DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Better Care Quarter 1 and 2 2020/2021 Report**		
DATE OF DECISION:		**15th October 2020**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE

BRIEF SUMMARY
This report provides a review of performance for Quarter one and two 2020/2021 against Southampton's Better Care programme and pooled fund. The most recent highlight report can be found in Appendix 1.

RECOMMENDATIONS:		
	(i)	To note Quarter one and two performance for Better Care.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Joint Commissioning Board (JCB) is responsible for oversight of the Better Care pooled fund. This responsibility has been delegated to JCB from the Health and Wellbeing Board (HWBB).
2.	The purpose of this report is to provide assurance to JCB that the Better Care programme and pooled fund is progressing to plan and to highlight any key issues.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	NOT APPLICABLE

DETAIL (Including consultation carried out)	
3.	**National and local overview** National Better Care Fund Operating guidance was last published on 18 July 2019 for 2019/20 and the Policy framework for 2020/21 has been delayed owing to the COVID pandemic. Prior to COVID, we were awaiting feedback from the national review of the BCF programme but the expectation was that 2020/21 would be a further transition year for the Better Care Fund with the potential for a 3 year plan for 2021/22 – 2023/24, subject to the outcome of the Comprehensive Spending Review. It is still anticipated that a document summarising the outcome of the national review work will be published to inform future discussion about how the Better Care Programme needs to adapt post COVID. During 2019/20, Southampton's Better Care programme was refreshed to align with the Southampton City Health and Care Strategy (2020 – 2025) which in turn aligns to the Council Strategy, NHS Long Term Plan and Hampshire and Isle of Wight Sustainability and Transformation Partnership/Integrated Care System plans. It is a subset of the wider 10 year strategy for health and wellbeing led by the Health and Wellbeing Board.

The Southampton City Health and Care Strategy sets out the following goals to be achieved across the full life course (Start Well, Live Well, Age Well, Die Well):

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

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

- To put **individuals and families at the centre of their care and support**, meeting needs in a holistic way
- To provide the **right care and support, in the right place, at the right time**
- To make **optimum use of the health and care resources** available in the community
- To **intervene earlier** and build resilience in order to secure better outcomes by providing more coordinated, proactive services.
- To **focus on prevention and early intervention** to support people to retain and regain their independence
- **Joining up Rehabilitation and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams** (and integrated health, education and social care teams for children and families, e.g. the 0-19 Prevention and Early Help service) that in turn link with each of the Primary Care Networks.
- **Building capacity** across the system to promote and support people to maintain their independence for as long as possible. This includes promoting self management approaches and supporting the role of carers. It also includes developing the capacity of the voluntary and community sector to meet lower level needs in local communities, as well as investing in the home care sector to enable more people to continue living in their own homes.

The **Better Care Fund** (BCF) pools resources from both Southampton City Clinical Commissioning Group (CCG) and Local Authority to support the delivery of the Better Care Programme. It also includes the improved Better Care Fund grant (iBCF) and Winter Pressures grant. In 2020/2021 the BCF totals £130.317M (£82.648M from the CCG and £47.669M from the Council), making Southampton one of the country's top authorities for pooling an amount way beyond its national requirement which is £16.484M, demonstrating its commitment to integrating health and social care at scale.

Southampton's Better Care Fund is made up of the following schemes:

1. Supporting Carers
2. Integrated Locality teams
3. Integrated Rehabilitation and Reablement and Hospital Discharge
4. Aids to Independence – Joint Equipment Store (JES) and Disability Facilities Grant (DFG)
5. Prevention and Early Intervention
6. Adult Learning Disability Integrated Commissioning
7. Promoting uptake of Direct Payments

