is an integrated Council/Solent NHS Trust Service. The Rehab and Reablement teams will work with ward staff to facilitate discharge through a "community pull" approach. 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 Rehab and Reablement Teams who "in reach" into the hospital.
- Pathway 3 Complex discharges - managed by the IDB and hospital discharge team. This involves those patients requiring complex assessments, e.g. those who are likely to be Continuing Health Care or where there are Safeguarding concerns. Ward staff are responsible for identifying and directing these patients to the IDB.

Integrated Discharge Model



*Patients may move between the Pathways as their circumstances change.

Progress to date

1.5 Southampton has modelled its DTOC work on the 8 High Impact Change Model published jointly by the Local Government Association (LGA), Department of Health, Monitor, NHS England and ADASS in 2015 and below is a summary of its most recent self-assessment.

High Impact Change	Self Assessed Position	Commentary
Early discharge planning	**Early Progress**	• Use of Expected Date of Discharge (EDD) established and electronically recorded on hospital discharge system (APEX) • Hospital has in place Board Rounds and Red and Green days However there is still more work to be done in ensuring that discharge planning commences at the point of admission, including planning for discharge at the hospital front door and ensuring that patients who are likely be complex are identified early on and case managed through their stay in hospital.
Systems to monitor patient flow	**Early progress**	Whilst systems are in place (SHREWD), challenges still exist in terms of sourcing capacity to meet demand, most specifically related to: • Increasing levels of complexity amongst patients being discharged. • Sourcing complex “double up” care packages. • Sourcing care home placements particularly for patients with dementia • Flow in NHS specialist rehabilitation beds
Multi-disciplinary/multi-agency discharge teams	**Mature**	A system wide Integrated Discharge Bureau (IDB) has been in place for some years with a system wide manager appointed in 2015, jointly accountable to the Acute Trust (University Hospitals Southampton), both CCGs (Southampton and West Hampshire) and both Local Authorities (Southampton and Hampshire). The IDB is made up of teams from UHS, Adult Social Care, Rehab and Reablement and Hospital at Home.
Home first/discharge to assess	**Mature**	Discharge to Assess (D2A) for pathway 2 (people requiring reablement or some level of additional support in their own homes) is now mainstreamed for all people leaving hospital (UHS as well as the community hospitals RSH, Western and Snowdon). There is evidence that discharge to assess and reablement for this group is reducing the need for ongoing care. In addition since November 2017 we have also introduced D2A for the more complex group of people leaving hospital on Discharge Pathway 3. This is now mainstreamed
Seven-day service	**Basic level**	Whilst 7 day processes are in place for rehab and reablement and the hospital discharge team, all partners need to expand their offer to support 7 day working including hospital transport and primary care. Brokerage services only operate Monday-Friday at present and there are challenges with social care providers taking new or receiving back residents over the weekend.

High Impact Change	Self Assessed Position	Commentary
Trusted assessors	**Basic level**	Trusted assessment is in place for Pathway 1 with hospital staff making decisions regarding return to placement. However we do not have Trusted Assessment in place for care home assessment processes. We are in the process of scoping a Trusted Assessor scheme with care homes. A nurse was appointed in January 2020 to take this work forward, engaging with homes to design the model.
Focus on choice	**Mature**	A choice Policy (referred to locally as complex discharge policy) has been in place for some years and has recently been reviewed and updated.
Enhancing health in care homes	**Substantial progress**	The EHCH Programme is well established within the residential care sector and we are planning on rolling this out to the 9 nursing homes in Southampton over the next few months.

1.6 A significant proportion of the Improved Better Care Fund (BCF)over the period 2017 - 2020 has been allocated directly to schemes that reduce DToC as follows:

- Extending Discharge to Assess (D2A) to the Royal South Hants (RSH), Snowdon and Western Community Hospitals (mirroring the scheme that is already in place at UHS) – approx. £122k investment per annum. This commenced November 17 offering 6 discharge slots a week. It has been successful both in accelerating discharge and also supporting people to return to independence with 40% of clients going on to have no ongoing care needs.
- Establishing a Discharge to Assess (D2A) Scheme for supported/complex discharge (pathway3) – approx. £400k per annum. This commenced in November 17 providing an additional 4 discharge slots a week. The scheme is jointly funded (50/50) by the Council and the CCG and the funding also covers additional social work capacity and capacity within the Care Placement Service. Evaluation of the scheme has shown that on average hospital length of stay is reduced by 27 days for each client. The Joint Commissioning Board agreed to mainstream the scheme in January 2020.
- Expanding 7 day social care operation in the hospital discharge team (approx. £100k per annum). We have used the iBCF funding to recruit permanent staff to this team, rather than relying on locums. This is increasing social care professional input in the Integrated Discharge Bureau.
- Increased capacity in the home care market, in particular to support 7 day working and bridging support (approx. £60k per annum).

1.7 Additional investment has also been transferred by the CCG to the Council to fund additional home care hours from both the Domiciliary Care Framework contract (280 hours a week) and also reablement care (120 hours a week) from the integrated Rehab and Reablement Service (£800k for period January 2019 – March 2021). Some of this investment has also been used to support training Framework home care providers to meet the needs of patients with specific health needs, e.g. collar care, enteral feeding. Some has also been used to fund additional capacity within the Care Placement Service.

