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NHS
Southampton City
Clinical Commissioning Group

Joint Commissioning Board

Thursday, 15th October, 2020 at 9.30 am

PLEASE NOTE TIME OF MEETING

PLEASE NOTE: this will be a 'virtual meeting', a link to which will be available on Southampton City Council's website at least 24hrs before the meeting

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 Penfold, Board Administrator,

Tel: 02380 296029

Email: emily.penfold@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.

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

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

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

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

4 BETTER CARE HIGHLIGHT REPORT - QUARTER 1 AND 2 (Pages 7 - 18)

Lead	**Item For: Discussion Decision Information**	**Attachment**
Moraig Forrest-Charde	Discussion	Attached

5 ADVICE, INFORMATION AND GUIDANCE (AIG) UPDATE (Pages 19 - 30)

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

6 JOINT COMMISSIONING BOARD - TERMS OF REFERENCE UPDATE (Pages 31 - 44)

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

7 BETTER CARE STEERING BOARD MINUTES (Pages 45 - 52)

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

Wednesday, 7 October 2020

Richard Ivory, Service Director Legal and Business Operations

SOUTHAMPTON CITY COUNCIL ®

NHS
Southampton City
Clinical Commissioning Group

Meeting Minutes

Joint Commissioning Board – Public

The meeting was held on Thursday 18th June 2020, 09:30 - 10:30
Microsoft Teams Meeting

	NAME	INITIAL	TITLE	ORG
Present:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	Councillor Lorna Fielker	Cllr Fielker	Cabinet Member – Adult Social Care	SCC
	Councillor Dave Shields	Cllr Shields	Cabinet Member - Health and Sustainable Living	SCC
	Matt Stevens	MS	Lay Member – Patient and Public Involvement	SCCCG
	James Rimmer	JR	Managing Director	SCCCG
In attendance:	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG / SCC
	Donna Chapman	DC	Associate Director	SCCCG
	Grainne Siggins	GS	Executive Director Wellbeing (Health & Adults)	SCC
	Sandy Hopkins	SH	Chief Executive Officer	SCC
	Beccy Willis	BW	Head of Governance	SCCCG
	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Angela Murrell (minutes)	AM	Senior Administrator	SCCCG
Apologies:	Keith Petty	KP	Co-ordinating Finance Business Partner	SCC
	Councillor Chris Hammond	Cllr Hammond	Leader of the Council	SCC
	Maggie MacIsaac	MM	Chief Executive Officer	SCCCG

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. It was noted that JR was attending as MM deputy. 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.	**Minutes of the Previous Meeting/Action Tracker**	
	The minutes from the previous meeting dated 20th February 2020 were agreed as an accurate reflection of the meeting. **Matters Arising** There were no matters arising. **Action Tracker** The outstanding actions were reviewed MK commented that most of the actions on the action tracker were on hold due to Covid-19 and will relook and reschedule all the actions at a future meeting.	
4.	**Five Year Strategy Priorities – Next steps**	
	SR and DC presented the Five Year Strategy Priorities report to the Board, explaining that this was a roadmap within the City moving forward. The Better Care Steering Board and sub groups related to that have undertaken a review of the Strategy in light of the impact of Covid-19 DC summarised some of the changes and key issues;- • The use of digital and virtual contact • Reduction in the routine work • Strong focus on self-management • Considerable effort and enhancement within the Community and Voluntary sector has taken place DC highlighted the main concerns across all of the groups: • Emotional and mental health, back log in activity and also new presentations of people with emotional and mental health difficulty. • Loneliness • Widening inequalities • Safeguarding DC talked through the Start Well priorities and highlighted the following;- • Short term – increase emotional and mental health offer • Short term – Promote and support re integration to school • Short term – Safeguarding • ICP level – CAMHS Crisis Pathway • ICS level – Suicide prevention plan YP – designed at ICS level but implemented at Place level • Medium term – Extend the locality	

	• Medium term – Review of Disabled Children's Health and Care • Medium term – Implementation of Phoenix • Specialist resource hub for YP with complex SEMH SR talked through the Live Well priorities and highlighted the following;- • reduce the impact of the inequalities and deprivation • Mental health and wellbeing • Supporting people to live independently DC talked through the Age Well priorities and highlighted what has changed due to the impact of Covid-19 and stated what the priorities will be:- • Specific focus on the shielded patient lists • Enhanced Health and Care Home programme • Pathway 3 and discharge to assess • Building on community hub offer • Social inclusion SR talked through the Die Well programme highlighting the following key points:- • Training for care homes has taken place • Out of hospital end of life care coordination service • Developing a workforce which is confident and competent to discuss end of life wishes. MS stated that 1 in 3 that have died from Covid-19 had diabetes and with this in mind should we now have a stronger focus in this area. SR confirmed that in the short term diabetes is a key priority. The Board support the revised priorities for the Southampton Five Year Health and Care Strategy.	
5.	**Covid-19 Overview of Health and Care Response in Southampton**	
	SR presented the Covid-19 overview of Health and Care Response in Southampton paper highlighting the key areas of focus and changes;- • Establish a Covid-19 Health Protection Board • All organisations being able to adapt to a local outbreak • A lot of work in the Social Care Market has taken place • Changes in the rehab and reablement service put in place • Financial impact of Covid-19 • Change to the discharge process – new discharge processes in place • CAMHS services adapted • Adapted how we are monitoring all services • Long term funding of packages	

	Cllr Fielker commended everyone who has being doing the work in response to Covid-19. MS asked if this way of working regarding the discharge team in place at Sembal House will continue. DC stated that it is a model that would like to be continued and this is being evaluated and how to sustain the model. GS commented that a fast discharge process is very important as well as ensuring people have the appropriate rehab and reablement, making sure that the whole journey is being thought about. The Board noted the report.	
6.	**Better Care Steering Board Minutes**	
	The Board received the Better Care Steering Board (BCSB) meeting minutes from 3rd March 2020 for information.	
7.	**Date of Next Meeting**	
	15th October 2020, 09:30 – 11:30, Microsoft Teams	

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	Nov-20	was scheduled for March, however Meeting was cancelled due to Covid19 response, all items to be reviewed and rescheduled, to be incorporated in MH briefing at meeting in November
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	Jan-21	was scheduled for March, however Meeting was cancelled due to Covid19 response, all items to be reviewed and rescheduled. Workplan reviewed and performance report now restarted, to be presented at next public meeting.
20/02/2020	Action tracker	Briefing to be provided on the results of the Primary Care East Estates review	Matt Stevens	Nov-20	November meeting.
20/02/2020	Action tracker	Update on DToC to be provided to a future JCB	Stephanie Ramsey	Apr-20	Complete - update on discharge has been provided
20/02/2020	Residential and Nursing Homes – Market Management Update and Commissioning Strategy	MW to bring briefing back to JCB on the Market Position Statement alongside progress of the RSH development	Matthew Waters	Nov-20	November meeting.

DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Better Care Quarter 1 and 2 2020/2021 Report**		
DATE OF DECISION:		**15th October 2020**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Moraig Forrest-Charde**	Tel:	023 80640375
	E-mail:	**moraig.forrest-charde@nhs.net**		
Director	**Name:**	**Stephanie Ramsey**	Tel:	023 80296941
	E-mail:	**Stephanie.Ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE

BRIEF SUMMARY		
This report provides a review of performance for Quarter one and two 2020/2021 against Southampton's Better Care programme and pooled fund. The most recent highlight report can be found in Appendix 1.		
RECOMMENDATIONS:		
	(i)	To note Quarter one and two performance for Better Care.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Joint Commissioning Board (JCB) is responsible for oversight of the Better Care pooled fund. This responsibility has been delegated to JCB from the Health and Wellbeing Board (HWBB).	
2.	The purpose of this report is to provide assurance to JCB that the Better Care programme and pooled fund is progressing to plan and to highlight any key issues.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	NOT APPLICABLE	
DETAIL (Including consultation carried out)		
3.	**National and local overview** National Better Care Fund Operating guidance was last published on 18 July 2019 for 2019/20 and the Policy framework for 2020/21 has been delayed owing to the COVID pandemic. Prior to COVID, we were awaiting feedback from the national review of the BCF programme but the expectation was that 2020/21 would 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 the outcome of the Comprehensive Spending Review. It is still anticipated that a document summarising the outcome of the national review work will be published to inform future discussion about how the Better Care Programme needs to adapt post COVID. During 2019/20, Southampton's Better Care programme was refreshed to align with the Southampton City Health and Care Strategy (2020 – 2025) which in turn aligns to the Council Strategy, NHS Long Term Plan and Hampshire and Isle of Wight Sustainability and Transformation Partnership/Integrated Care System plans. It is a subset of the wider 10 year strategy for health and wellbeing led by the Health and Wellbeing Board.	

The Southampton City 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):

- Reduce health inequalities and confront deprivation
- Tackle the city's three 'big killers': Cancer, Circulatory diseases and Respiratory diseases
- Improve earlier help, care and support
- Improve mental and emotional wellbeing
- Work with people to build resilient communities and live independently
- Improve joined up, whole person care

Southampton's Better Care Plan is at the foundation of the Southampton City 5 Year Health and Care Strategy and has the following aims:

- 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
- **Joining up Rehabilitation and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams** (and integrated health, education and social care teams for children and families, e.g. the 0-19 Prevention and Early Help service) that in turn link with each of the Primary Care Networks.
- **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.

The **Better Care Fund** (BCF) pools resources from both Southampton City Clinical Commissioning Group (CCG) and Local Authority to support the delivery of the Better Care Programme. It also includes the improved Better Care Fund grant (iBCF) and Winter Pressures grant. In 2020/2021 the BCF totals £130.317M (£82.648M from the CCG and £47.669M from the Council), making Southampton one of the country's top authorities for pooling an amount way beyond its national requirement which is £16.484M, 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 – Joint Equipment Store (JES) and Disability Facilities Grant (DFG)
5. Prevention and Early Intervention
6. Adult Learning Disability Integrated Commissioning
7. Promoting uptake of Direct Payments

8. Long Term Care – investment in the social care market
9. Integrated provision for children with SEND
10. Integrated health and social care provision for children with complex behavioural & emotional needs

To date reporting on iBCF and BCF delivery has been under these ten schemes, providing a coordinated approach to the oversight of Better Care locally.

4. **Performance as at Q1 & 2 2019/2020**

The table below provides the Performance against the key Better Care national indicators. Owing to monthly reporting time lags, it is only possible to provide activity data up to Month 4, i.e. 31 July 2020 (August and September 2020 activity data will be available in November 2020).