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

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

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

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

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

City-Wide Dashboard

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

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

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

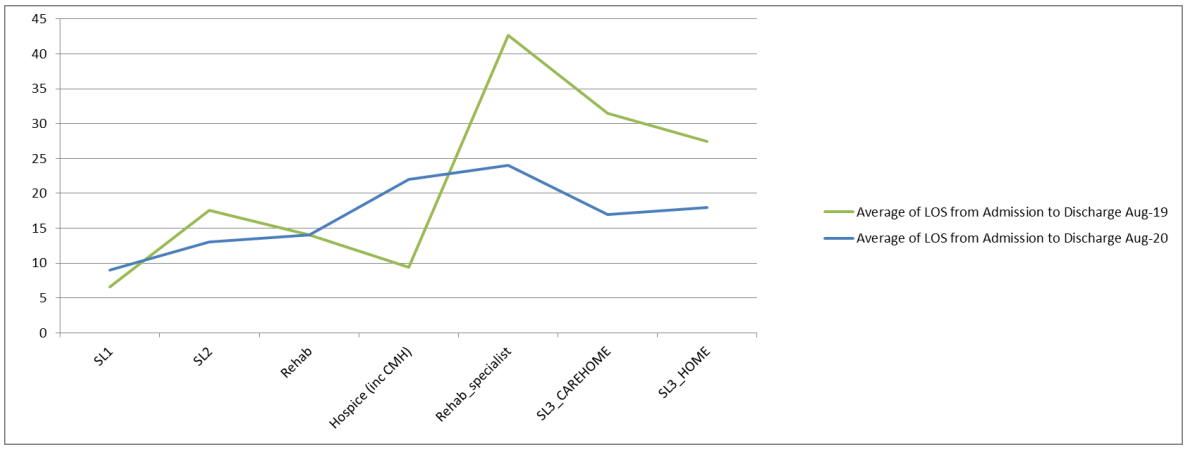
5. **Performance Headlines**

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

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

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

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



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

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

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

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

These figures demonstrate the following key challenges:

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

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

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

	➢ Improvement in the quality of discharge thereby reducing the number of failed discharges as a result of such problems as delayed patient transport, medications not being ready on the day or poor information transfer ➢ Development and embedding of clearer processes for people who are homeless to ensure discharge is not delayed. ➢ Implementation of a consistent approach to Discharge to Assess across Southampton and South West Hampshire. This includes securing appropriate resources to support people to have a discharge to assess approach and to ensure that the onward care is well planned and supported across the system of health and care. ➢ Increasing capacity in other key services such as Stroke early supported discharge (ESD) and Community Rehabilitation beds ➢ Promoting further development of 7 day and flexible working to support more discharges to take place at the weekend, preventing the usual spike in referrals to the community discharge hubs on a Monday or Tuesday which are then difficult to process ➢ Work with community equipment and transport providers to understand any gaps in provision and work towards resolving these. • **Non Elective (NEL) admissions:** at month 4, NEL admissions are 25% lower than this period in the previous year. During this period the rate has steadily risen, starting in March at 41% below the previous year's performance and in July 16% lower than last year. The main contributory factor to lower non elective admissions is the impact of the pandemic itself. Going forward it will be important to prevent avoidable A&E attendance and NEL admissions in order to support system recovery and in particular recovery of elective planned care in line with government targets alongside maintaining capacity to respond to Wave 2 and the additional pressures that winter brings. To do this key areas of focus will include: o Reductions in admissions amongst high intensity users o Increasing capacity within Urgent Response to promote a stronger focus on Admission Avoidance. o High level of collaboration between community partners to assist people with support needs promptly, including the development of the One Team/Integrated Care team approach. **Injuries due to falls** – performance is 33% lower than the previous year mainly owing to the overall reduction in non-elective admissions; this indicator is specifically counting hospital admissions due to falls injuries. As with other non-elective metrics there has been an increase month on month i.e. from month 1 to month 4.
6.	**Covid impact on BCF** o During the immediate response to Covid-19 some services experienced increased demand whilst also being required to change the way in which they deliver services to keep their clients/patients safe. Many services have shown significant levels of flexibility and innovation to meet this demand within the funding available to them. This includes a new, Covid safe, approach to making contact with clients, implementing flexible working patterns and working collaboratively with other services in order to meet the needs of their client group. o In response to the new national discharge process, the system has worked in true partnership to develop the integrated discharge hub which brings together Adult Social Care, Urgent Response Service, Care Home Support and Continuing Health Care. Together they enable a Discharge to Assess (D2A) approach, allowing people to be discharged to their own home or another suitable environment to continue their recovery. The model developed through this approach has proven successful and as such will be promoted further as we move into implementing our

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

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

	in complexity of client care, particularly impacting on the CCG which is showing a forecast overspend of £238,000 whilst the Council 's proportion is £46,000. These overspends are not currently being offset by projected underspends on other schemes, noting that ongoing review, challenge and action to support recovery of this position is undertaken by the BCF Finance and Performance Group. This is monitored on a monthly basis by the group.
Property/Other	
9.	There are no specific property implications arising from the Better Care pooled fund.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006, which requires that in each Local Authority area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2017-19, NHS England set the following conditions, which with the pause in the annual planning round apply for the first part of this year: • Agreement of a joint plan between the CCG and Local Authority • NHS contribution to social care is maintained in line with inflation • Agreement to invest in NHS-commissioned out-of-hospital services • Implementation of the High Impact Change Model for Managing Transfers of Care. Southampton is compliant with all four of these conditions.
Other Legal Implications:	
11.	None
CONFLICT OF INTEREST IMPLICATIOINS	
12.	None
RISK MANAGEMENT IMPLICATIONS	
13.	Risks on specific Better Care Fund Schemes are monitored on a monthly basis. Key risks and issues for the Better Care Programme overall are summarised below: • **Capacity of the care market** to meet increasing needs and support additional schemes to improve discharge particularly with the additional costs and challenges related to Covid - To mitigate this, the ICU is working proactively with the care market and utilising alternative mechanisms such as retainers and block contracts to provide increased stability. In addition SCC will consider how best to support the market through the second tranche of Infection Prevention Funding which has been released by DHSC for the remainder of this year. • **Resilience in the voluntary sector** and ability to respond to new ways of working, during a time when funding for the community and voluntary sector has slowed in line with the national economic position - A number of mitigating actions are being taken including: various procurement options being considered to make best use of local market and encourage innovation; support to local agencies also being considered as part of the developments; proactive review of any bidding opportunities. • **IBCF arrangements for 2021/2022** Should the iBCF be discontinued after 31 March 2021, the alternative to mainstreaming the services and schemes would be to discontinue them. This would seriously impact the progress that has been made with the city's Better Care programme and Health and Care Strategy, reversing the benefits already achieved and