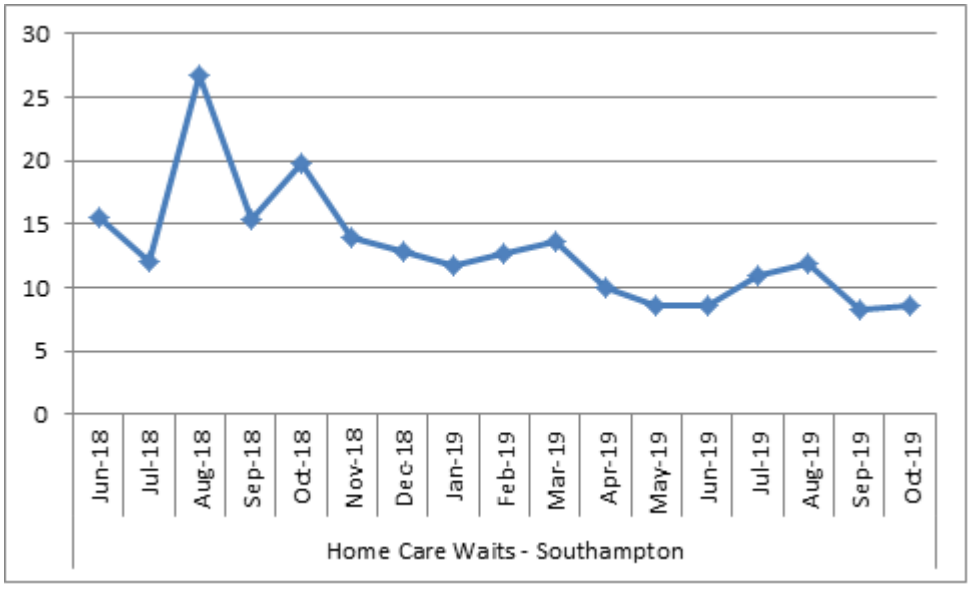
1.8 Overall there has been an increase in home care capacity 2018 to 2019 as follows:

Month	Hours a week	Month	Hours a week
Sept 2018	22,326	Sept 2019	22,834
Oct 2018	22,598	Oct 2019	23, 094
Dec 2018	21,953	Dec 2019	23,500

NB. Please note available hours do vary, as a provider leaves the market for example or has difficulties in recruitment, but overall the trend in available hours is demonstrating an increase.

1.9 This time last year we supported on average 147 people a month to source home care, with this year the figure being 173. Of these, last year 16 people per month were acute hospital discharges, with this year the figure being 20.

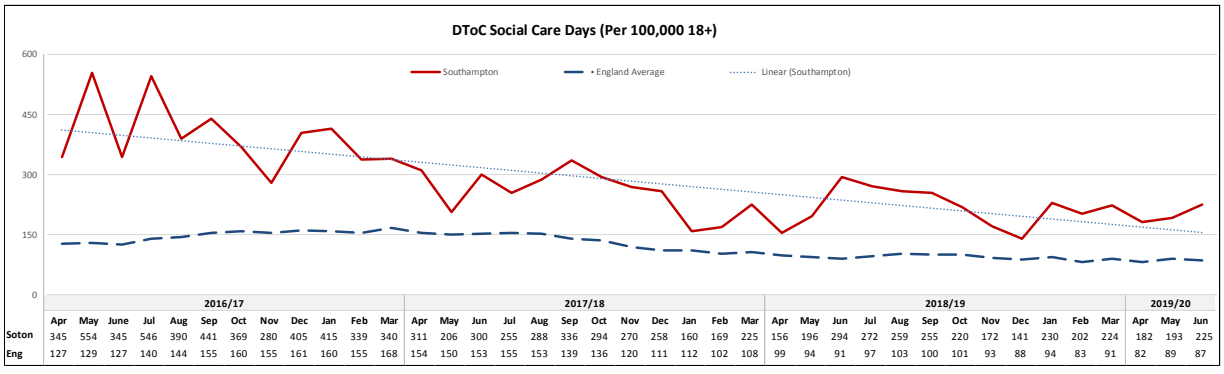
1.10 There has also been an improvement in the waiting times for Home care as shown in the chart below which shows the time in days between referral and package starting:



NB. It should be noted that the chart includes all clients who require support from Home Care and will mask the fact that responses to the acute hospital are significantly faster than that of other sites/referral sources.

2. Impact

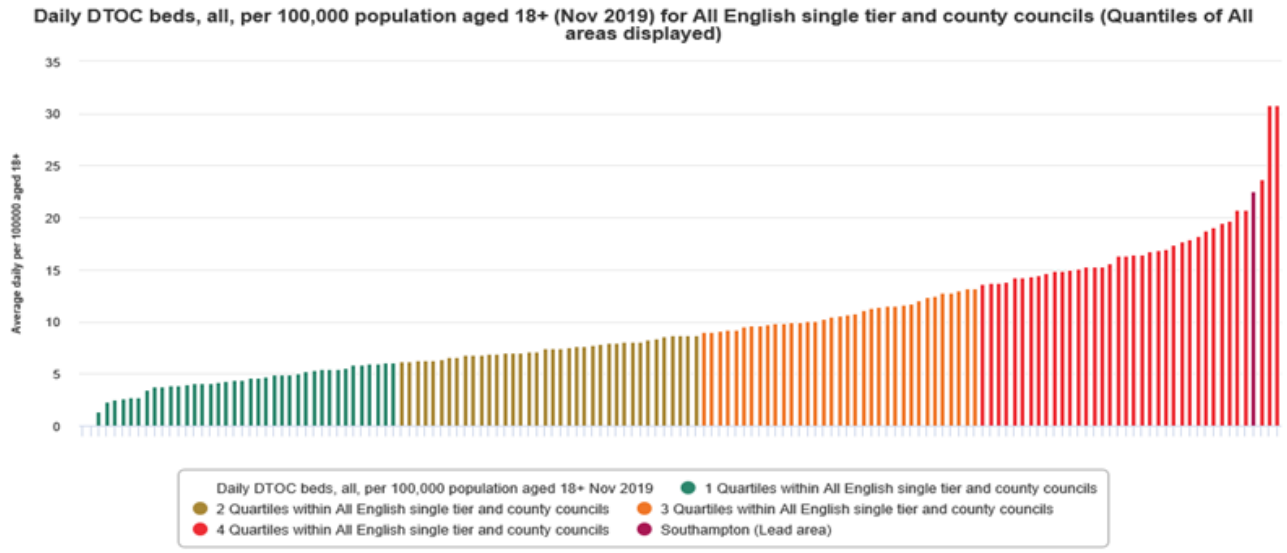
2.1 The improvement work undertaken to date has resulted in a significant reduction in DToC since 2016/17 as can be seen in the chart below.