It should be noted that performance during this period has been significantly skewed by COVID with far fewer people attending A&E and other open access health services resulting in far fewer non elective admissions. This is also reflected in the injuries due to falls metric which is based on hospital admissions due to falls. The nationally required changes to processes are also distorting the permanent admissions into residential care data as a Discharge to Assess model is in place.

City-Wide Dashboard

Year to Date to Month 4 (Apr – Jul 2020)

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

Metric	Year to Date vs. Target	Year to Date vs. Last Year	Commentary
Urgent Care Demand			
A&E Attendances (Type 1)	Annual Planning Round was Suspended due to COVID so no Targets have been set	Better (31% lower than last year)	• At the end of Month 4, **all three age groups have had a decrease** in A&E attendances compared to last year – Children 40% decrease; Working Age Adults 27% decrease; Older People 23% decrease. This metric has been heavily impacted by the pandemic with weekly data suggesting that UHS Type 1 attendances were just 50% of the levels the previous year however latest weekly data shows that activity has returned to previous weekly levels.
Non Elective Admissions		Better (25% lower than last year)	• At the end of Month 4, NEL admissions are 25% lower than last year. Again this metric has been impacted by the pandemic with a 41% reduction in activity in Month 1, this is steadily increasing and at Month 4 was 16% lower than Month 4 2019/20.
Non Elective Short Stay Admissions (Length of stay <24 hours)		Better (27% lower than last year)	• NEL short stays are 27% lower than last year – again the pandemic has had an impact. In month 1 activity was 45% lower than last year but by Month 4 activity is 20% lower.
Non Elective Super Stranded Admissions (Length of stay ≥21 days)		Better (47% lower than last year)	• NEL Super Stranded patients waiting over 21 days are 47% lower at Month 4 than the same period last year. Figures have been consistent across the 4 Months of 20/21.
Discharge & Out of Hospital Model			
DTOC rate	Metric Suspended from March 2020 due to COVID		
Delayed days	Metric Suspended from March 2020 due to COVID		
Permanent admissions into residential care	No target set	Better (58% lower than last year)	• At the end of Month 4, permanent admissions are 58% lower than the same period last year. The 20/21 figures exclude the COVID-19 placements which are being treated as short stays. These figures are subject to validation.
Prevention			
Injuries due to falls	No target set	Better (33% lower than last year)	• At Month 4, Injuries due to falls were 33% lower than the previous year. As with other NEL metrics there has been an increase month on month from Month 1 (44% down) to Month 4 (23% down).

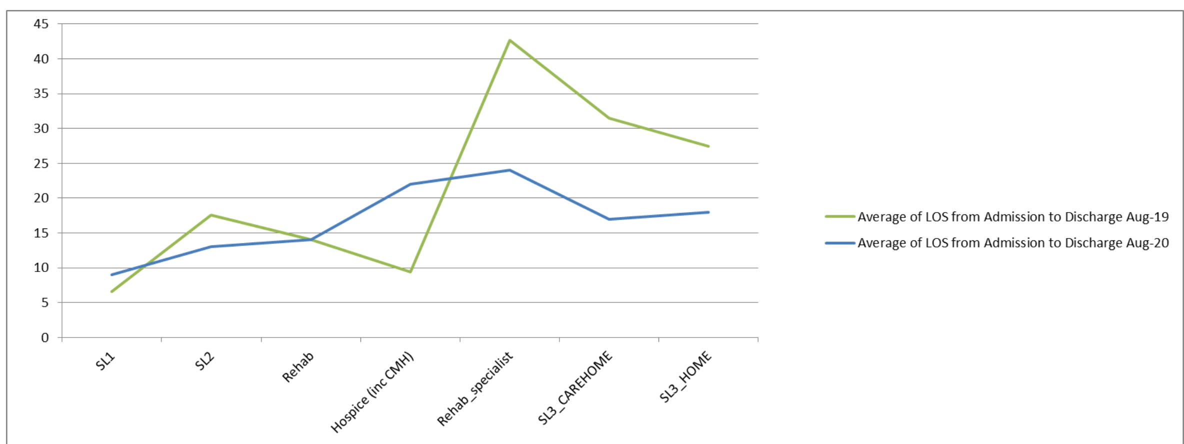
5. **Performance Headlines**

- **Permanent admissions to residential and nursing homes:** On the surface, performance would appear to be better than the same period last year. However, in line with the new

COVID discharge guidelines, discharge to assess is being rolled out at scale which will be artificially deflating the number of permanent admissions. Once assessments have been completed and eligibility established, the figure will increase. There is also a risk that implementation of the new discharge guidance, which is focussed on earlier discharge at the point a patient is deemed medically fit for discharge – as opposed to being therapy fit for discharge – will in fact increase permanent admissions to care homes as patients are coming out of hospital with increased levels of complexity. Therefore, whilst permanent admissions are 58% lower than the same period last year, the figures are subject to significant change in the coming months and will require careful monitoring.

- **Delayed transfers of care** (DTOC) – The monthly recording and reporting of DTOC was suspended on 19 March 2020 in line with the new Covid discharge processes and there are currently no plans to return to this reporting for the remainder of 2020/21. In place of this, NHS providers are required to provide daily reporting identifying the numbers of people leaving hospital and where they are discharged to, the reasons why people continue to remain in hospital when they are medically fit to be discharged and specifically the number of people who are fit to be discharged but still in hospital after 14 days and 21 days with the reasons why. Key local measures also being recorded include:
  - Number of patients who are medically optimised for discharge (MOFD) and still in hospital on any given day and what this is as a % of occupied hospital beds
  - % patients who are discharged to their own home
  - % patients discharged within 24 (pathway 0 and 1[1]), 48 (pathway 2) and 72 hours (pathway 3)
  - Numbers and % of failed discharges

The chart below represents the difference in average length of stay (LOS) when August 2020 is compared with August 2019. The table provides a little more detail when considering discharges on a particular pathway or to a specific destination.



[1] **Pathway 0 and 1 are patients being discharged with no or very little need for additional health or care support. Pathway 2 are patients discharged into rehab and/or reablement who, in the main, will be able to return home with some additional support. Pathway 3 are the most complex patients, including those eligible for Continuing Healthcare**

Average of LOS from Admission to Discharge		
Pathway	Aug-19	Aug-20
SL1	6.6	9
SL2	17.6	13
Rehab	14	14
Hospice (inc CMH)	9.4	22
Rehab_specialist	42.7	24
SL3_CAREHOME	31.5	17
SL3_HOME	27.5	18

The following table provides detail on the performance against hospital discharge KPIs which reflect the new discharge arrangements.

Ref	Performance Measure	Target	Baseline (Taken from June)	April	May	June	July	August
KPI-01	The number of acute beds occupied per day by patients who are MOFD and how this translates as a % of: - all occupied acute beds	**Improvement trajectory to reach 3.5% by Winter:** **10% by 31 July** **5% by 30 Sept** **3.5% by 31 Oct**	**15%**	15%	12%	15%	13%	15%
KPI-02	The number and percentage of patients that are **discharged home** with support against the total number of patients discharged	**85%**	**71%**	66%	73%	71%	70%	74%
KPI-03	The number and percentage of patients that are discharged on **pathway/support level 0 within 24 hours** of becoming MOFD	**95%**	**77%**	89%	87%	74%	75%	67%
KPI-04	The number and percentage of patients that are discharged on **pathway/support level 1 (restarts & returns) within 24 hours** of becoming MOFD	**90%**	**82%**	58%	70%	82%	62%	60%
KPI-05	The number and percentage of patients that are discharged on **pathway/support level 2 within 48 hours** of becoming MOFD	**90%**	**59%**	65%	76%	59%	55%	43%
KPI-06	The number and percentage of patients that are discharged on **pathway/support level 3 within 72 hours** of becoming MOFD	**85%**	**41%**	58%	38%	41%	26%	23%

These figures demonstrate the following key challenges:

- The need for further work to reduce the number of long stay patients (i.e. over 21 days), building on the improvements already made between Q1/2 20/21 and the same period last year. The main reasons for very long stays are specialist rehab capacity and the ability to source nursing home placements for patients with challenging behaviour.
- The percentage of patients in hospital who are deemed medically fit for discharge remains high, averaging at 15%. The percentage of patients actually discharged within 24 (pathway 0 and 1), 48 (pathway 2) or 72 hours (pathway 3) of becoming medically fit remains significantly off target, particularly for pathway 3 which is for the most complex patients
- The percentage of patients being discharged back to their own homes is below where we would like it to be at 85%, although this is linked to the increased levels of complexity which seem to be associated with discharging patients at an earlier stage.

A Southampton and South West Hampshire Discharge Action Plan has been agreed with the following key actions:

➢ Enabling earlier discharge decision making in the hospital to promote referrals being made earlier in the day to the community discharge hub, leading to more patients being discharged that same day

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Improvement in the quality of discharge thereby reducing the number of failed discharges as a result of such problems as delayed patient transport, medications not being ready on the day or poor information transfer
Development and embedding of clearer processes for people who are homeless to ensure discharge is not delayed.
Implementation of a consistent approach to Discharge to Assess across Southampton and South West Hampshire. This includes securing appropriate resources to support people to have a discharge to assess approach and to ensure that the onward care is well planned and supported across the system of health and care.
Increasing capacity in other key services such as Stroke early supported discharge (ESD) and Community Rehabilitation beds
Promoting further development of 7 day and flexible working to support more discharges to take place at the weekend, preventing the usual spike in referrals to the community discharge hubs on a Monday or Tuesday which are then difficult to process
Work with community equipment and transport providers to understand any gaps in provision and work towards resolving these.

Non Elective (NEL) admissions: at month 4, NEL admissions are 25% lower than this period in the previous year. During this period the rate has steadily risen, starting in March at 41% below the previous year’s performance and in July 16% lower than last year. The main contributory factor to lower non elective admissions is the impact of the pandemic itself. Going forward it will be important to prevent avoidable A&E attendance and NEL admissions in order to support system recovery and in particular recovery of elective planned care in line with government targets alongside maintaining capacity to respond to Wave 2 and the additional pressures that winter brings. To do this key areas of focus will include:

Reductions in admissions amongst high intensity users
Increasing capacity within Urgent Response to promote a stronger focus on Admission Avoidance.
High level of collaboration between community partners to assist people with support needs promptly, including the development of the One Team/Integrated Care team approach.

