Community Wellbeing HOSP

25th April 2024

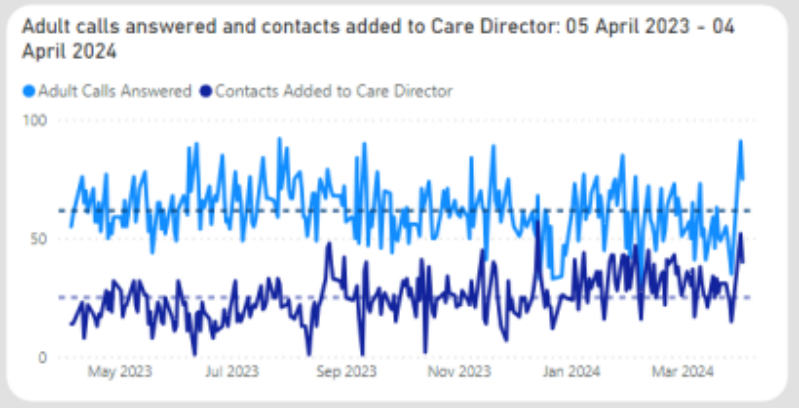
Performance

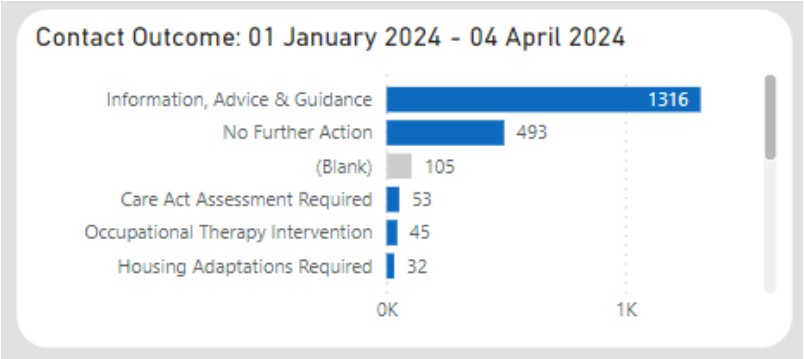
KPI summary and Trend analysis

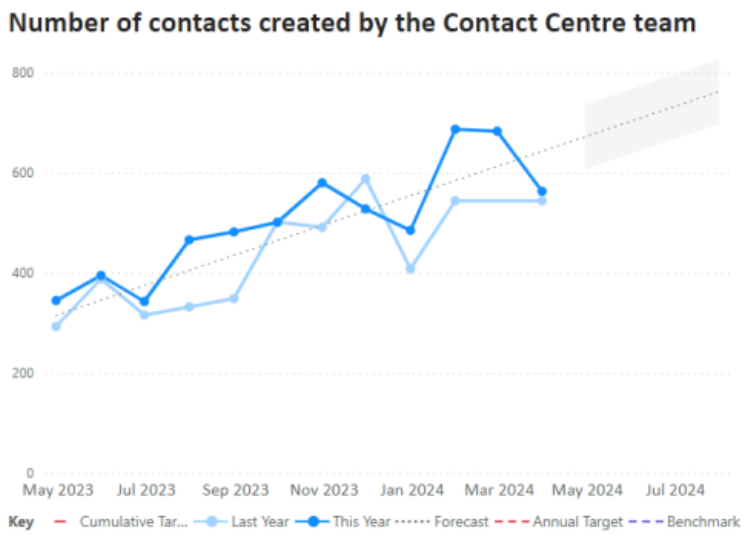
Contact Centre

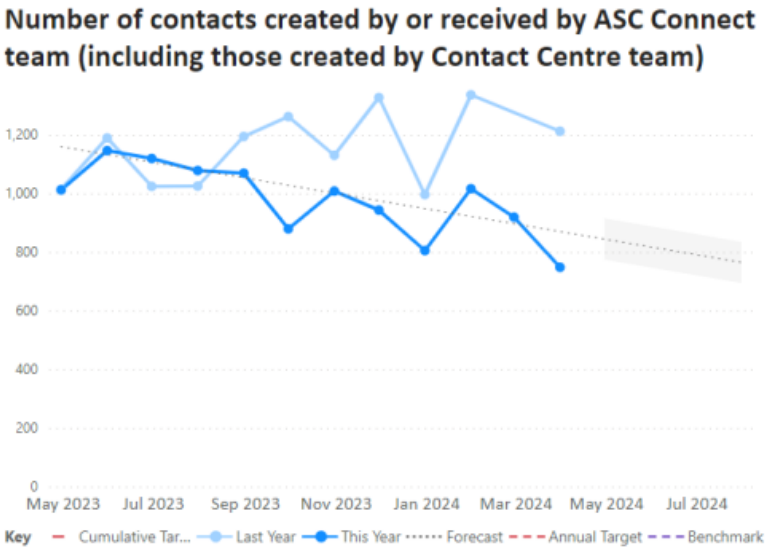
Demand has increased with the Contact Centre receiving and resolving more contacts, 85% are resolved most with outcomes of advice or no further action in the last quarter.