	2016/17												2017/18												2018/19												2019/20		
	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Soton	345	554	345	546	390	441	369	280	405	415	339	340	311	206	300	255	288	336	294	270	258	160	169	225	156	196	294	272	259	255	220	172	141	230	202	224	182	193	225
Eng	127	129	127	140	144	155	160	155	161	160	155	168	154	150	153	155	153	139	136	120	111	112	102	108	99	94	91	97	103	100	101	93	88	94	83	91	82	89	87

2.2 Data comparing December 2019 with December 2018 shows that we are discharging more patients than ever (96 patients were discharged in December 2019 compared to 74 in December 2018) and the overall length of stay is reducing.

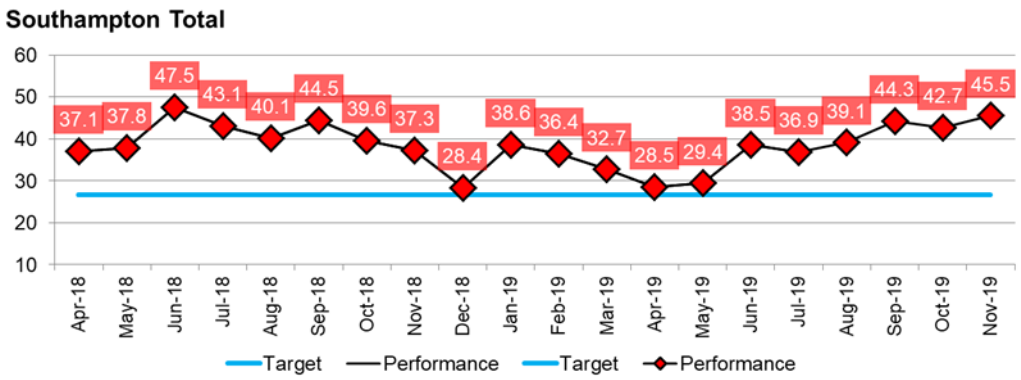
2.3 However, Southampton remains a long distance from its national targets and benchmarks poorly against other Local Authorities as shown in the chart below.

