Appendix 1

Southampton City Better Care Partnership Agreement 2017/18

Quarter 4 and End of Year Performance Report

1. Carers

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

Overall Financial Performance

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

Overall Delivery

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

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

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

2. Clusters

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

Overall Financial Performance

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

Reasons for Over/Underspends:

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

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

Actions being taken to address Over/Underspends:

- No action required

Opportunities for Savings:

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

Key opportunities:

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

Predicted Cost Pressures:

- None

Overall Delivery

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

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

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

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

Summary

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

3. Integrated Rehabilitation and Reablement and Hospital Discharge

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

Overall Financial Performance

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

What are the reasons for Over/Underspends?

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

What actions are being taken to address Over/Underspends?

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

Are there any opportunities for Savings?

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

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

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

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

Overall Delivery

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

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

Summary

Describe any proposed Changes/ Recommendations for consideration	None Currently

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

4. Care Technology

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

Overall Financial Performance

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

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

Variance	Underspend of £23k

What are the reasons for Over/Underspends?

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

What actions are being taken to address Over/Underspends?

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

Are there any opportunities for Savings?

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

Predicted Cost Pressures:

- None

Overall Delivery

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

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

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

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

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

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

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

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

Summary

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

5. Prevention and early intervention

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

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

Overall Delivery

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

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

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

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

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

Summary

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

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

6. Learning Disability Integration

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

Overall Financial Performance

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

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

Overall Delivery

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

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

Delivery of original aims outcomes

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

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

•*Support Transforming Care agenda*

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

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

- Increases in reviews undertaken

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

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

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

•*Reduction in cost of packages of care*

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

Support for BCF targets

Reducing permanent admissions into residential homes

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<tr><td>Performance Indicators

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

90% clients have review within target period

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

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

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

Summary

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

7. Direct Payment Scheme

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

Overall Financial Performance

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

Overall Delivery

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

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

Summary

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

8. Transforming Long Term Care

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

Overall Financial Performance

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

Overall Delivery

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

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

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

Summary

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

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

9. Children - SEND Integrated Health and Social Care Provision

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

Overall Financial Performance

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

Overall Delivery

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

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

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

Summary

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

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

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

Overall Financial Performance

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

Overall Delivery

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

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

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

Summary

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

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