	would also have an impact on the city's performance for a number of nationally reported indicators. The biggest areas of impact associated with loss of iBCF tranche 2 are summarised below: o Worsening of hospital discharge performance – as a result of not being able to deliver discharge to assess and maintain a 7 day week service o Failure to achieve the government's High Impact Change model for hospital discharge published jointly by the Local Government Association (LGA), Department of Health (DH), Monitor, NHS England and Association of Directors of Adult Social Services (ADASS) in 2015 – particularly in relation to delivering a home first, discharge to assess approach and 7 day service o Increased waiting lists and reliance on statutory social care provision – as a result of not being able to meet social care demand for assessment, support planning and reviews and not having the capacity to intervene early o Increased admissions to residential and nursing care as a result of not being able to intervene early enough
POLICY FRAMEWORK IMPLICATIONS	
14.	Southampton's Better Care Programme supports the delivery of outcomes in the Council Strategy and the city's Five Year Health and Care Strategy (2020-2025), which in turn complement the delivery of the local HIOW Integrated Care System, NHS Long Term Plan and Care Act 2014.
15.	Southampton's Better Care Plan also supports the delivery of Southampton's Health and Wellbeing Strategy 2017 - 2025 which sets out the following 4 priorities: • People in Southampton live active, safe and independent lives and manage their own health and wellbeing • Inequalities in health outcomes and access to health and care services are reduced. • Southampton is a healthy place to live and work with strong, active communities • People in Southampton have improved health experiences as a result of high quality, integrated services

KEY DECISION?	**Not Applicable - No decision required**
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION

Appendices	
1.	Q1 and Q2 highlight report.

Documents In Members' Rooms

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

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

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

<table>
<tr><td>Author: MFC</td><td colspan="2">BCF/iBCF Finance and Performance Highlight report for Southampton</td><td>Date: 15/09/2020</td></tr>
<tr><td colspan="2">Highlights</td><td colspan="2">Priorities for next quarter</td></tr>
<tr><td colspan="2">• Rehab and reablement - Delivery of pathway 2 through SPoA and onward services
• Implementation progressing well with new JES provider
• Carers – beginning the development of 5 yr strategy for carers and promoting further the identification of carers
• BRS – management of higher demand within budget and delivering on key targets
• Plans for Potters Court – potential for an earlier start than the delayed February 2020 date
• Community transport – support to front door discharges from UHS
• Direct payments/personalisation
  • PA finder, on line portal, became operational in July 2020
  • Implementation of a managed account service</td><td colspan="2">• Embedding SPoA – Sembal House Hub
• Business Case – Step up reablement or admission avoidance work
• Foundations to report on review of DFG and options for future approaches.
• Preparing to offer leadership training opportunity to informal carers and develop a more comprehensive engagement approach.
• Market Position Statement for social care
• BRS – considering how to mainstream extended hours provision
• Resolution for underspend iBCF (approximately £171k)
• DP – Develop a greater understanding of the early impact of our new support structures for DP clients and staff</td></tr>
<tr><td colspan="2">Pressures and Blocks</td><td colspan="2">Risk and Escalation</td></tr>
<tr><td colspan="2" rowspan="2">• A number of services across the schemes seeing demand rising with recovery underway: CIS; Community Nursing; AIG - employment, welfare and SEND; BRS
• Rehab and Reablement – requirement to reinstate integrated oversight
• Work to resolve challenge from outgoing JES provider
• Integrated LD commissioning – significant overspend forecast related to complexity of care for new clients
• Jigsaw – staffing challenges, including management, seeking to manage this internally
• Insulin pump challenge within Integrated locality scheme
• Impact of Covid-19 - capacity within Adult Social Care to maintain a focus on DP</td><td>Risks / Issues</td><td>Mitigation</td></tr>
<tr><td>Sustainability of living well contract provider – Covid safe capacity does not support private payers.

Potential for significantly increased costs to SCC for care provision as Covid funding arrangements end or change.</td><td>Working with provider to understand position and seek sustainable approach to delivery for SCC clients.
Drafting of MPS and monitoring of position.</td></tr>
</table>