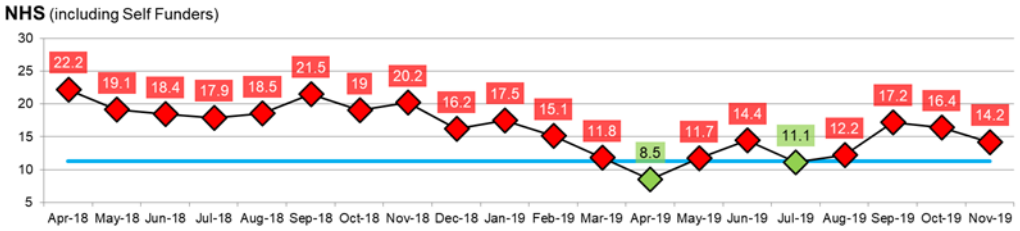


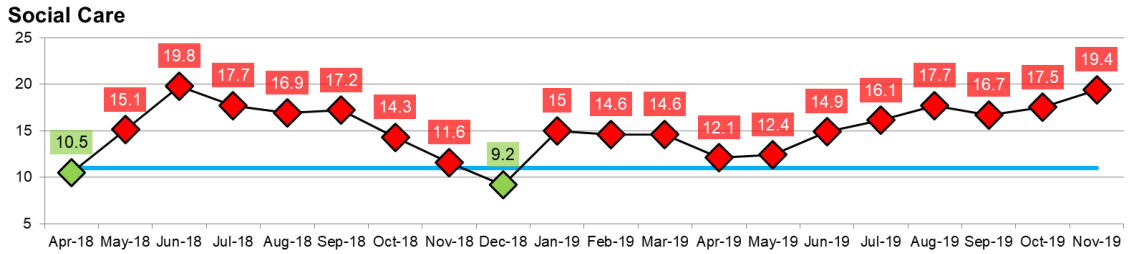
3. Current Position

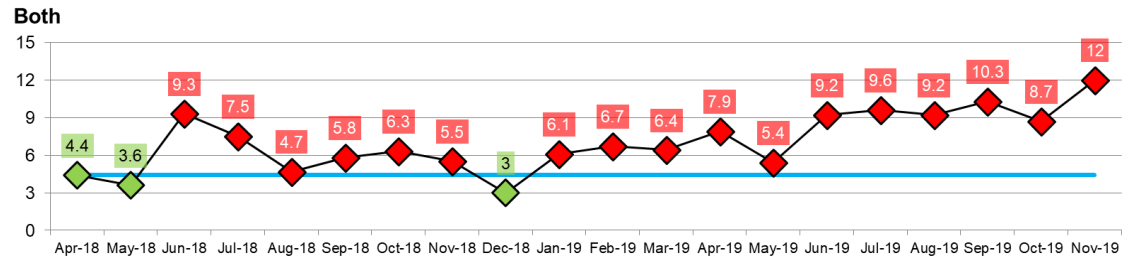
3.1 As at November 2019 (latest available data at time of writing), Southampton's percentage DTOC across all hospitals was 6.6% against the NHSE target of 3.5% with a year to date average of 5.6%. The average daily number of delays for November 2019 was 45.5 against the national target for Southampton of 26.7, with a year to date average of 38.1. The charts below show how this breaks down by delays attributed to the NHS, Social care and both agencies, illustrating that the increase has been more marked in social care delays. The increase in delays recorded as "both" is primarily linked to a change in recording whereby reablement delays, previously recorded as social care delays, are now recorded as "both".

<u>Southampton Average daily delays (across all hospitals)</u>



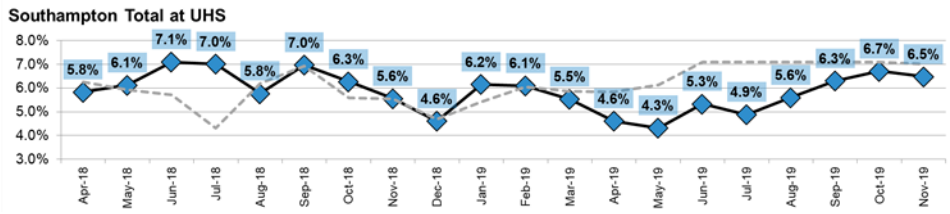


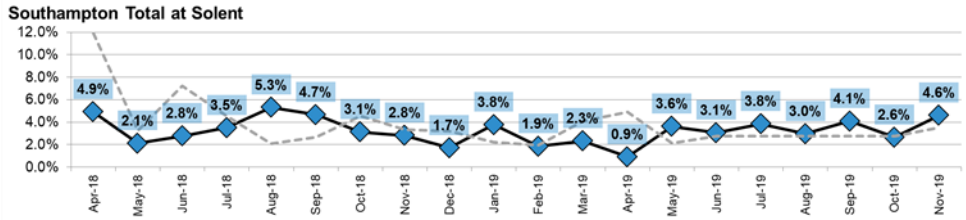


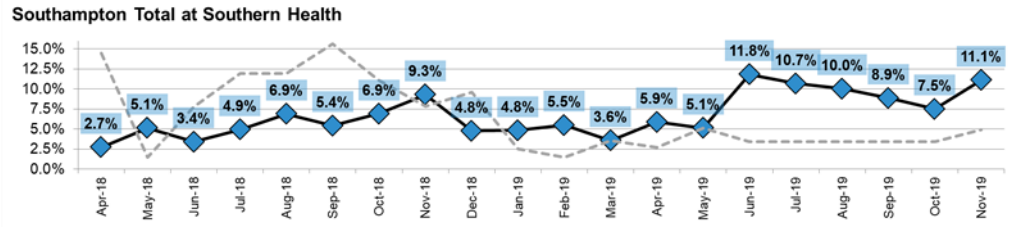


3.2 In terms of overall hospital discharges for Southampton residents, UHS accounts for around 75%, Solent for 10% and Southern Health for 15%. Trust level data on DTOC is shown in the charts below against the 3.5% NHSE target and shows the greatest areas of challenge to be at UHS and Southern Health (mental health and older person's mental health).

The dotted line shows the trend for the previous year.







3.3 Further analysis of the Southern Health delays shows that the high proportion of DTOC relates almost exclusively to the adult mental health wards.

OPMH **Delayed Transfers of Care Number of delayed days versus occupied bed days**

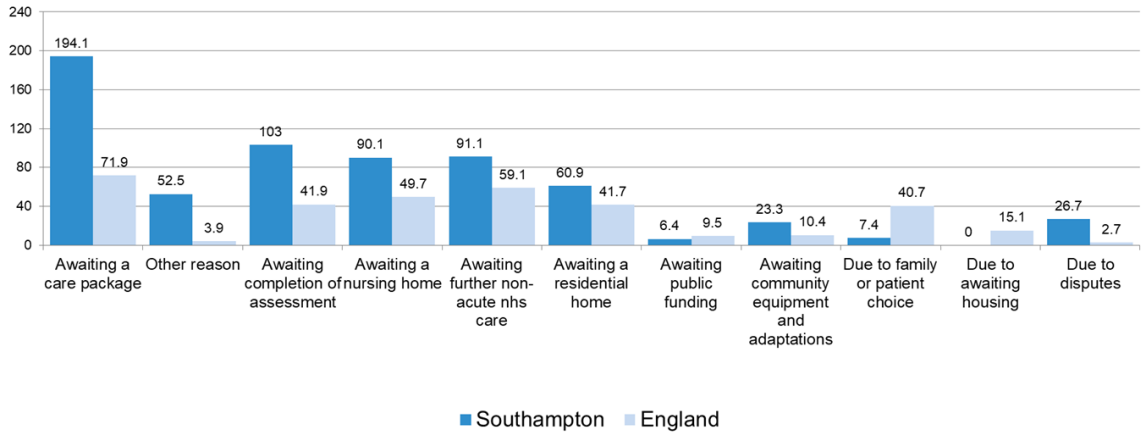
	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
OBD	576	598	597	623	457	554	639	629	625
DToC Days	32	58	46	2	0	0	0	0	0
Rate %	5.6%	9.7%	7.7%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%