A restructure of adult social care underway and to be implemented in September 2024 will strengthen the ASC Connect Team to improve response times and outcomes for residents.





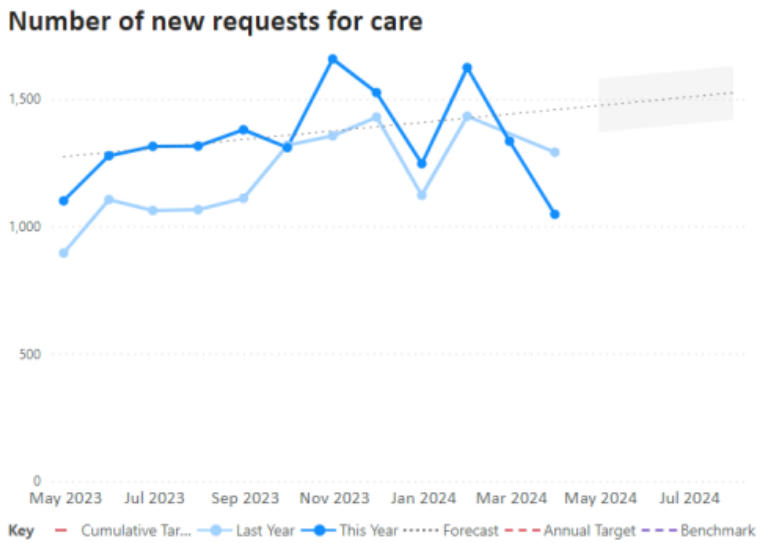


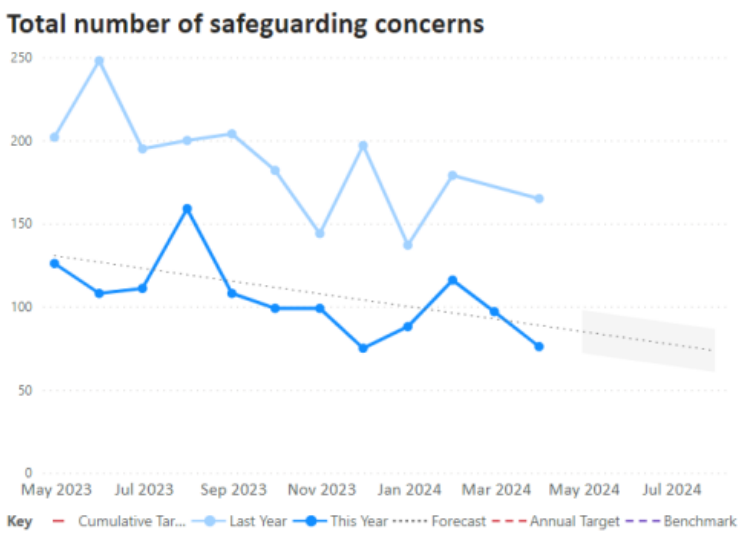


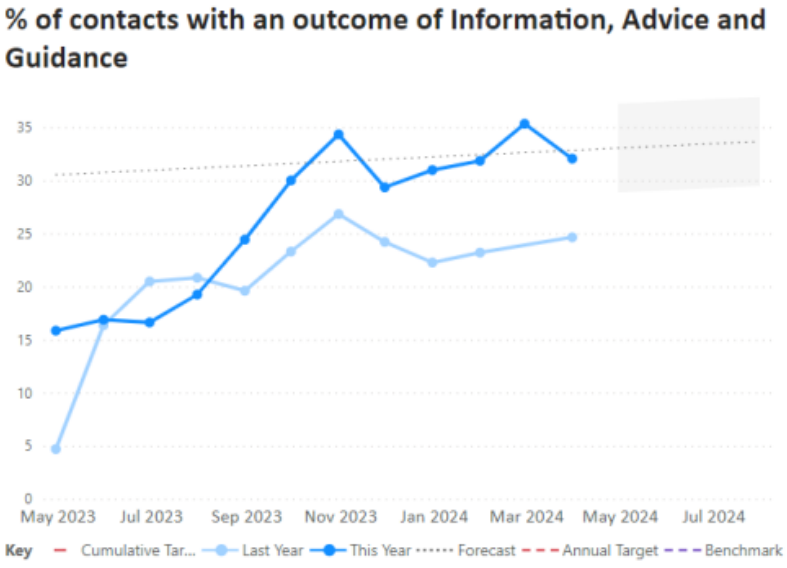
New Requests

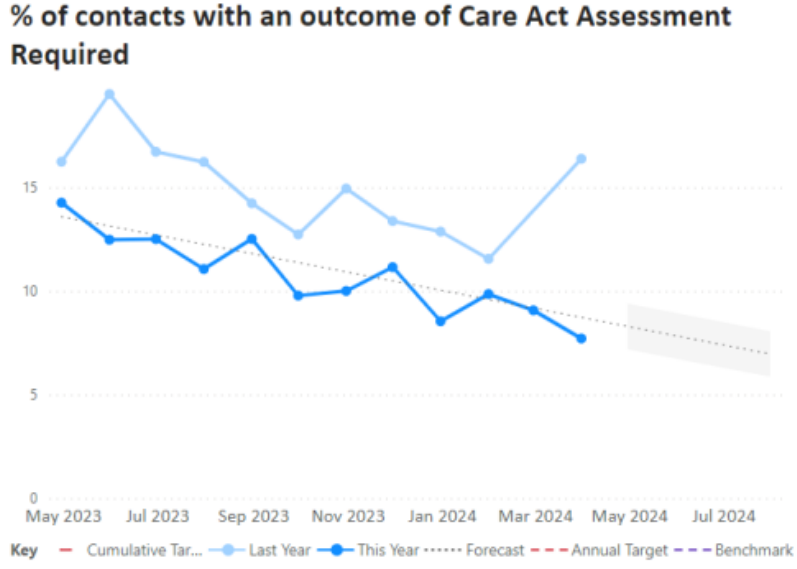
There is an overall increase in requests for care, but proportionally an increase in outcomes of information, advice and guidance and reduction in care act assessment required. This will be further improved as reablement is now provided when it appears that care is required.