Injuries due to falls – performance is 33% lower than the previous year mainly owing to the overall reduction in non-elective admissions; this indicator is specifically counting hospital admissions due to falls injuries. As with other non-elective metrics there has been an increase month on month i.e. from month 1 to month 4.
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Covid impact on BCF

During the immediate response to Covid-19 some services experienced increased demand whilst also being required to change the way in which they deliver services to keep their clients/patients safe. Many services have shown significant levels of flexibility and innovation to meet this demand within the funding available to them. This includes a new, Covid safe, approach to making contact with clients, implementing flexible working patterns and working collaboratively with other services in order to meet the needs of their client group.
In response to the new national discharge process, the system has worked in true partnership to develop the integrated discharge hub which brings together Adult Social Care, Urgent Response Service, Care Home Support and Continuing Health Care. Together they enable a Discharge to Assess (D2A) approach, allowing people to be discharged to their own home or another suitable environment to continue their recovery. The model developed through this approach has proven successful and as such will be promoted further as we move into implementing our

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	recovery plans. Whilst the model will be developed further, the site for delivery will move to a new site in order to enable the recovery of services which would normally be in place at Sembal House. o Implementation of the new Joint equipment service (part of the aids to independence scheme) was successfully completed in Q1, despite the challenges faced as a result of Covid-19. In addition a review of the Disability Facilities Grant started early in Q2 and is expected to report its findings in Q3. o The development of Potters Court, the new extra care facility for the city, was delayed as a result of the lock down restrictions placed on the developers early on. However the building and development work has since restarted and we expect to be undertaking planning in Q3 for our first residents in Q4. o The Enhanced Health into Care Homes work, which forms part of the CCG contribution to the BCF fund, expanded early in the Covid response to all care homes in the city. This means that a comprehensive offer of support is now available to all care homes. Taking into account the challenges faced by services under the Better Care Fund, for the remainder of this year, the following system wide priorities have been agreed: I. Embed the integrated discharge hub and processes so that they become business as usual for the city. II. Continue to mainstream discharge to assess, noting that further development is needed for the more complex client group i.e. those described as being on pathway 3. III. Improve planning at the hospital front door to assess needs, direct people to the most appropriate setting, avoid admission where possible, commence early discharge planning and early conversations about discharge. IV. Test and learn approach for integrated care development providing a person centred, proactive, coordinated care and support, capable of managing greater levels of acuity outside of hospital. V. Increase the supply of home care to meet greater levels of complexity and address gaps e.g. people with low level health needs. VI. Work towards flexible or 7 day discharge.
7.	**Key highlights for Quarter One and Two 2020/2021** • **Priority 1: More rapid expansion of the integration agenda across the full life-course, building on the city's model of person centred integrated care** ➢ Work is progressing between commissioners and managers across the Council, Southern Health, Solent Medical Services, Primary Care Networks and Solent to explore a more integrated model of delivery encompassing the following services: Community Independence Team, Community Nursing, Community Wellbeing Service, Older Person's Mental Health teams and Social Care locality teams. Included within these discussions is the involvement of the community and voluntary sector. Alongside this, work is also progressing to further develop the model of Extended Locality Teams focussed on prevention and early help for children and their families. This includes building stronger partnerships between physical health, social care, education and mental health services and with adult health and care teams through a "Think Family" approach. • **Priority 2: A much stronger focus on prevention and early intervention** ➢ Development of a business case to support the expansion of Urgent Response prevention of admission work. ➢ Embedding the work to reduce frequent ED attendances and emergency admissions

	amongst some of the most vulnerable people in the city centre working with a voluntary sector provider. ➢ Implementation of a temporary self-harm pathway across Hampshire for children and young people, aiming to relieve pressure during the Covid response. ➢ 111 mental health triage pilot launched with No Limits for children and young people • **Priority 3: A more radical shift in the balance of care away from bed based provisions and into the community** ➢ Rolling on from 2019/20 continue to embed the High Impact Change Model for hospital discharge. D2A for Pathway 2 is now mainstreamed for all patients and, under the Covid response, D2A for Pathway 3 has been expanded and is subject to further development. ➢ The Enhanced Health in Care Home work is now focusing on all care homes having shown a significant impact on reducing Emergency Dept attendances and Non elective admissions. It has also helped to build positive relations between commissioners, health and care services and these homes. • **Priority 4: Significant growth in the community and voluntary sector** ➢ Work with the new SO:Linked service, which provides community navigation and support for developing community and voluntary sector has continued. In Q1 preparation was made for this service to take on the Covid community hub, which was started by the council, with the move completed in the first part of Q2. Proposals have now been finalised for setting up a 'Place Based Giving Scheme' that was a key element of the original specification. ➢ SO: Good Giving ('The Southampton Fund') ➢ In addition work with community and voluntary sector partners is underway to understand how they may be impacted by the current circumstances. Initially a plan to expand Advice and Information services is being developed to focus upon the predicted increase in demand for employment, financial and welfare advice. • **Priority 5: Develop new models of care which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies** ➢ Service commenced for those schools currently signed up to the mental health support teams (MHSTs) ➢ The integrated discharge hub has illustrated the benefit of working collaboratively with joint use of estates and development of a shared discharge to assess pathway. The highlight report for BCF Q1 and Q2 (Month 4 and 5) can be found in the appendix.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
8.	The total value of the pooled fund for 2020/2021 is just over £130m. As at Month 5, overall performance against the pooled fund was a projected year end overspend of £423,000, which represents a percentage variance against budget of 0.32%. This is made up of a £426,000 overspend for the CCG and a £3,000 underspend for the Council. The two main areas of overspend relate to the Integrated Locality Teams, and Learning Disabilities Schemes where there is a projected year end overspend of £84,000, and £285,000 respectively. For Integrated Locality Teams this is due to additional costs for insulin pumps and the home oxygen contract. For the Learning Disabilities Scheme, this is due to an increase

	in complexity of client care, particularly impacting on the CCG which is showing a forecast overspend of £238,000 whilst the Council 's proportion is £46,000. These overspends are not currently being offset by projected underspends on other schemes, noting that ongoing review, challenge and action to support recovery of this position is undertaken by the BCF Finance and Performance Group. This is monitored on a monthly basis by the group.
Property/Other	
9.	There are no specific property implications arising from the Better Care pooled fund.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	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, which with the pause in the annual planning round apply for the first part of this year: • 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:	
11.	None
CONFLICT OF INTEREST IMPLICATIOINS	
12.	None
RISK MANAGEMENT IMPLICATIONS	
13.	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 particularly with the additional costs and challenges related to Covid - 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. In addition SCC will consider how best to support the market through the second tranche of Infection Prevention Funding which has been released by DHSC for the remainder of this year. • **Resilience in the voluntary sector** and ability to respond to new ways of working, during a time when funding for the community and voluntary sector has slowed in line with the national economic position - 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. • **IBCF arrangements for 2021/2022** Should the iBCF be discontinued after 31 March 2021, the alternative to mainstreaming the services and schemes would be to discontinue them. This would seriously impact the progress that has been made with the city's Better Care programme and Health and Care Strategy, reversing the benefits already achieved and

	would also have an impact on the city's performance for a number of nationally reported indicators. The biggest areas of impact associated with loss of iBCF tranche 2 are summarised below: o Worsening of hospital discharge performance – as a result of not being able to deliver discharge to assess and maintain a 7 day week service o Failure to achieve the government's High Impact Change model for hospital discharge published jointly by the Local Government Association (LGA), Department of Health (DH), Monitor, NHS England and Association of Directors of Adult Social Services (ADASS) in 2015 – particularly in relation to delivering a home first, discharge to assess approach and 7 day service o Increased waiting lists and reliance on statutory social care provision – as a result of not being able to meet social care demand for assessment, support planning and reviews and not having the capacity to intervene early o Increased admissions to residential and nursing care as a result of not being able to intervene early enough
POLICY FRAMEWORK IMPLICATIONS	
14.	Southampton's Better Care Programme supports the delivery of outcomes in the Council Strategy and the city's Five Year Health and Care Strategy (2020-2025), which in turn complement the delivery of the local HIOW Integrated Care System, NHS Long Term Plan and Care Act 2014.
15.	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**

<u>SUPPORTING DOCUMENTATION</u>

Appendices

1.	Q1 and Q2 highlight report.

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**	

Appendix 1 – Highlight report for Q1 and Q2 Better Care Fund.

Author: MFC	**BCF/iBCF Finance and Performance Highlight report for Southampton**	**Date**: 15/09/2020

Highlights	**Priorities for next quarter**

• Rehab and reablement - Delivery of pathway 2 through SPoA and onward services
• Implementation progressing well with new JES provider
• Carers – beginning the development of 5 yr strategy for carers and promoting further the identification of carers
• BRS – management of higher demand within budget and delivering on key targets
• Plans for Potters Court – potential for an earlier start than the delayed February 2020 date
• Community transport – support to front door discharges from UHS
• Direct payments/personalisation
    • PA finder, on line portal, became operational in July 2020
    • Implementation of a managed account service
	• Embedding SPoA – Sembal House Hub
	• Business Case – Step up reablement or admission avoidance work
	• Foundations to report on review of DFG and options for future approaches.
	• Preparing to offer leadership training opportunity to informal carers and develop a more comprehensive engagement approach.
	• Market Position Statement for social care
	• BRS – considering how to mainstream extended hours provision
	• Resolution for underspend iBCF (approximately £171k)
	• DP – Develop a greater understanding of the early impact of our new support structures for DP clients and staff

Pressures and Blocks	**Risk and Escalation**	
	Risks / Issues	**Mitigation**
• A number of services across the schemes seeing demand rising with recovery underway: CIS; Community Nursing; AIG - employment, welfare and SEND; BRS • Rehab and Reablement – requirement to reinstate integrated oversight • Work to resolve challenge from outgoing JES provider • Integrated LD commissioning – significant overspend forecast related to complexity of care for new clients • Jigsaw – staffing challenges, including management, seeking to manage this internally • Insulin pump challenge within Integrated locality scheme • Impact of Covid-19 - capacity within Adult Social Care to maintain a focus on DP	Sustainability of living well contract provider – Covid safe capacity does not support private payers. Potential for significantly increased costs to SCC for care provision as Covid funding arrangements end or change.	Working with provider to understand position and seek sustainable approach to delivery for SCC clients. Drafting of MPS and monitoring of position.

Advice Information and Guidance Service response to COVID-19 emergency briefing

1.0 Summary

This paper outlines the work which has been undertaken by the Advice Information and Guidance Service provided by Citizens Advice Southampton and their partner organisations over the Covid-19 emergency.

