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

Achieving Transformation Change

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

Quality

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

KEY

Compared to Previous Year

↑ Better than previous year

↓ Worse than previous year

→ Same as previous year

Compared to Target

Within 10% of Target

Target Achieved

<10% below target

2. ICU Workstream Progress

a. Achieving Transformation Change

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

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

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

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

b. Procurement & Market Mananagement

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

c. Quality

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

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

3. Key Performance Indicators

a. Integrated Care (Better Care)

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

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

Summary

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

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

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

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

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

b. Prevention and Early Intervention

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

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

Summary

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

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

c. Commissioning Safe & High Quality Services

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

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

Summary

d. Managing and Developing the Market

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

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

Summary

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

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

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

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