The number of safeguarding concerns is reducing as adult social care has worked with the police and is working with University Hospital Southampton and South-Central Ambulance Service to improve understanding of safeguarding and reduce the 90% of unnecessary safeguarding referrals.







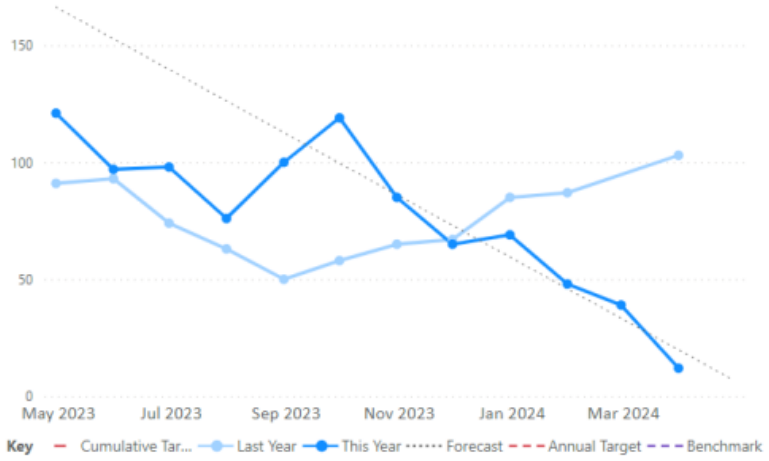


Care Act Assessments

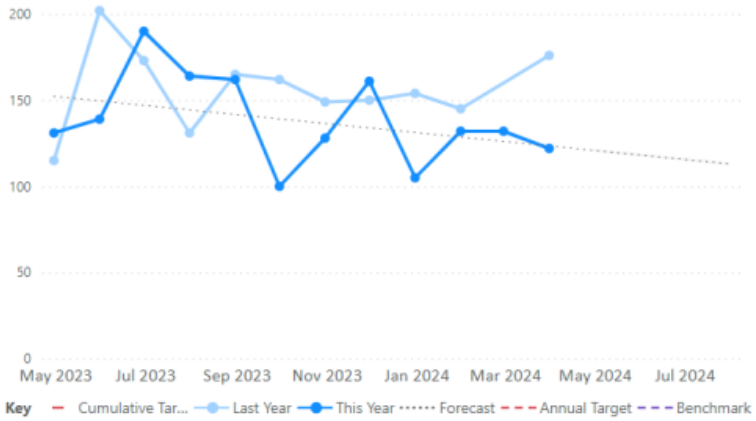
The timeliness of Care Act assessment allocation is improving, the restructure of adult social care will improve process and practice to further improve timeliness of allocation and completion.

Annual reviews have improved since last year and performance is higher than national average.