The paper outlines key achievements and predicted increases in need for advice information and guidance support over the coming year as a result of Covid-19.

The Board are asked to receive this paper for information only.

2.0 Background

2.1 The Advice Information & Guidance Service was commissioned by the Integrated Commissioning Unit (ICU) on behalf of SCC Health and Social Care in April 2017 to deliver information, advice and guidance in order to meet Care Act requirements and achieve the following key objectives:

- Provision of a seamless offer of Advice, Information and Guidance (AIG) coordinated by a single contractor through a network of providers.
- Delivery of a single reliable information resource, which promotes self-serve or supported self-management across the system. Building capacity within the community, individuals and families for self-reliance wherever possible, seeking to develop new capacity in volunteering.
- Promoting accessibility of AIG services in order to meet the needs of all those who require the service and supporting low level AIG delivery in core providers of health, care and wellbeing services in the city.
- Promoting new ways of accessing and using information through innovation and new technologies.
- Empowering parents, children and young people with special educational needs or disabilities through information and support to achieve the best educational, health and care outcomes for themselves, promoting independence and self-advocacy (SEND).

2.2 The contract was awarded to Citizens Advice Southampton as the lead provider, with organisations such as Age UK, Rose Road Association, No Limits, CLEAR, EU Welcome, Environment Centre (tEC) partners, Southampton Advice & Representation Centre (SARC) subcontracted to provide specialism in key areas and additional capacity.

2.3 Contract value is £613,000 per annum funded by the Council. Contract commenced April 2017 (5 years + 2 year possible extension).

2.4 The main performance outcomes of the AIG Service are to deliver:

- Improved health and wellbeing for people – seeking to prevent problems arising
- Promotion of self-management/self-serve approaches within the city
- Reduced risks attributable to wider social determinants for wellbeing, including education, health, social care, employment, poverty and housing

- Individuals and carers knowing how and when to access services appropriately
- Financial or social gain by individuals accessing the services of AIG, noting that there may be a range of measures within this outcome requiring development with commissioners through the first year of this contract (social return on investment)
- Reduced/managed need for more specialist support/services in the long term as a result of the above.

2.5 The Service is available to all residents of Southampton City

- Children and young adults – wide range of advice ranging from health/wellbeing to welfare, housing and homelessness and more specifically information and advice relating to SEND
- Adults seeking asylum in the city and Immigrants within 5 years of first coming to the city – wide range of advice relating primarily to welfare, employment and housing.
- Adults and older people – general advice regarding welfare, benefits, family, consumer, law, employment, housing, health and wellbeing.
- Adults seeking more specialist employment advice and representation.
- Other specialist advice provisions which closely link with well-being
    - Fuel poverty and economy
    - Immigration
    - SEND – children, young people (0-25 years) and parents

3.0 Impact of Covid on Service Performance

Appendix 1 outlines key outcomes achieved by the AIG services prior to the pandemic. At the start of lockdown in March 2020 it was decided to suspend performance management of the contract for the AIG service. At least weekly commissioning contact was made with Citizens Advice Southampton to provide support to ensure that continuity of service was maintained. Commissioner and provider partners worked together to problem solve and adapt the service to ensure immediate need for help was delivered. Below is a brief summary of the impact of Covid-19 on the service's contract performance indicators and how the service responded to COVID-19.

3.1: Improved health and wellbeing for people – seeking to prevent problems arising

The ability of the service to use Make Every Contact Count principles during the current pandemic has been severely limited as face to face consultations has been limited due to social distancing measures and provider buildings not being adaptable to manage the risks associated with COVID-19.

3.2: Promotion of self-management/self-serve approaches in the City

Citizens Advice Southampton and partners have been working since the commencement of the contract to shift low complexity advice, information and guidance to an online offer. As a result of the pandemic it has been possible to accelerate this shift. The Service was able to track the changing needs and themes as the pandemic took hold by monitoring access to partner websites. Initially there was a high demand online for people accessing information relating to employment, housing and welfare rights. As the government's Furlough Scheme and limitations on housing landlord actions were introduced this demand dropped to near normal levels into

May and June 2020. With the ending of the economic schemes the service has experienced a return to employment, housing, welfare and debt advice.

3.3: Reduced/managed need for specialist support/services in the long term

The number of requests for specialist support fell during the first period of the pandemic, particularly relating to children's education related issues. Providing support to individuals who have no recourse to public funding was challenging due to the COVID-19 guidance and the need to see documentary evidence. With the recommencement of tribunals, complex employment and housing issues the service is expecting an increasing demand due to the changing need in the population and as a result of the backlog caused by the suspension of government processes.

3.4: Reducing risks attributable to wider social determinants for wellbeing, including education, health, social care, employment, poverty and housing

The holistic nature of AIG services ensures that clients are supported beyond the presenting issue. It is common for clients to ask about the most pressing problem – an imminent bailiff visit, for example – but a thorough exploration will reveal additional issues such as further debts, unclaimed benefits, poor quality housing and more. Tailored advice and support is designed to address all issues to improve the client's overall situation, and can have a direct effect on health and wellbeing through resolving problems as well as indirect improvements through reducing stress and ensuring access to appropriate services. Providing this function has become more challenging as face to face support has been significantly reduced with other issues more difficult to detect.

3.5: Individuals and carers knowing how and when to access services appropriately

Knowledge of AIG services is often through word-of-mouth, and this issue is being addressed through implementation of a Communications Strategy. So with social isolation and the numbers of citizens in the city who are not yet digitally engaged this method cannot be relied upon to connect with people needing access to the service.

The AIG service is working with the council to develop a digital inclusion strategy.

The AIG service identified that some frontline services are unaware of the support offered, resulting in patchy referrals. For example, SCC social workers are on frequent rotation and it is necessary to ensure that new staff are aware of the services available. To address this, AIG intend to create a quarterly newsletter that can be cascaded down through relevant teams such as social care, the CCG, Council teams in housing, benefits and Gateway, and local community and voluntary organisations.

3.6: Financial or social gain by individuals accessing the services of AIG

Over the past year, AIG services collectively supported an income gain for Southampton residents of at least £2,471,931 – an increase of 29% on the previous year. Over the year 12,483 clients have been supported with generalist services and 2,789 in specialist projects, not including people who self-serve by accessing the AIG partner websites directly. Part of this increase is attributable to improved recording of outcomes, as specified in the service's development objectives for 2019-20. Work to establish the value of Social Return on Investment was started this year but was unfortunately suspended due to the outbreak of COVID-19. AIG

intend to resume the SROI study in 2020-21 to establish the social gains that clients experience following advice.

With the changing needs and increases in claimants for welfare benefits in the city there is likely to be a large increase in the amount of funding coming into the city. The measure used in this metric will need to differentiate between universal credit and other income sources to demonstrate the service's added value to the population of the city.

3.7 Overview of client support

This year, AIG partners supported 12,483 clients through generalist services and 2,789 through specialist services, of whom 10,026 were unique clients, across a total of 48,696 client interactions. AIG also provided light-touch support to 5,939 clients, supporting Southampton City Council's early intervention and prevention agenda.

AIG supported clients in the following categories:

SEND	280
Tribunal	114
Home visiting	360
Immigration	736
Young people (0-24)	6,103
Fuel poverty	687

4.0 AIG Recovery and response to changing needs and anticipated increases in demand

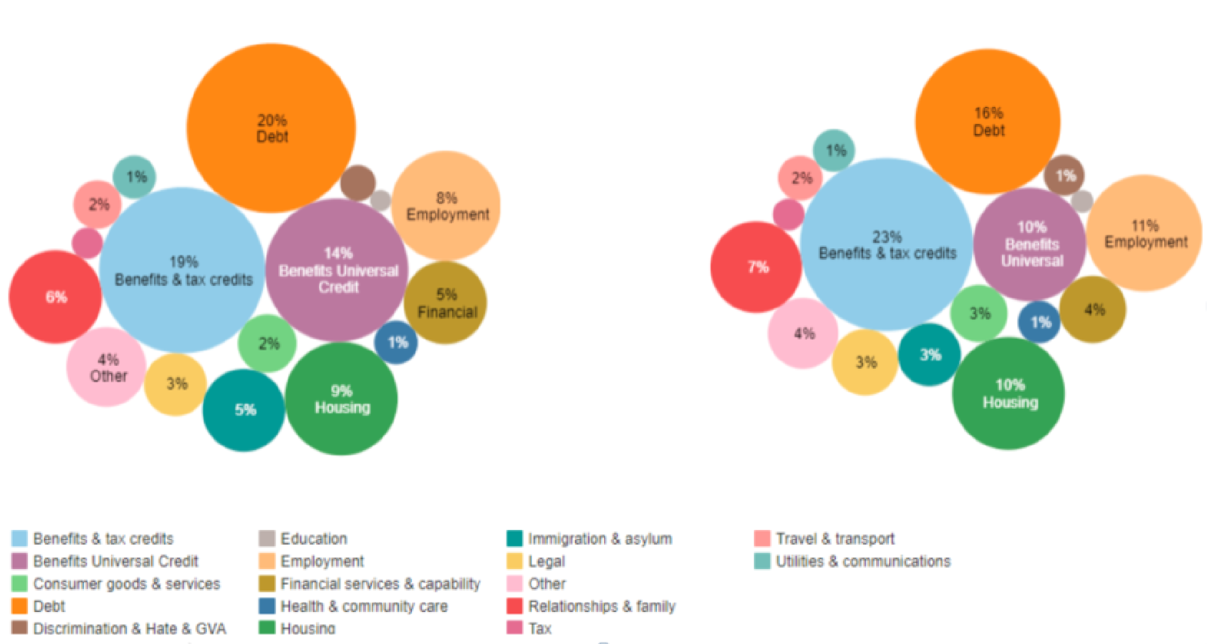
Partners providing the AIG service have responded to the changes in demand for advice information and guidance over the initial period of COVID-19 in the following ways:

- CAS has secured a freephone number for clients to access advice. This replaces the current Adviceline and local telephone numbers.
- CAB has reopened limited face-to-face services at the Central Library.
- A video (advice pods) advice pilot has been introduced with commencement of a Data Processing Impact Assessment in conjunction with Citizens Advice Hampshire.
- CAB are having productive conversations with other local debt advice providers, Christians Against Poverty and Frontline from City Life Church, about how best to work together to meet the expected increasing demand over the coming months. Novel ways of working together in partnership are being explored such as:
    - Shared referral system using the Refernet portal, so that referrals can be forwarded directly to other agencies when there are capacity issues at the agency receiving the referral. AIG partners are currently setting up a data sharing agreement to enable use of Refernet across the relevant organisations.
    - Exploring how best to monitor and share information regarding capacity so that this information is readily accessible to all debt advice providers in the City.
    - Potential for CAP Money Coaches to support clients with budgeting and collating evidence prior to a full debt advice appointment, reducing the workload for specialist advisers and caseworkers.