AMH **Delayed Transfers of Care Number of delayed days versus occupied bed days**

Value	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
OBD	1813	1748	1718	1591	1580	1483	1615	1698	1897
DToC Days	91	65	188	217	237	194	152	219	202
Rate %	5.0%	3.7%	10.9%	13.6%	15.0%	13.1%	9.4%	12.9%	10.6%

3.4 The increase in DTOC on the Adult MH wards which is visible from June 2019 is understood to be reflective of more robust identification, standardisation and governance of DToC that was put in place around this time. Southern Health has identified suitable supported housing as a significant discharge barrier in a number of cases. There are some particular challenges with a number of long stay patients on the male acute ward, which is a top priority for Southern Health and correlates to use of out of area beds. Other issues that have specifically been identified impacting on Adult MH delays relate to timescales for completion of Care Act Assessments (although a new process has in the last week been put in place), training hospital staff on processes and timescales for social care funding decisions. Action being taken specifically to address these issues is discussed in the next Section.

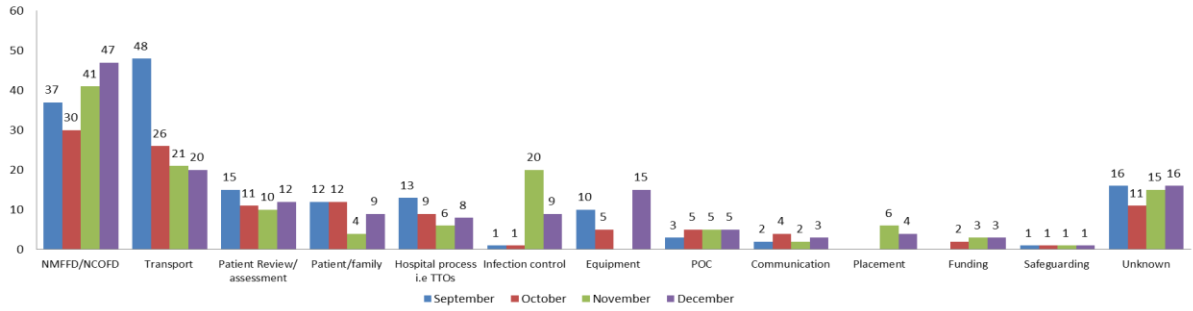
3.5 When reviewing the main reasons for delay across the board, home care placement is the most prominent, followed by awaiting assessment (which relates almost exclusively to social care providers coming into hospital to assess), nursing home placement and then awaiting further non acute NHS care. This is shown in the chart below.



3.6 Further analysis of the factors underpinning these delays shows that the main reasons are associated with increasing levels of complexity requiring more “double up” care or harder to source nursing home placements. This is borne out in further data which shows that for 2018 the percentage discharges for each of the pathways were: 8% for Pathway 1 (simple discharges), 39% for Pathway 2 (supported discharges) and 53% for Pathway 3 (complex discharges) compared to 8%, 27% and 65% respectively for 2019.

3.7 The delays in further non acute NHS care also seem to be related to increasing complexity and demand for specialist rehab beds e.g. Spinal or neuro rehab, the main provisions being Salisbury Hospital (spinal rehab) and Snowdon (Solent) for neuro rehab.

3.8 Additionally it is recognised that process issues are still contributing to a number of the delays. For example, on any given day there are approx. 6 failed discharges across UHS (which will be a mix of both Southampton and Hampshire patients) owing to hospital processes as shown in the chart below, hospital transport making up 20% of these (the improvement from October onwards relating to introduction of a dedicated transport team in the IDB which has been funded from the South West System Winter Pressures Fund).



4. Summary of additional work underway to improve the position

4.1 Building on the output from the April 2019 Peer Review facilitated by the LGA on 30 April 2019, senior oversight and leadership has been strengthened by ensuring that there is a regular focus on DTOC performance at the monthly Better Care Steering Board meetings; reporting processes and accountability have also been strengthened so that on any one day performance can be tracked against each of the 3 discharge pathways.

4.2 On top of this the system is taking the following additional actions:

<u>In recognition of Home Care Capacity being the main cause for delay:</u>

- Use of South West System Winter Pressures Fund to increase home care, bridging and Discharge to assess capacity:

- 300 additional hours a week from Enthuse for bridging from 16 December 2019 (approx. 20 additional packages) and an additional 260 hours a week from early January 2020 (approx. 17 additional packages)
- An additional reablement bed in the residential care sector from September 2019
- 2 additional D2A Pathway 3 beds (on top of existing 5 beds) from 31 December 2019

- Employment of an OT locum (using iBCF) to review double up home care packages with a view to identifying any packages that can be reduced and freeing up capacity. It is believed that there could be a reduction of up to 40% in double up care packages through training, risk management and using equipment out of the approx. 200 Southampton City Council cases that have a double up package due to mobility and hoisting.