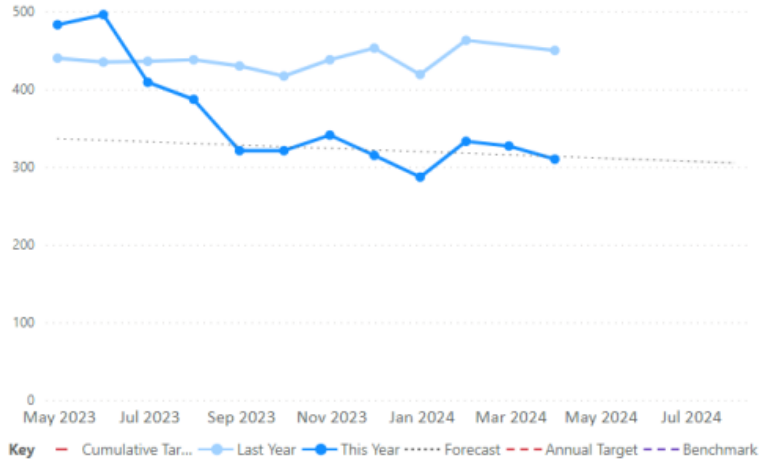
Number of new Care Act Assessment forms waiting to be allocated



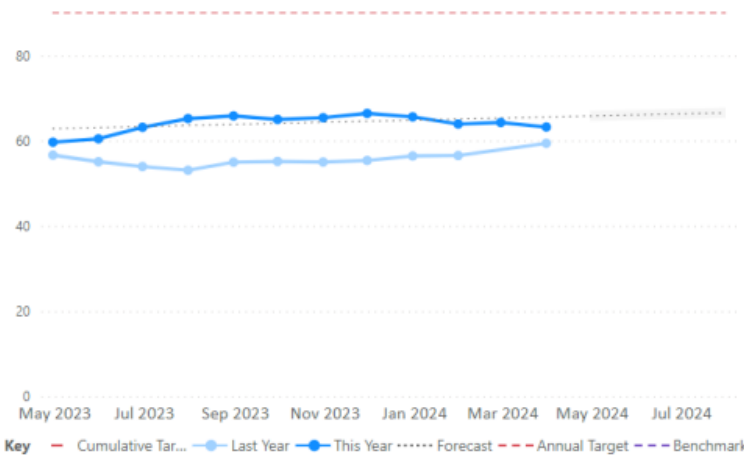
Number of new Care Act Assessments completed in the month (excludes terminated assessments and unplanned or planned reviews)



Number of new Care Act Assessment forms waiting and allocated to a worker



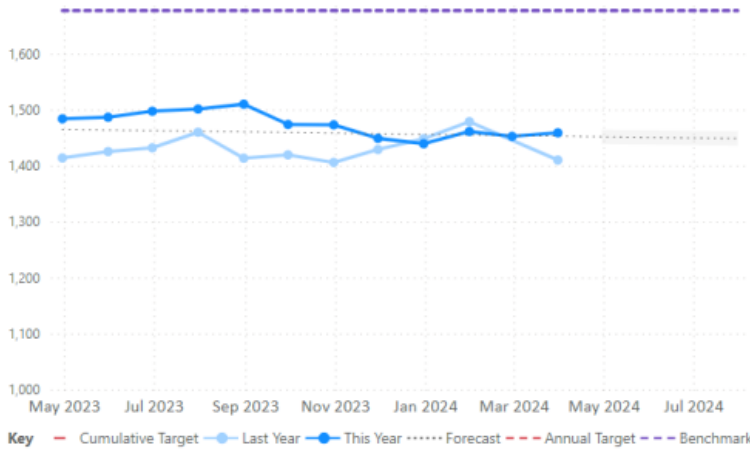
Percentage of people receiving Long Term services who have been assessed / reviewed in the last 12 months



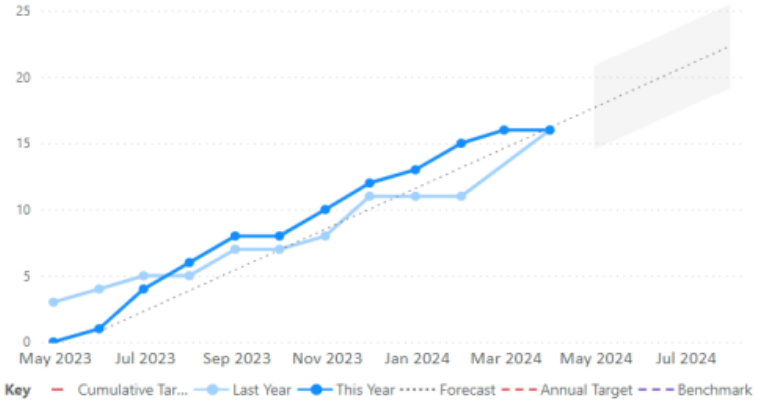
Placements - Residential

There is a slight increase in the number of people in residential care, all have been subject to rigorous management oversight to ensure that all other options have been considered. Development of assistive technology options and in the longer term an increase in extra care sheltered care provision will be key to supporting people to remain in their own homes longer in future and prevent or delay the need for residential care.