    - Setting up a Debt Advice Forum for the City to pool knowledge and resources, initially online through a platform such as Workplace and with the potential to progress to face-to-face events when circumstances allow.
- AIG partners are also looking at Workplace as a potential platform for the wider partnership to facilitate shared learning and enhanced partnership working between organisations.
- Age UK Southampton has started reintroducing staff to the workplace. They currently have 4 volunteers who are working from home, and are steadily increasing volunteering hours; volunteers are keen to do more and to return to the office but as many are over 70, they are unable to progress this until Government guidance allows.
- AIG partners are currently in talks with the Clinical Commissioning Group (CCG) around increasing referrals through primary care, working with cluster groups across the City. GPs will be supported to identify those most in need and with clear information on how to refer to Age UK Southampton. AIG are proposing to use this approach for the wider partnership in future as a means of achieving improved health and welfare outcomes for clients.
- AIG partners have previously worked with Solent University on developing and piloting an Age UK app in response to a significant gap identified in the digital opportunities for older people. This would be a very simple, one-touch support offer for emergencies or to access information and advice. The project has been ongoing for a couple of years and is currently with a group of students at Solent University. Provision of equipment has been one of the biggest challenges of this project; partners are now in the early stages of investigating the possibility of using repurposed phones to cover the equipment requirements.
- The Environment Centre continues to operate remotely with a full complement of staff with fewer referrals than usual. Work is underway to consider how and when services might reopen, including what circumstances would warrant face to face support with specific consideration to enable access for those clients who struggle to use telephone or digital channels, particularly those in urgent situations or who need to prepare ahead of winter.
- The Rose Road Association has now recommenced face-to-face meetings. All requests for face-to-face contact are referred to a manager who assesses the need for a meeting in person and conducts an individual risk assessment. Rose Road Association now seeing an increasing number of contacts, including both new referrals and contacts from existing clients. Many enquiries are about child safety in school and whether parents will be fined if they choose not to send their children to school.

5.0 Future clients, channels and demand

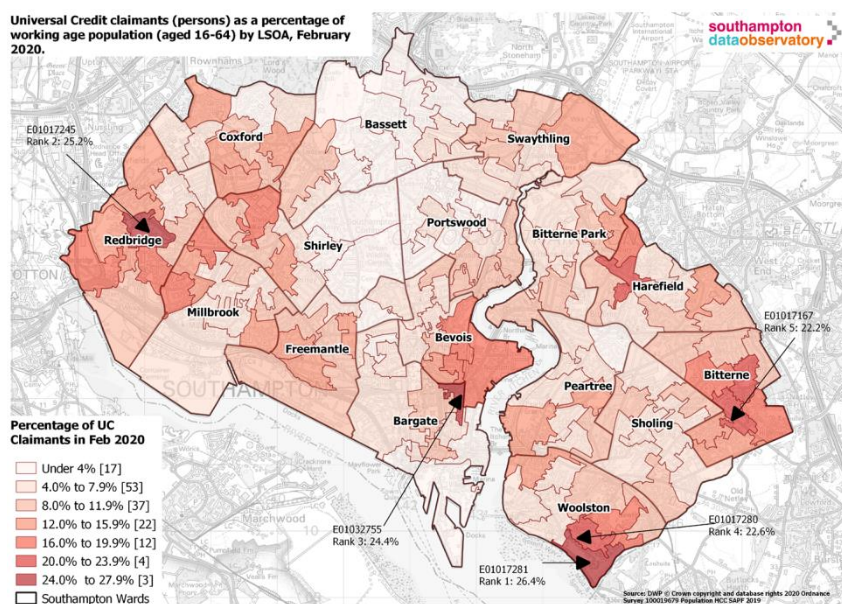
5.1 The AIG partners have experienced a shifting pattern for help. The chart below compares the types of advice requested quarter 1 in 2019/20 to quarter 1 2020/21



5.2 There is concern within the AIG partners about the future demand for advice information and guidance as a result of the COVID-19 economic impact.

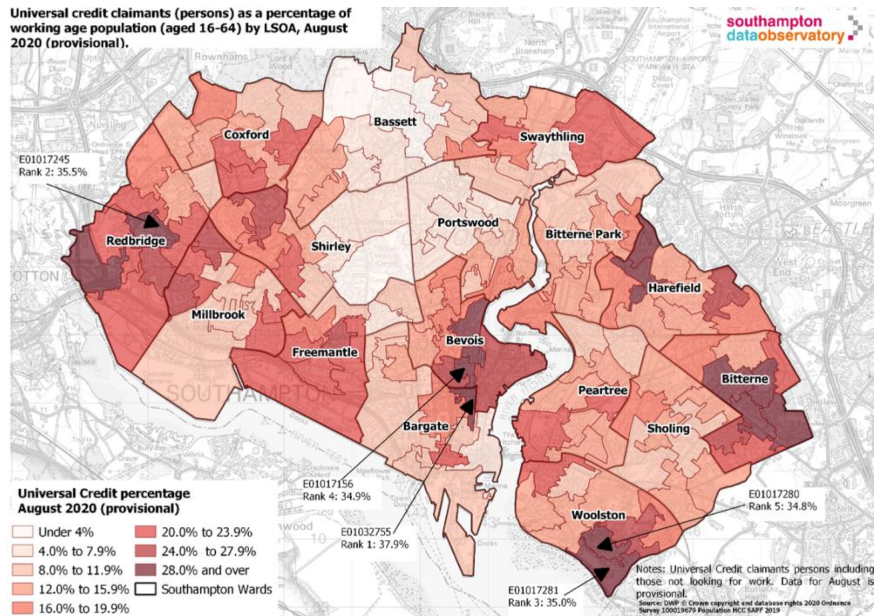
The Council is monitoring the levels of unemployment and people accessing Universal Credit.

The 1st map of the City shows the percentage of all people (Working Age People) in each LSOA (Neighbourhood) who were in receipt of Universal Credit in February 2020 (The last full month prior to 'lockdown').The highest rate was in Weston at 26.4% , with similar pockets of deprivation in Thornhill, Bargate, and Redbridge.



6

The 2nd map illustrates the change in deprivation by August 2020, where the same neighbourhoods' percentage had increased to approx. 35% of the Working Age Population in receipt of UC. It is concerning to record that over a third of the Working Age Population in some of our communities were reliant on UC at the start of the Summer, and even more worrying when it is remembered the data was recorded prior to Furlough beginning to be dismantled.



It is anticipated that levels of unemployment and applications to Universal Credit will continue to rise during the remainder of 2020 and into 2021. Levels of unemployment are a good predictor of future demand for advice services.

5.3 Based on a direct proportional comparison:

Unemployment Rate	Predicted number of clients (annual)	Predicted number of clients (per week)	% increase compared to baseline	Additional FTE resources required (minimum)
4.6% - 2019 baseline	15,272 (actual)	294		
9%	21,700	417	42%	8.6
12%	26,200	503	71%	14.6
15%	30,600	588	100%	20.4

The predicted number of staff needed takes into account an increased use of technology to access advice information and guidance. It should be noted the figures above do not include clients supported or predicted to require debt advice from CAS, as this is sourced under a different project funded by the Money Advice & Pension Service (MaPS) via the national Citizens Advice charity. Debt advice at No Limits is included in the above figures.

5.4 It has been predicted by national CAB that, demand for debt advice is expected to rise by up to 60%.

5.5 To meet this rising need the AIG Service is planning to strengthen the online offer and to enable people to help themselves. However there remains a significant pressure and the likelihood of further need emerging, as people who are currently furloughed being made redundant, increases in debt due to payment holidays ending, and increases in home eviction proceedings.

5.6 In response to rising demand the AIG Service is likely to incur further expenditure, as follows:

- Training significant number of new staff and volunteers
- Additional debt advice expertise
- Providing equipment to new staff and volunteers who will be remote working
- Updates to AIG and Partner websites to improve accessibility and increase visibility
- Production and dissemination of written information (leaflets, posters)
- Provision of loan equipment to vulnerable clients to access advice via video call
- External communications support to improve service visibility and distribute service information across primary and secondary healthcare providers, frontline services etc
- Implementation of video advice pilot and subsequent expansion, if pilot is successful
- Costs of making offices and advice centres physically safe – PPE, screens, partition walls etc. E.g No Limits have had a new front office built so clients can be triaged without accessing the main office.

5.7 The AIG partners are therefore seeking an uplift in funding, of approximately £91,950, to meet this and new need above the current contract levels which will be considered separate to this report.

5.8 It is difficult to determine the target groups of the future demand; however the bulk of the new demand is expected from younger people and families, rather than individuals who would be clients or patients with complex or significant health and social needs. A small proportion of the increased demand (approximately 1%) could be considered as a cost pressure due to challenges in providing face to face support.

5.9 This projected rise in demand does not include any rise in need as a result of the Home Office asylum contract recently placed within the City.

6.0 Summary

- The Council will need to consider how best to support the AIG service to enable a response to the economic impact of COVID-19 and the changing profile of needs of people for advice information and guidance services.
- Commissioners will continue to maintain close contact with the AIG partners to identify issues for resolution and support the development of innovative responses to problems

Adrian Littlemore
Senior Commissioner
Integrated Commissioning Unit
3rd October 2020

Appendix 1

Key Performance Indicators

1.0 Improved health and wellbeing for people – seeking to prevent problems arising

The partners delivering the service have taken on a Making Every Contact Count (MECC) approach which involves using every contact as an opportunity to promote positive health and wellbeing at the same time. A total 8,483 MECC interventions have taken place over the past year across the Partnership. MECC contacts are often related to mental health, with advisers signposting clients to services such as Steps to Wellbeing or their GP for support with mental health issues. Services have also directed clients to support with smoking cessation, healthy eating, sexual health, increasing physical activity, and accessing aids and adaptations for physical health needs.

2.0: Promotion of self-management/self-serve approaches in the City

During 2019-20 AIG offered light-touch or information-only support to 5,939 clients, supporting the Council's early intervention and prevention agenda. Generalist and specialist advice interventions also support clients to manage their problems longer term, as clients gain skills in budgeting, dealing with correspondence, and understanding processes and forms.