<u>In recognition of waits for Care Home assessment and placements being a key cause for delay:</u>

- Piloting a trusted assessor scheme for care homes in order to improve responsiveness and reduce the number of repeat assessments for patients by different homes. Southampton is already engaged in a Hampshire wide project aimed at engaging care homes in the trusted assessment approach. Recognising the importance of building trust and relationships, the pilot which commenced in January 2020 will focus on engaging with local care homes to design and implement a trusted assessor scheme.
- Care Home Hotline introduced by UHS in December 2019 for post discharge medical advice and support within the first 48 hours of post discharge – in response to care home concerns around being able to contact someone should a resident's condition deteriorate

<u>In recognition of NHS non acute onward care being a key cause for delay:</u>

- Joint review with West Hampshire CCG of Specialist Rehab provision to gain a greater understanding of the level of demand and associated processes in order to better manage flow going forward. This is due to conclude in March 2020.
- Use of South West System Winter Pressures Fund to increase capacity in the integrated rehab and reablement service to improve flow:
  - Advanced Practitioner Therapist post in the Community Independence team to undertake Comprehensive Geriatric Assessment with a view to reducing hospital length of stay
  - Additional therapy capacity over weekends at the Royal South Hants Hospital to improve flow
  - Enhanced Community 'In-reach' to UHS over the weekends to facilitate weekend discharges

    (NB. Along with the additional home care and D2A capacity referenced above, this equates to an additional £196k investment from the SW System Winter pressure fund)

<u>In addition the following actions are being taken to improve flow:</u>

- A system wide marketing campaign to promote key messages to the public and staff about the benefits of "home first" and out of hospital provision, linked to other work we are doing on "ageing well". This was launched 20 January 2020.

- Delegation of an enabling budget directly to the IDB manager to be used to "unblock" common causes of delay such as patient transport to enable someone to go home on time. British Red Cross have specifically been commissioned to provide additional transport capacity to the IDB. (NB. This has been funded through the SW System Winter Pressures Fund)
- Work underway with UHS ward staff (as part of the "Always Improving Inpatient Care" programme being led by PWC for UHS) to improve the interface between the IDB and the wards – workshop planned for February 2020 followed by training programme for ward staff.
- Commissioning the voluntary sector to work alongside the Care Placement Service and provide support to families in making timely choices around onward care. This is currently being scoped and is due to commence March 2020.

4.3 In addition, the IDB leaders group is planning to undertake a series of Rapid Improvement Workshops during March and April to process map each of the discharge pathways and identify key areas for improvement. Pathway 3 will be the initial priority.

4.4 In addition the following specific actions are being taken to address discharge delays at Southern Health (adult mental health wards):

- Daily/weekly escalation calls
- Mental health and housing action plan in place to improve accommodation pathways
- Established Rehab Outreach team to support discharge to the community for people who may need a period of enhanced support
- Council/CCG flexibility to offer out of panel funding decisions to support discharge if applicable/supported by appropriate application information to avoid DToC status; same arrangement being explored for housing gateway panel
- Exploring possibility to pilot Housing Officer In Reach support to Antelope House/Forest Lodge
- ICU undertaking a housing needs assessment and market position statement to address demand/availability of housing/ supported accommodation
- Winter pressure funding secured to focus on improving flow; increased social worker capacity on inpatient wards and additional funding to complement the existing bed management team; new Social Care process being trailed from 3 February 2020.

5. Offer from Better Care support

5.1 Southampton City has been offered 15 days of peer-facilitated support by the national Better Care Programme as part of its national support offer – to be used before April 2020. The Better Care Support programme has commissioned the Local Government Association (LGA) to undertake this programme of work. This will link with the UHS PWC work as well.

5.2 This support will be tailored to meet the needs of our system and officers will be actively involved in selecting the best-fit peers to meet our needs, and in agreeing the scope and key lines of enquiry of this work.

5.3 It is proposed that this support is used to undertake a deep dive into each of the Discharge pathways to test and challenge current practice, identifying bottle necks in the process and thereby informing an improvement plan.

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IBCF Expenditure

IBCF Expenditure 2019/20

Scheme	Spend (£)	Commentary
Increasing uptake of Direct Payments (DP)	223,899	Investment has been made in a dedicated team to support the uptake of DPs and in a dedicated post within Adult Social Care to undertake carers assessments
Maximising use of Care Technology	50,724	This has comprised a project officer to take forward work on maximising the uptake of Care Technology and to begin work on scoping a more integrated adaptations/equipment offer, with a review of the use of the Disability Facilities Grant (DFG.)
Weston Court Replacement Care / Short breaks	222,000	This has comprised additional short break provision for adults with learning disabilities aimed at supporting families in the community
Expanded 7 day social care operation in the hospital discharge team	90,269	This investment has been used to fund additional posts in the hospital discharge team to provide a 7 day service
Speeding up hospital discharge for people with complex needs	498,625	This has included: • A discharge to assess (D2A) scheme for patients on the rehab/reablement pathway out of the acute and community hospitals • A D2A scheme for patients with complex needs including CHC • A specialist sensory rehabilitation post • An additional reablement bed in residential care home to increase reablement capacity over the winter
Meeting increased demand and complexity	115,564	This funding has been used for additional care package and placement capacity throughout the year.
Stabilising the provider market	453,324	This has included additional home care hours over the winter using the retainer as well as investment in a home care service development post to manage the home care Framework

Scheme	Spend (£)	Commentary
		It has also included investment in preventative activities which reduce/delay the need for care
Accelerating the extra care housing programme	32,000	Investment to cover emergency calls at Erskine Court and Potters Court
Building extra nursing home capacity to meet complex needs	155,212	Investment has been used to undertake a land options appraisal to identify potential future sites for nursing homes. It has also included additional quality team capacity to work with homes on skills development, IT and scoping a Trusted Assessor scheme
Additional social work capacity in community based social wellbeing service	164,265	Investment in additional capacity to meet need
Additional social work capacity in new integrated LD service	225,179	Investment used for additional locum posts to undertake assessments
Additional social work capacity to undertake reviews	62,534	Locum posts to undertake reviews
IBCF Miscellaneous	49,740	A number of one off investments
Total Spend	2,343,335	
Total Grant	2,672,279	
Carry forward	328,944	