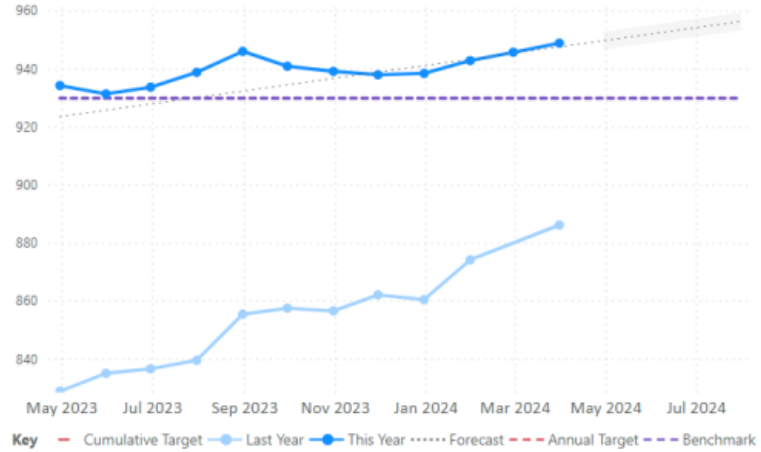
Average cost per week of Long Term Residential for 18-64 year olds



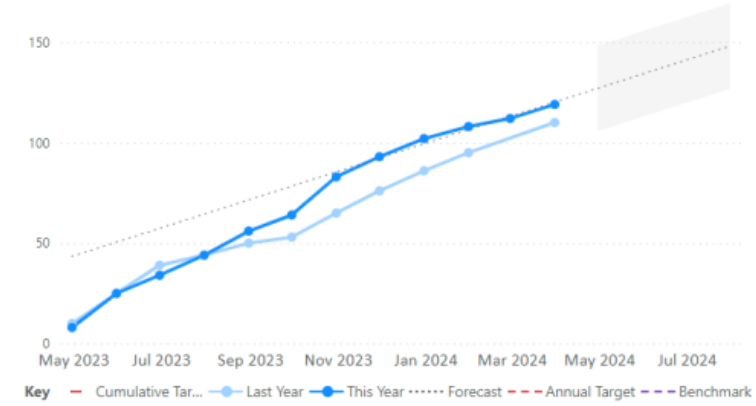
Cumulative number of younger adults (aged 18-64) whose long-term support needs are met by admissions to residential care homes ONLY



Average cost per week of Long Term Residential for ages 65 and over



Cumulative number of older adults (aged 65 and over) whose long-term support needs are met by admissions to residential care homes ONLY