Over 2019-20 generalist websites had 188,538 unique visits, with a further 3,919 visits to specialist service sites. Both the CAS and AUKS sites also link through to national service websites, where detailed information is available to the public on a wide range of advice topics. Unfortunately full-year data on Southampton residents' use of the national sites is not available, however new reporting systems were introduced in Q4 which recorded that Southampton residents made approximately 32,726 visits to the National Citizens Advice website in Q4 alone.

Use of our websites suggests a large number of clients are seeking information and support online, and many of these will have been able to self-help with the information and links provided. However there are indications from AIG website data that a significant proportion of clients are using the website to seek contact details for full advice with "Contact Us" pages being the most commonly hit for some services (CAS and tEC) - although this does not take into account the number of clients clicking through to external sites (such as the National Citizens Advice website) who may have self-helped following their visit.

Some partner websites offer detailed information and data shows that clients are making good use of this – for example, The Rose Road Association's most viewed page is on requesting a school or college in an EHCP, whilst the advice indices on the CLEAR and EU Welcome sites are commonly viewed. Partners have in some instances produced factsheets and videos for clients to access, further supporting self-help, including new information related to COVID-19. These have proved popular with clients.

3.0: Reduced/managed need for specialist support/services in the long term

Support at the early stages of the advice process can help to reduce the need to access expert advice. For example, generalist services can support clients to fill out benefit application forms correctly, preventing the need for specialist support to appeal to Tribunals. There are of course some areas of advice, and some client groups, who will inevitably require more intensive, specialist support. Regulation of advice areas such as debt and immigration requires highly

trained and qualified advisers, and representation at Tribunal for benefits and employment issues also requires a high level of expertise.

Advice in Southampton's goal is to increase interventions in the earlier stages of clients' problems, reducing the need for specialist services in the longer term. Over the year 12,483 clients have been supported with generalist services and 2,789 in specialist projects. This compares to 13,613 clients supported by generalist services and 2,811 in specialist services in 2018-19. This could be interpreted as the service intervening earlier and so avoiding the need for specialist support at a later date. The drop in client numbers is partially attributable to the introduction of new services, such as Help to Claim and the EU Settlement Scheme, which are not funded under the AiS contract; and also due to a drop in capacity seen in mid-March resulting from the implementation of business continuity plans in response to the COVID-19 pandemic.

At Citizens Advice Southampton, 81% of clients said the service had helped them find a way forward and 76% said their problem was now resolved following intervention; of those whose problem was not yet resolved, client feedback suggests that a significant proportion were due to problems with external agencies such as creditors or the DWP, or that the client was being supported with ongoing casework or awaiting the outcome of an external agency decision. These figures suggest that generalist advice services are effective in preventing the need for clients to access specialist services except in more complex cases.

Refernet a secure interagency referral portal, has been fully operational since Q3 2018-19. Referrals via this channel between agencies in the Partnership have increased, with 182 referrals via this route in 2019-20, ensuring there is 'no wrong door to get the right advice'. Use of Refernet enables clients to be transferred directly between agencies, preventing the need for clients to access two services separately and having to repeat their story.

4.0: Promotion of self-management/self-serve approaches in the City

Citizens Advice Southampton and partners have been working since the commencement of the contract to shift low complexity advice, information and guidance to an online offer. As a result to the pandemic it has been possible to accelerate this shift.

During 2019-20 AIG offered light-touch or information-only support to 5,939 clients, supporting the Council's early intervention and prevention agenda. Generalist and specialist advice interventions also support clients to manage their problems longer term, as clients gain skills in budgeting, dealing with correspondence, and understanding processes and forms.

Over 2019-20 generalist websites had 188,538 unique visits, with a further 3,919 visits to specialist service sites. Both the CAS and AUKS sites also link through to national service websites, where detailed information is available to the public on a wide range of advice topics. Unfortunately full-year data on Southampton residents' use of the national sites is not available, however new reporting systems were introduced in Q4 which recorded that Southampton residents made approximately 32,726 visits to the National Citizens Advice website in Q4 alone.

Use of our websites suggests a large number of clients are seeking information and support online, and many of these will have been able to self-help with the information and links provided. However there are indications from AIG website data that a significant proportion of clients are using the website to seek contact details for full advice with "Contact Us" pages

being the most commonly hit for some services (CAS and tEC) - although this does not take into account the number of clients clicking through to external sites (such as the National Citizens Advice website) who may have self-helped following their visit.

Some partner websites offer detailed information and data shows that clients are making good use of this – for example, The Rose Road Association's most viewed page is on requesting a school or college in an EHCP, whilst the advice indices on the CLEAR and EU Welcome sites are commonly viewed. Partners have in some instances produced factsheets and videos for clients to access, further supporting self-help, including new information related to COVID-19. These have proved popular with clients.

AIG Service provides performance data on support provided to target groups. See AIG's Annual Report published August 2020 (AiS End of Year Report 19-20 - shared).

5.0 Activity & Demand

Based on available data for quarter one 2020/21, AIG websites received 24,622 unique visits of which 17,283 visits were made to generalist websites and 7,339 to specialist sites. A total of 49,126 pages were hit. The number of unique visits is comparable to previous quarters, however some sites saw a significant increase in traffic whilst others saw a reduction. For example, CAS had received around 5,000-5,350 unique visits in previous quarters; in Q1 20-21 this rose to 6,427 representing an increase of around 24%. TEC also recorded a significant increase of 400%, to 886 unique visitors this quarter from 200-230 in previous quarters. Age UK Southampton recorded a slight increase in traffic this quarter. The data clearly shows the importance of these services to Southampton residents during the crisis. Work is now underway at both CAS and TEC to improve and update their websites to ensure they can effectively meet increasing demand.

Debt enquiries dropped off significantly at the start of the financial year; in total the AIG service supported 139 clients with 397 debt issues, compared to 331 clients for the same period last year. In addition to the drop in capacity at the start of the crisis, many clients will have benefited from creditor forebearance measures and will not have sought debt advice as a result. However it is expected enquiries will rise significantly as these measures come to an end, particularly as collection activity is the most common trigger for seeking debt advice. The All Party Parliamentary Group on Debt and Personal Finance, chaired by Yvonne Fovargue MP, predicts that demand for debt advice could rise by as much as 60% over the coming months with a surge expected in November and December in the run up to Christmas.

Clients are asking about a range of priority debt problems, including rent arrears (24 clients), Council Tax arrears (16 clients), mortgage/secured loan arrears (5 clients) and fuel debt (15 clients). Despite the moratorium on evictions and suspension of possession claims, clients asked us about eviction for arrears by private landlords (4 clients) and mortgage lenders (2 clients) and possession claims for arrears by the LA (1 client) and mortgage lenders (1 client).

Employment issues have risen dramatically. Employment usually makes up around 10-11% of AIG client capacity, since 9th March this has risen to over 21% of clients and 15% of issues. Up to August 2020 AIG supported 320 clients with 585 employment issues, including 62 clients with furlough queries (actual figure likely to be higher as the furlough case recording code wasn't introduced until mid-April) of which 17 asked about refusal of furlough; 118 clients reporting issues with pay and entitlements; and smaller numbers presenting with problems related to

terms and conditions of employment, dispute resolution, dismissal and redundancy. 46 clients asked us about Statutory Sick Pay; unfair dismissal was identified for 26 clients.

AIG supported 287 clients with housing issues in quarter one 2020/21 – an increase on the previous year, when 283 clients were supported over the whole year. Housing enquiries have risen significantly since the start of the year, and it is expect further increases over the coming months as protections for renters come to an end.

AIG have noted increases in the proportion of people from BAME communities accessing our services, particularly those who are Asian or mixed race but also Black clients. Again, national data suggests that BAME clients are particularly hard-hit by the crisis and local data would appear to support this.

Interesting results are seen when changes are correlated with the Index of Multiple Deprivation. Results in this section are calculated for Southampton residents who were supported by Citizens Advice Southampton only, excluding clients who spoke to other offices on Adviceline. Although clients in the lowest deciles (i.e. the most deprived areas) still constitute the greatest proportion of CAS clients, a significant increase in the number of clients contacting CAS from more affluent areas has occurred, corresponding to deciles 4, 7 and 8 on the IMD. Many clients who have worked all their lives will have been furloughed, or made redundant and forced to claim benefits as a result. When moving onto benefits these better-off clients are likely to experience proportionally larger changes to their household finances than those in the lower IMD brackets, leading to debt and difficulties in meeting rent and mortgage payments.

CAS also note that changes in client numbers are spread unevenly by geographic area. For example, the decrease in client numbers of 23% in Bargate ward is similar to the service-wide decrease of 25% when compared to the same period last year; but far greater reductions are seen in Bitterne Park, Harefield and Redbridge (-38%, -42% and –34% respectively). Conversely CAS have seen a significant increase in clients contacting the service from Bitterne (+16%), and proportionate increases in clients from Bassett, Portswood and Freemantle. IMD data will help to inform service planning in response to the crisis.

Levels of unemployment are a good predictor of future demand for advice services. The Future Communities report (SCC) assume predicted levels of unemployment in 2020/21 in Southampton of between 9% and 15%. The rate of unemployment in Southampton in 2019 was 4.6%, with 15,272 clients seen across the whole of the AIG partnership during this period. Of these, it has been estimate that up to 8,000 clients had issues unrelated to unemployment. Detailed assumptions, national, regional and local data sources and methodology have been used to estimate future demand.

DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**JCB Terms of Reference**		
DATE OF DECISION:		**15 October 2020**		
REPORT OF:		**Beccy Willis**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Beccy Willis	Tel:	023 80
	E-mail:	Beccy.willis@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	023 80
	E-mail:	Stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY		
N/A		
BRIEF SUMMARY		
The Joint Commissioning Board (JCB) Terms of Reference have been updated in line with their review date.		
RECOMMENDATIONS:		
	(i)	JCB are requested to recommend approval of the proposed updated Terms of Reference by the appropriate Boards in each organisation
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Terms of Reference are subject to annual review. They must be approved and adopted by the CCG Governing Body and the City Council's Cabinet as overseeing organisations of the JCB.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	N/A	
DETAIL (Including consultation carried out)		
3.	The changes that have been made within the Terms of Reference, there has been a general tidy up of sentences, however the main changes are set out below:	
4.	Inclusion of the following bullet points under the introduction: • The Board will ensure the development and implementation of the Southampton Five Year Health and Care Strategy • The Board will maintain a focus on the commissioning of services to meet the outcomes of the citizens of Southampton, and those registered with GP's in Southampton whilst working in the Southampton and SW Hampshire and wider Hampshire and Isle of Wight context.	
5.	Clarity provided on the membership and sets out who is a member for each organisation.	
6.	More detail included in annex a which covers integrated commissioning and examples of potential scope	

RESOURCE IMPLICATIONS	
Capital/Revenue	
7.	N/A
Property/Other	
8.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
9.	N/A
Other Legal Implications:	
10.	N/A
CONFLICT OF INTEREST IMPLICATIOINS	
11.	N/A
RISK MANAGEMENT IMPLICATIONS	
12.	N/A
POLICY FRAMEWORK IMPLICATIONS	
13.	N/A

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	N/A

SUPPORTING DOCUMENTATION

Appendices	
1.	Draft JCB Terms of Reference

Documents In Members' Rooms

1.	N/A
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.	N/A	

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SOUTHAMPTON CITY COUNCIL

NHS Southampton City Clinical Commissioning Group

Terms of Reference for the Joint Commissioning Board

1. Introduction

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

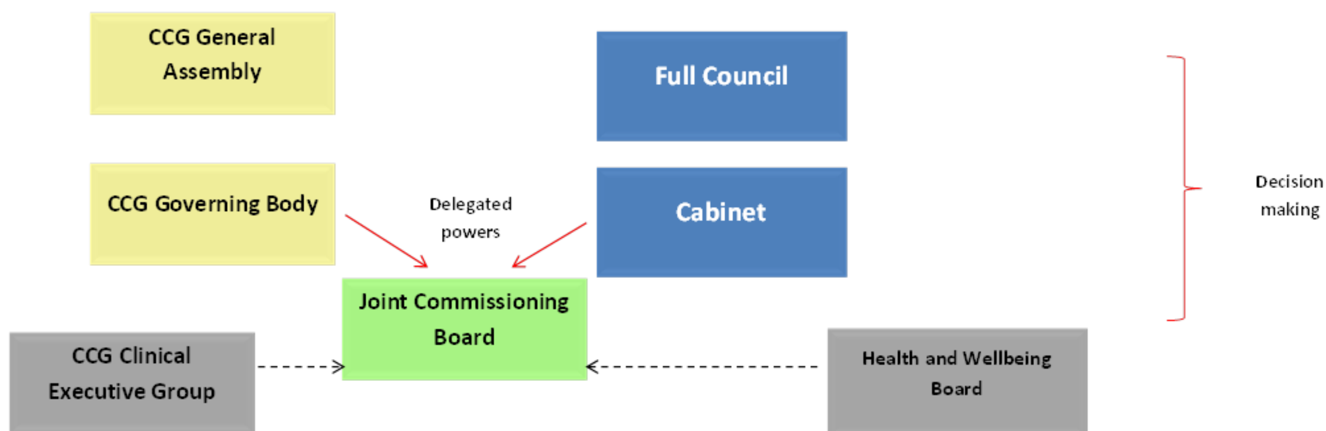
If we are to realise this vision and meet the challenges we face then we will need to:

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

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

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

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



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

1.5. The Board has been established to ensure effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements between Southampton City Council and Southampton City CCG.

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

1.6 The Board will monitor the performance of the Integrated Commissioning unit and ensure that it delivers the statutory and regulatory obligation of the partners of the Better Care Fund and relevant Section 75 agreements.

1.7 The Board will ensure the development and implementation of the Southampton Five Year Health and Care Strategy

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

1.9 The Board will maintain a focus on the commissioning of services to meet the outcomes of the citizens of Southampton, and those registered with GP's in Southampton whilst working in the Southampton and SW Hampshire and wider Hampshire and Isle of Wight context.

2. Scope

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

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

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

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

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

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

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

3 Role and Objectives

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

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

3.3 To ensure that all commissioning decisions are made in line with the principles set out in the Integrated Commissioning plan, including providing challenge regarding the scale and pace of integrated commissioning approaches.

3.4 To monitor the financial plans and financial performance of the integrated Commissioning Unit including forecasts for the year.

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

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

3.7 To ensure the appropriate management of risks regarding the integrated commissioning function.

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

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

arrangements.

To seek assurance on the quality and safety of commissioned services in relation to key performance indicators and standards.

3.10 To provide system leadership and direction to the staff of the integrated Commissioning Unit.

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

3.12 To maintain oversight of the Section 113 arrangements between the two organisations for the Integrated Commissioning Unit.

4 Better Care Section 75 Partnership Agreement

The Board:

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

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

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

- Annual forward financial plans setting out the projected annual spend
- Review of the operation of each scheme covering:

  - evaluation of performance against agreed performance measures targets and priorities and future targets and priorities;
  - quality of service delivery and how the arrangements benefit and meet the needs of client groups;
  - any service changes proposed;
  - any shared learning and opportunities for joint training;
  - assurance that monitoring and evaluation processes take account of statutory guidance and policy directives pertaining to quality standards, best value and audit arrangements of the Council and the CCG.

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

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

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

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

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

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

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

5 Risk Sharing principles

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

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

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

5.4 The statutory requirements of each organisation must be maintained.

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

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

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

6 Governance and Reporting

The Board will be accountable to the Council's Cabinet and / or Council as appropriate and the CCG Governing Body.

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

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

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

6.4 At least one meeting each quarter will receive and review the performance of the Better Care S75 Partnership Agreement, undertaking those responsibilities as set out in Section 4.

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

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

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

6.8 The agendas, minutes, decision notices and briefing papers of the meetings of this Board are subject to the provisions of the Freedom of Information Act 2000, the Environmental Information Regulations and the Data Protection Act 2018. If the Chair concludes that specific issues are exempt from publication and should not be made available under the terms of the Freedom of Information Act, a Part 2 meeting of the Board shall be convened to consider them.

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

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

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

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

6.13 The Health and Wellbeing Board have delegated responsibility for Better Care and the Southampton City Five Year Health and Care Strategy implementation to the Board and the Board will be accountable to the Health and Wellbeing Board for this element.

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

7 Membership

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

Members

- The Leader of the Council (SCC)
- Cabinet Member - Health and Adult Social Care (SCC)
- Cabinet Member - Stronger Communities (SCC)Chief Executive Officer (SCCCG)
- Clinical Chair (SCCCG)
- Lay Member for Patient and Public Involvement (SCCCG)

7.2 In exceptional circumstances for Southampton City Council, a decision maker can be changed from a cabinet member to the Leader of the Council as long as the forward plan has been amended in line with appropriate timescales and papers have not been published

7.3 Other attendees

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

7.4 The Chair will be a politician from the council or a member from the CCG Governing Body. The Vice Chair of the Board will be from the alternate partner organisation.

8 Quorum, Decision Making and Voting

8.1 The CCG Governing Body and SCC Cabinet may grant delegated authority (with any appropriate caveats) to those of its members or officers participating in the Board to make decisions on their behalf, whilst retaining overall responsibility for the decision made by those members or officers. It is therefore the individual member or officer who has the delegated authority to make a decision rather than the Joint Commissioning Board itself.

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

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

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

8.5 Legally, it is not possible to have a mechanism that requires individual decision makers to exercise their decision making function in accordance with the will of a majority or quorum of a Board. Any individual decision maker must consider any decision on its merits as a whole in accordance with established decision making principles. The process for seeking the support of the Board prior to exercising any delegation meets a requirement in the Scheme of Delegation to limit the power to exercise that delegation to situations only where the support of the Board is demonstrated. For the CCG the delegated authorisation limit is up to £1 million, for the City Council the delegated authorisation limit is up to £2 million with any decisions over £500k being classed as a key decision.

8.6 Functions outside the decision making scope of the Board, but related to health and social care will be discussed for information only at the Board, with the considerations and any recommendations of the Board formally minuted. Items will then be referred to the relevant decision maker (e.g. CCG Governing Body, Council).

9 Dispute Resolution

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

10 Scrutiny

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

11 Conflict of Interests

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

12 Variation

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

The Terms of Reference will be reviewed annually

October 2020

Annex A

Integrated Commissioning – Examples of potential scope

Jointly commissioned/funded services

1. These will be services currently in scope for the 2020/21 Better Care Fund S75 agreement. In addition, the scope will include other existing partnership agreements/shared funding arrangements:
   - Support Services for Carers
   -
   - Integrated Locality Teams (previously known as cluster working): Community health services for adults (Community Nursing, Continence, Podiatry, Community Wellbeing Services, Community specialist services for people with long term conditions, case management, Palliative Care, community navigation, Community Adult Mental Health Services and IAPT (Improving access to psychological therapies) , Adult Long Term Social Care Teams)
   - Integrated rehabilitation, reablement and hospital discharge services (including the Hospital Discharge Team, Discharge to Assess, residential reablement and extra care, Falls Assessments)
   - Aids to Independence: including Joint Equipment Service, Wheelchair service and Disability Facilities Grant
   - Prevention and Early Intervention services –Older Person's Offer, Information, Advice and Guidance, Community Solutions and Housing Related Support
   - Integrated Learning Disabilities Commissioning (placements)
   - Promoting the uptake of Direct Payments
   - Transformation of Long Term Care provision (Adult Social Care additional/improved BCF funding to support transformation of Extra Care and conversion of a Residential Unit to Nursing Care as well as stabilising the Domiciliary Care and Care Home market)
   - Integrated services for children with complex health needs (specifically Building Resilience Service and SEND integrated health and social care team).