IBCF planned expenditure 2020/21

Scheme	Spend (£)	Commentary
Increasing uptake of Direct Payments	154,122	Investment to sustain key elements of the DP team (in particular DP clerk and service development officer), whilst mainstreaming other elements, plus approx £75k for a support planning and brokerage pilot to increase uptake.
Expanded 7 day social care operation in the hospital discharge team	97,565	Continuation of additional posts to ensure 7 day service

Scheme	Spend (£)	Commentary
Speeding up hospital discharge for people with complex needs	573,300	Continuation of D2A scheme for patients on rehab/reablement pathway out of acute and community hospitals Continuation of D2A scheme for patients with complex needs including CHC Continuation of Specialist sensory rehabilitation post
Meeting increased demand and complexity	16,000	Contribution towards Better Care communication and data analysis resource to support planning/service redesign to meet increased demand and complexity
Stabilising the provider market	293,008	Additional home care hours over the winter using the retainer and continuation of home care service development post Appointment of an OT to review two-carer packages with a view to releasing capacity
Accelerating the extra care housing programme	48,000	Continued investment to cover emergency calls at Erskine Court and Potters Court
Building extra nursing home capacity to meet complex needs	206,777	Service Development Officer post to manage strategic options appraisal Continuation of additional quality team capacity to work with homes on skills development, IT and scoping Trusted Assessor scheme
Additional social work capacity in community based social wellbeing service	164,265	Building on recommendations from the Peer Review, continuation of locum posts
Additional social work capacity in new integrated LD service	277,088	Continuation of additional posts to complete reviews
Additional social work capacity to undertake reviews	57,466	Continuation of work to review clients with off framework home care packages to see if they could move onto framework
IBCF miscellaneous/grants	8,900	To be kept available for grants to support prevention agenda
Total Spend	1,896,491	

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.

Meeting Minutes

Meeting:	**Better Care Southampton Steering Board**
Date:	**27 November 2019**
Time:	**09:00 – 12:00**
Location:	**Seminar Room, Oakley Road, Ground Floor**

Present:

Name	Job title	Organisation
Dr Mark Kelsey (Chair)	SCCG Chair	SCCCG
Sarah Turner (ST)	BCS Programme Lead	BCS
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
Matt Stevens (MS)	Lay Member	SCCCG
Donna Chapman (DC)	Associate Director System Redesign	SCCCG
David Noyes (DN)	Chief Operating Officer	Solent
Julia Watts (JW)	Locality Lead	East Locality
Naz Jones (NJ)	Locality Lead	East Locality
Sarah Olley (SO)	Director of Operations	SHFT
Sundeep Benning (SB)	PCN Clinical Director/GP	West End Road
Dr Sara Sealey (SS)	Locality Lead / GP	East Locality
Andrew Smith (AS)	Business Manager	Solent
Janine Gladwell (JG)	Senior Transformation Manager /West Locality Lead	Solent

Apologies:
None noted

Item	Subject	Action
1.	**Welcome and apologies**	
	MK welcomed everyone to the meeting. Introductions were made and apologies for absence were noted.	
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 conflicts of interest were declared.	
3.	**Southampton City 5 Year Health and Care Strategy** • **For BCSB to receive and approve Work Programmes**	
	CY and DC provided an overview of the Southampton 5 Year Health and Care Strategy, noting that the BCSB is responsible for overseeing the strategy. It was noted that this is still work in progress, implementation of this. Comments are very welcome. Proposal that the Board needs to prioritise the work across the 5 year span. **CY to bring timelines to next meeting for consideration.** The following comments were made by Board members: • SO suggested consideration of the layout. This is already in progress. • PAH stressed the importance of refreshing the Primary Care section to describe PCN priorities and outcomes • JH noted the need to align the strategy with the System Planning session being held on 29/11/19. This will be to focus on investments in the system to make most impact and how all organisations will be achieving the Long term plan assumptions. The involvement of primary care needs consideration • JA requested that aspiration for estates accessibility is fully incorporated into all planning. Noted that this is incorporated in latest version • **Suggestion that the plan should be circulated to staff through all organisations to gain feedback and understanding.** The direction of travel was supported by the Board. Final plan to be finalised by February 2020	**CY** **CY**
4.	**Alignment of Locality and 5 Year Health & Care Strategy Work Programmes**	
	DC provided an overview of Better Care and a proposed set of principles to illustrate how the locality and city wide workstreams align with each other and with wider scale work programmes. There was general support for the principles and the clarity they provide. The following comments were made: • DN- raised importance of sustaining the housing link, as move towards	

	integration. • JH – noted the key role PCNs will have in designing and delivering community services going forward. It was noted that this is why PCNs are part of the BCSB and that we need to ensure co-production with them, acknowledging that in some cases there would need to be more of a whole city approach.	
5.	**Integrated Locality Teams - Update from SHFT and Solent**	
	DN and SO fed back on the work they have been doing to take forward integrated locality teams – with a specific focus on co-location. DN explained that a subgroup has been set up, initially with Solent, SCC, SHFT and Paul Benson from the CCG (estates advice), to develop a model to bring together and co-locate 3 integrated teams. East locality has been identified as the first opportunity, using Bitterne Health Centre and Bitterne Park Medical Centre. For Central locality, the RSH is being explored and for West locality the Western Hospital. The following comments were made: • JW highlighted the need to be clear about the end point – what are we aiming to achieve? Is it just co-location or will there be other elements such as single assessment?. DN highlighted that the end goal is for all organisations to be working together as if they were one. • PAH highlighted that from a primary care perspective, work is also underway to consider estate options with Paul Benson and noted that the East is being looked at initially for this too. • MS raised the need to reflect on how this fits with political priorities as well e.g. there is a lot of political interest in the development of "hubs". It was noted that the locality work is focussed more on co-locating staff than patient/client facing initiative. Need to consider terminology. • Transport was identified as a major issue, particularly for the East of Southampton. SR noted that a transport strategy is underway within SCC. **Update to be provided at a future meeting.** This gave rise a conversation about geography and the need to be clear about what provision is available where. **Agreed that PAH would work with Paul Benson to pull together a map of current provisions and planned future provisions, e.g. Bitterne hub, RSH.** JH suggested it would be helpful to link this to metrics around service utilisation.	**SR** **PAH**