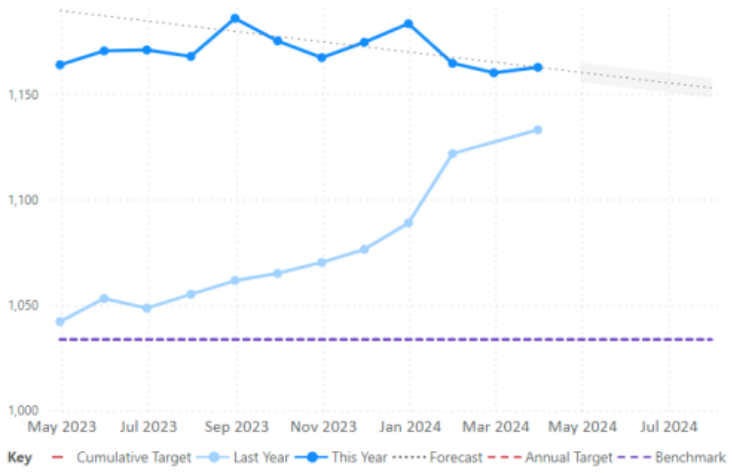


Placements - Nursing

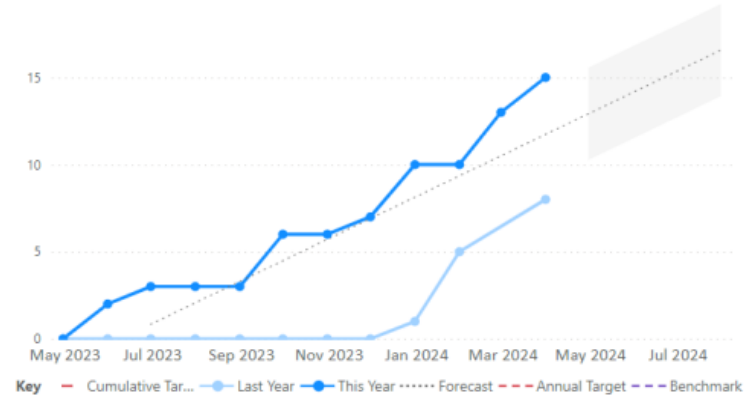
The increasing number of people going into nursing care is reflective of an increasing number of people with multiple and complex health conditions in people under and over 65.

30 people moved from residential to nursing care in the financial year 23-24 (3 under 65) as their health condition deteriorated.

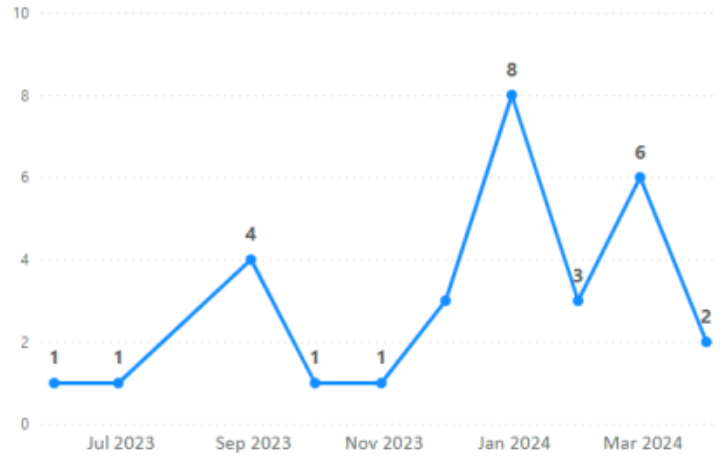
Average cost per week of Long Term Nursing



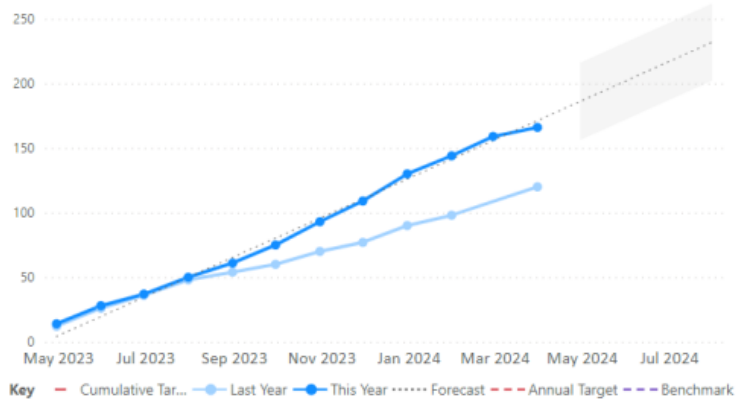
Cumulative number of younger adults (aged 18-64) whose long-term support needs are met by admissions to nursing care homes ONLY



Total people moving from residential to nursing care



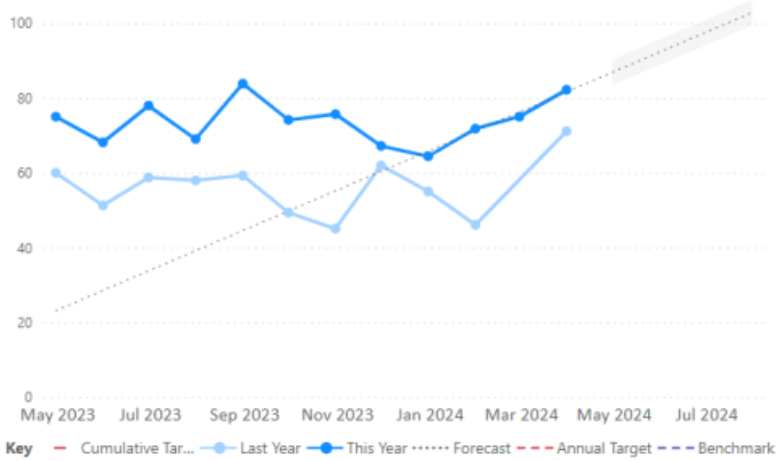
Cumulative number of older adults (aged 65 and over) whose long-term support needs are met by admissions to nursing care homes ONLY