Single agency commissioning aligned under a jointly agreed strategy

2. This would mean that commissioning responsibility/ decision making remains solely with the CCG or City Council but the funding is aligned to deliver a jointly agreed strategy. This could include:
   - Long Term Care provision (including domiciliary care, nursing and residential CHC and social care packages) – aligned to Better Care strategy
   - 0-19 prevention and Early Help, CAMHS, Community midwifery – aligned to 0-19 prevention and early help strategy/CAMHS Transformation
   - Sexual health (integrated level 3 service, voluntary and primary care prevention services, termination of pregnancies, vasectomies) – aligned to Sexual Health and Reproductive Strategy
   - Substance Misuse Services – aligned to Substance Misuse Strategy
   - Respite and Short Breaks – aligned to Replacement Care Strategy, services for children, e.g. Edge of care, Family Drugs and Alcohol Court, Looked After Children, Safeguarding – aligned to children's strategy
   - Benefits

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

Better Care Southampton
working together to make a difference

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MINUTES

Meeting: **Better Care Southampton Steering Board on 2nd June 2020**
Virtual Meeting on Microsoft Teams

Present:

Dr Mark Kelsey (Chair)	SCCG Chair	SCCCG
Matt Stevens (MS)	Lay Member	SCCCG
Janine Gladwell (JG)	Senior Transformation Manager /West Locality Lead	Solent
Adam Cox (AC)	Clinical Director Southampton	Southern Health
Dr Nigel Jones (NJ)	GP and PCN CD	East PCN
Janet Ashby (JAy)	Head of Transformation	SPCL
Jo Ash (JA)	Chief Executive	SVS
Naz Jones (NazJ)	Locality Lead	East Locality
Jane Hayward (JH)	Director of Transformation	UHS
Stephanie Ramsey (SR)	Director of Quality and Integration	SCCCG / SCC
David Noyes (DN)	Chief Operating Officer	Solent
Grainne Siggins (GS)	Executive director Wellbeing (Health and Adults)	SCC
Donna Chapman (DC)	Associate Director System Redesign	SCCCG/SCC
Dr Sara Sealey (SS)	Locality Lead / GP	East Locality
Dr Fraser Malloch (FM)	PCN Clinical Director / GP	Central PCN
Sarah Turner (ST)	BCS Programme Lead	BCS
Hayden Kirk (HK)	Clinical Director Adults Southampton	Solent
Tristan Chapman (TC)	Director of Improvement and Partnerships	UHS

In attendance:

Hannah Gehling (HG)	Administrator	SCCCG

Apologies:

Sarah Olley (SO)	Director of Operations, Southampton	SHFT
Rob Kurn (RK)	Deputy CEO	SVS/HWS
Dr Ali Robins (AR)	Director	SPCL
Andrew Smith (AS)	Business Manager & Locality Lead	Solent/Central Locality
Julia Watts (JW)	Locality Lead	East Locality
Sundeep Benning (SB)	PCN Clinical Director/GP	West PCN
Phil Aubrey Harris (PAH)	Associate Director of Primary Care	SCCCG
Matthew Prendergast (MP)	PCN Clinical Director/GP	North PCN
Sanjeet Kumar(SK)	PCN Clinical Director/GP	West PCN
Chris Sanford(CS)	PCN Clinical Director/GP	Living Well Partnership
Sara A'Court(SA)	PCN Clinical Director/GP	West PCN
Pauline Grant	PCN Clinical Director/GP	West PCN

Item	Subject	Action
1.	**Welcome and apologies**	
	MK welcomed everyone to the meeting. Introductions were made and apologies for absence were noted, as above.	
2.	**Declarations of Interest** *A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship*	
	No conflicts of interest were declared.	
3.	**Update from localities and PCN's**	
	MK opened the discussion by explaining the background to the localities and the Primary Care Network's (PCN) and asking how we can link them together. NazJ questioned whether there is still commitment for localities to exist or whether they can work together. MK explained that consideration needs to be given to the best model for Southampton moving forward, however, there is currently some overlap between the work both the localities and PCN's undertake. It was discussed that it does not make sense to have two different structures. DN stated that it is a good time to look into the systems and see how they can be improved and what transformation work can be done to support the PCN's after the pandemic. It was questioned what work needs to be completed at a city level and a PCN level. MK explained that the Integrated Care Partnership (ICP) will create different levels of workflows, however there will still be a need for a local level. JAy stated that it can be confusing to understand the difference between the localities and PCN's, for example; the West locality is the same boundaries as the PCN. MK stated that the localities were set up before the PCN's and the idea was for the PCN's and localities to join together. NJ explained that each area is different - in the East the locality is holding together work across the three different PCN's, adding value by developing the wider community offer. A discussion took place earlier this year to see whether the locality should continue and it was agreed that the locality is still needed. SS felt that we need to realign ourselves with the PCN footprints. The localities can work alongside the PCN's supporting with the development of the wider community offer. The PCN work is primarily focussed on primary	

	care work. FM explained that the surgeries can choose what PCN they want to be in however they do not get to choose their locality. MK stated that there is a need for PCN's to include other services from their communities within their work. PCN's have a clear remit of strategic work, however how can the localities be used to support them to benefit the communities and the population. NazJ explained that the joint working for the providers has been interesting as they are working across different localities and PCN's. DN acknowledged that there can be confusion between the localities and PCN's. More work needs to be completed at a very local level (i.e. PCN) to create a better local service, however there is some work that needs to be completed at a wider level (across several PCNs, city wide or even wider). It was agreed that for providers it would be hard to provide 6 people for the PCN's compared to the 3 localities. MK stated that PCN's and localities need to work together and agree what needs to be done with the resources available. ST suggested focussing on designing a system based on the levels at which services are best delivered as opposed to getting too hung up on the labels (PCNs, Localities etc) and how we can all work together to achieve the goals. MK agreed that we should stop using localities as a name and recognise that there is leadership at a local population level made up of PCNs and representatives from other sectors. The local leadership will then be able to decide how work is split and how it can help at the different population levels. GS stated that we need to pull together a detailed paper with the different views and concerns. The paper then will be able to be discussed at the next meeting. It was stated that we should get the views from the front line staff as well, as COVID has broken down some of the previous working barriers. It was agreed that a paper should be brought back to the next meeting. **Action: DC/ST to collate feedback and responses about PCN and Localities and bring a paper to the next meeting.**	**DC/ST**
4.	**5 Year Health and Care Strategy**	
	SR and DC presented an impact assessment undertaken by the Integrated Commissioning Unit in consultation with other key stakeholders of the 5 Year Health and Care Strategy to determine what is now different as a result of COVID and what the short, medium and long term priorities should	

now be.

Start Well –

DC explained that the assessment was completed through the Children's Multiagency Board and there has been strong education and social care involvement. This year is the Year of the Child.

The impact assessment highlights the impact of schools being closed, fewer face to face contacts with families, increased anxiety and economic hardship created by the lockdown. Particular concerns include increased safeguarding incidents (e.g. domestic violence), widening health inequalities, increased emotional and mental health needs and backlogs in treatment and reviews.

Live Well –

SR recapped that the live well targets included key areas such as increasing life expectancy, reducing smoking prevalence, increasing cancer being diagnosed at an earlier stage and reducing alcohol related mortality. The previous deadlines will have to be adjusted due to the current pandemic.

DC stated that the Age Well sub-group has been reinstated to identify and take forward the key priorities. She highlighted that during the pandemic a huge amount of work has been progressed to support vulnerable people which will be built on as part of the short-medium term priorities. This includes sustaining and further building on the enhanced community/voluntary sector offer, including volunteering and the new Hello Southampton initiative; new ways of integrated working focussed on targeting those most at risk and supporting self-management; greater use of digital/technology e.g. remote consultations; accelerating the roll out of the Enhanced Healthcare in Care Homes model to all residential and nursing homes; implementing a new model of community discharge hubs, further integrating community health and care services. Some of the concerns and impacts of COVID19 include isolation, loneliness, economic hardship and safeguarding risks including domestic violence.

Die Well –

SR stated that there has been a lot progress and creative work in the current situation. The key ambitions include the services to be more integrated and to allow people to be identified earlier. A road map was created to show the work plan for the next couple of years. The changes during COVID19 have been very positive .The key collaboration approach

	will continue after COVID19. DC and SR went on to present a summary of all the short and medium term priorities split by how the work could best be taken forward at a Southampton level, Hampshire and Isle of Wight (HIOW) level (ICS) or Southampton and South West Hampshire level (ICP). It was noted that where work happens at an Integrated Care System (ICS) or ICP level, Southampton colleagues are also central to the planning and the actual implementation will remain place based. **DECISION:** The short and medium term revised priorities were supported by the BCSB with the following additional comments: Start Well – • GS stated that we need to be mindful of the attention that will still need to be given to the COVID response and what capacity is available to achieve the priorities. MK explained that if there was a second wave, the work would need to be paused again. Live Well – • JA stated that she was surprised to see mental health and bereavement at an ICS level. SR explained that work is already being completed at a HIOW level, as well as local level. • AC explained that his biggest concern is that the escalation of capacity is difficult as there are not many ways to increase capacity due to staffing and number of beds. Southern Health are supporting Steps to Wellbeing to expand access. • JH questioned that if we are restarting services do we need to assess how much PPE the city will need. Age Well – • GS queried the levels in that some things that are being developed at a ICS level also need to be delivered at a city level. MK explained that different work needs to be undertaken at different levels because there needs to be some alignment across Hampshire; however, the city level work needs to be kept unique. JA suggested need for principles underpinning place versus ICP versus ICS. • JG questioned how this aligns to the system wide restoration and recovery plans	

	• JAy questioned why the volunteer and community work is in the medium term plan not the short term plan, because a lot of work has been undertaken during COVID. These changes have made huge changes to the patients. Wording to be amended Die Well – • JA explained that she has a short video on how to cope with bereavement for front line staff who do not usually have to deal with it. • NazJ stated that it is important to support the care homes as a lot of the shielding patients are becoming more complex. SS questioned how this information will be communicated outside this group. SR stated that it would be good to revise the documents and then they can be shared wider. **Summary of next steps and actions** **ACTION: DC/SR to make amendments to the priorities following feedback from BCSB with a view to then presenting to Joint Commissioning Board in June for approval** **ACTION: BCSB subgroups to then start working up detailed implementation plans** **ACTION: DN, MS and MK to meet with colleagues in West Hampshire to compare our strategy with the Hampshire one.** **ACTION: Post approval by JCB, DC and SR to work with Clare Young to update and relaunch Strategy**	**DC/SR** **BCSB Sub Groups** **DN/MS/MK** **DC/SR**
5.	**Future Action and Agreement how to take forward**	
	Owing to time, this item was deferred to the next meeting. **Action: HG to add to the next meeting agenda:** • Learning from the Portsmouth and SE Hampshire aligned incentive contract: **ACTION: HG to invite Rod Ashman to attend the next meeting** • Finance mapping: To discuss approach at the next meeting • Demand and Capacity Modelling: GS stated that we need to look into what the impact on activity has been since COVID-19 and what	**HG** **HG**

	does the future forecast look like for the rest of the year. MK agreed that it would be interesting to see how the demand for the different services will have changed. SR stated that we need to factor in how the long term chronic illness's activity will impact the services. **ACTION: GS to discuss with JH and James House approach and feedback to the next meeting**	**GS**
6.	**Minutes of the Previous Meeting & Matters Arising**	
	The minutes of the Better Care Southampton Steering Board on 03/03/2020 were approved.	
7.	**Any Other Business and items for future meetings**	
	Future Agenda Items: • Update about Localities and PCN's • Update re 5 Year Health and Care Strategy • Future Actions & Agreement how to take forward	
8.	Close	

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