6.	**Locality Priorities** • **To receive presentation on priorities identified by each locality** • **For the Board to agree and endorse the work to be taken forward**	
	ST introduced the work that localities have been undertaking to develop a number of projects, noting that these are currently at headline level to seek agreement to progress with full scoping. The Board were asked to consider a number of key questions: • Whether the locality project should proceed to full implementation. • If the locality project should proceed but should be led by a system wide programme group and the locality be a member of that programme. • If a system programme: which programme should the locality project be part of? • Whether the locality project should cease and not progress any further. <u>West Locality projects</u> - Virtual Ward – how to make it more effective? - Integrated Community hub – improving access to information and prevention focus. Support from Age Well Group – pilot in one area Questions and discussion: • DN is it a physical hub? – to be explored, may be other alternatives such as IT. May need to be called something else as confusion with different uses of word "hub" • SO – scoping work may alter the vision, may be opportunities in working with So Linked outreach sessions. JA noted that So Linked are going to be rolling out 6 sessions across the city and from Jan to April will be holding "community conversations" with the Local Solutions Groups in each area. • NJ – would it include GP input? Need to see what the scope is. • MK – confirmed that there is active link with the PCN. • JH – query re support needed from UHS. Noted that there is	

geriatrician input to the working group.

- SO – offered support/input from SHFT into the virtual ward work.

Central/North

- Communication – engagement with wider locality, co-production
- Referral pathway review – both for community mental health team and Steps to Wellbeing. Process to support referrals and what alternative support could be available.
- Development of personalised care information – sharing information between services. Not just statutory services – but also voluntary, community, private care etc. Co-production – what works and what patients see as a challenge
- Alcohol – alcohol admissions key issue for locality. Want to understand more why. Workshop planned – what questions need asking, what are any potential gaps? Not just a locality issue – would be a pilot.

Questions and discussion :

- DN - Positive about the Communications – need to ensure linked to and supported by city wide Better Care communication work. ST noted that the central locality has specifically identified the Muslim community as an area of focus.
- Mental health – FM highlighted work already underway with Hanna Burgess and need to link into this
- Alcohol – wide involvement of a range of stakeholders, including public health and Alcohol Team at UHS. SR emphasised benefit of local in depth work to impact city wide planning
- Personal Care information – SO queried how does this link to CHIE?

East

- Social prescribing – build on community navigation pilots. Network meeting to bring all players together and maximise impact.
- Wound Care – ongoing initiative. Pilots with Solent community nursing online prescription service; planning how to engage with practices more

	- Mental health High Intensity Users (HIU) – working with Tara Bell in SHFT to explore this cohort from a primary care perspective - COPD – patient self-management and pathway review, noting that locality is outlier for COPD outcomes. Task and finish group – connected with Wessex Activation Self-Management Programme (WASP) to identify interventions, trial and share city wide - Nursing Pathway – how maximise use of entire nursing workforce in the locality. - Breast feeding – uptake poor, meeting with Mia Wren to consider existing initiatives and see how this can be strengthened Questions and discussion: • DN ensured the link with So linked and Local Solutions groups was in place • DC queried breastfeeding – there is a city wide strategy group already in place chaired by Amy McCullough – need to link with this • DC noted very positive work on MH HIU bridging the gap between work in the hospital and primary care – importance of linking this up with city wide HIU programme In summary the Board noted the really positive work that the localities have started and agreed that all the projects should proceed but need to link with city wide work programmes where they exist. The only exception to this may be the Central mental health project where it was felt there may be duplication with the work that FM is doing with Hana Burgess – to be confirmed. ST also highlighted a potential risk around overlap and duplication of work on integrated teams. FM queried the future of localities moving forward with projects versus PCNs. MK highlighted that there will need to be an ongoing discussion. NJ gave assurance that projects have been co-produced with frontline services, linking with the PCNs. Next steps: - **ST and DC to review links with city wide work programmes** - **BCSB to oversee the projects – ST to organise quarterly**	**ST/DC** **ST**

	feedback to the board. - **Communications to go out about the projects – ST to link with new Comms lead**	**ST**
7.	**Better Care Steering Board Term of Reference (ToR) - To review TOR and agree voting rights**	
	Voting proposal to be developed and brought back to future meeting.	**Agenda**
8.	**Minutes of the Previous Meeting (25.9.19) & Matters Arising**	
	The minutes of the Better Care Southampton Steering Board on 25th September 2019 were approved. **Matters arising** There were no matters arising.	
9.	**Risks, Action, Issue and Decision (RAID) Log**	
	Risks and issues noted and RAID log updated.	
10.	**Any Other Business and items for future meetings**	
	• MK to bring IT update at next meeting • Partnership Agreement – to be dealt with between statutory organisations outside the meeting.	**MK/ Agenda** **SR/DN/ SO/MK/ JH/AR**
Date of next meeting: Wednesday 29 January 2019, Seminar Room, NHS Southampton City CCG, Oakley Road, Millbrook, Southampton, SO16 4GX		

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