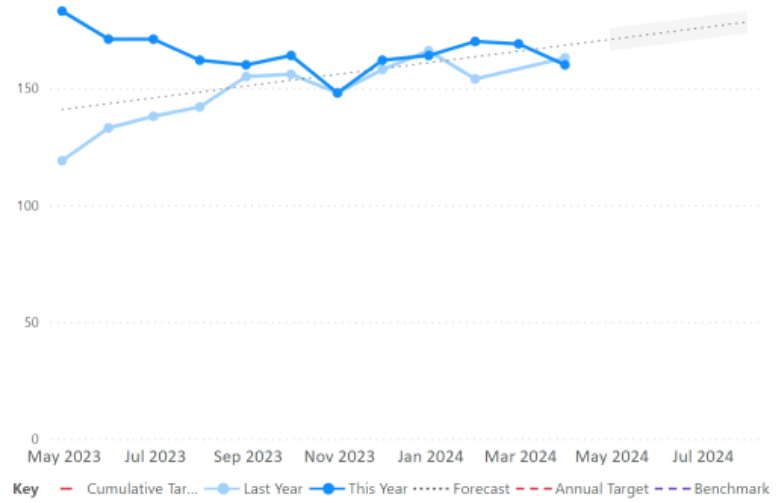
Reablement

Reablement criteria were introduced at the end of February 2024 to ensure that the service is targeted at improving independence and moving from a focus on hospital discharge to prevention of admission and maintaining people in their own homes. This is reflected in improving the already good performance in the number of people exiting with a decrease or no ongoing care. The number of people receiving reablement will increase as this model is further embedded. Occupational Therapy leadership will be implemented to further improve performance and outcomes for people.

Percentage of people exiting reablement with a decrease or no ongoing care

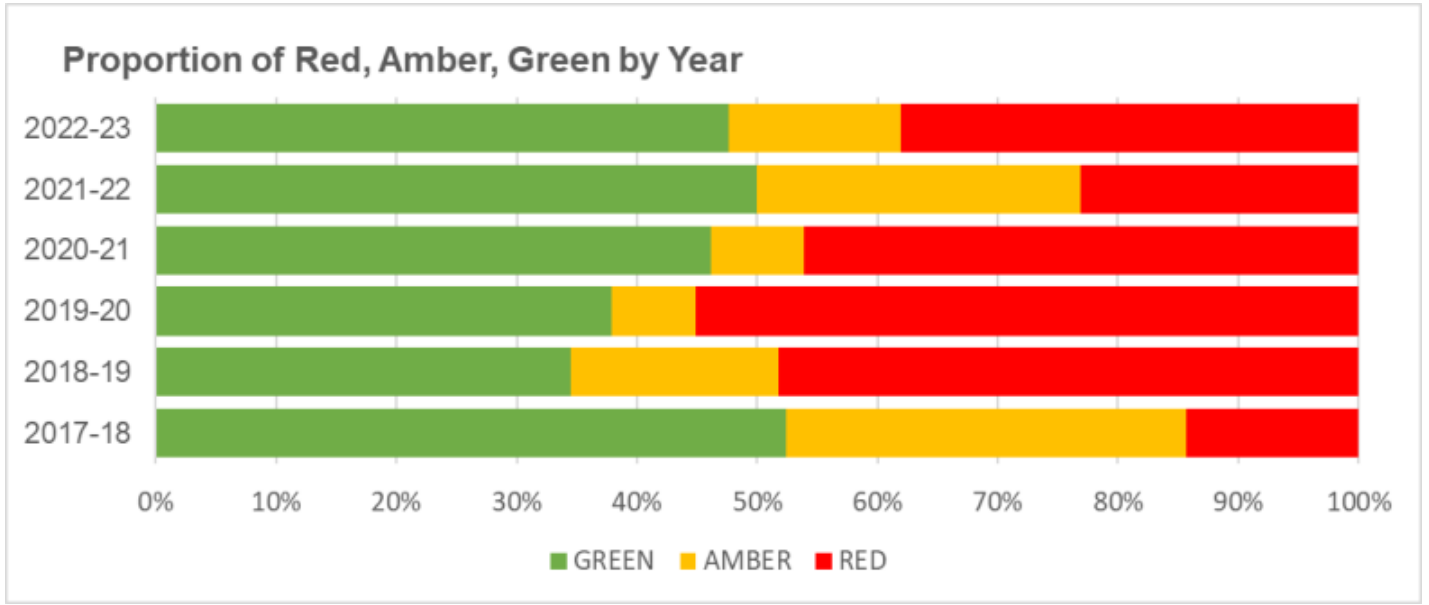


Number of people receiving reablement



2022-2023 ASCOF Results Highlights

- **The proportion of GREEN outcome ASCOF measures has been maintained overall.**
- **2B(2) at 5.2% is significantly higher than last year (4.4%) and both England (2.9%) and South East (2.6%) Benchmarks.**
- **1B maintained steady performance at 77.1% which is in line with benchmarks.**
- **2A(1) (14.1) was lower than the England (14.6) and South East (15.4) results.**
- **For 2023-2024 the ASCOF measures will be significantly changing where SALT is replaced with the new statutory return Client Level Dataset (CLD), this is detailed further on in this report.**



2B(2) Proportion of Older people (65+) who were discharged from hospital into reablement and rehabilitation services (offered the service)

1B Proportion of people who use services who have control over their daily life

2A(1) Permanent admissions of younger adults (aged 18-64) to residential and nursing care homes, per 100,000 population

2022-2023 ASCOF All Results (Green)

Below are the ASCOF measure results rated as Green.

ASCOF ID	New ASCOF ID	Description	Polarity	SCC 22-23	England 22-23	South East 22-23	SCC 21-22	RAG
1B	3A	Proportion of people who use services who have control over their daily life	UP	77.1	77.2	76.8	79.0	
1C(1B)	dropped for 23-24	Carers receiving self-direct support	UP	100	89.3	98.9	100	
1C(2B)	3D	Carers receiving direct payments	UP	100	76.8	91.9	100	
1F	dropped for 23-24	Proportion of adults in contact with secondary mental health services in paid employment	UP	6	6	8	5	
1G	2E	Proportion of adults with learning disabilities who live in their own home or with their family	UP	81.9	80.5	78.3	81.9	
1H	dropped for 23-24	Proportion of adults in contact with secondary mental health services living independently, with or without support	UP	32	22	24	28	
2A(1)	2B	Permanent admissions of younger adults (aged 18-64) to residential and nursing care homes, per 100,000 population	DOWN	14.1	14.6	15.4	12.0	
2B(2)	2D	Proportion of Older people (65+) who were discharged from hospital into reablement and rehabilitation services (offered the service)	UP	5.2	2.9	2.6	4.4	
3D1	3C	The proportion of people who use services who find it easy to find information about services	UP	65.7	67.2	68.1	64.5	
4B	dropped for 23-24	Proportion of people who use services who say that those services have made them feel safe and secure	UP	87.7	87.1	86.9	88.4	

22-2023 ASCOF All Results (Amber, Red)

Below are the ASCOF measure results rated as Amber or Red.

ASCOF ID	New ASCOF ID	Description	Polarity	SCC 22-23	England 22-23	South East 22-23	SCC 21-22	RAG
1E	dropped for 23-24	Proportion of adults with learning disabilities in paid employment	UP	4.1	4.8	6.6	3.1	
1J	1B	Adjusted Social care-related quality of life-impact of Adult Social Care Services	UP	0.388	0.411	0.417	0.38	
4A	4A	Proportion of people who use services who feel safe	UP	68.2	69.7	70.4	67.8	
1A	1A	Social care-related quality of life	UP	18.3	19	19.2	18.9	
1C(1a)	dropped for 23-24	Adults receiving self-directed support (service users only)	UP	87.6	93.5	94.2	93.1	
1C(2a)	3D	Adults receiving direct payments (service users only)	UP	13.6	26.2	25.9	14.3	
1I(1)	5A	The proportion of people who use services who reported that they have as much social contact as they would like	UP	39.2	44.4	45.2	39.6	
2A(2)	2C	Permanent admissions of older people (aged 65 or over) to residential and nursing care homes, per 100,000 population	DOWN	662.9	560.8	556.9	645	
2B(1)	2D	Proportion of Older people (65+) who were still at home 91 days after discharge from hospital into reablement and rehabilitation services (effectiveness of the service)	UP	74.1	82.3	78.6	75.2	
2D	2A	The outcome of short-term services: sequel to service	UP	73.2	77.5	77.7	84.7	
3A	1D	Overall satisfaction of people who use services with their care and support	UP	60.8	64.4	64.6	66.6	

ASCOF Measures expected for 2023-2024

Prior Code	New Code	Description	Source	Notes
Objective 1: Quality of Life				
1A	**1A**	*Quality of life of people who use services*	ASCS	
1J	**1B**	*Quality of life of people who use services – adjusted to account only for the additional impact of local-authority funded social care on quality of life, removing non-service related factors (underlying health and care needs, gender, and so on)*	ASCS	New methodology
1D	**1C**	*Quality of life of carers*	SACE	
3A	**1D**	*Overall satisfaction of people who use services with their care and support*	ASCS	
3B	**1E**	*Overall satisfaction of carers with social services (for them and for the person they care for)*	SACE	
Objective 2: Independence				
2D	**2A**	*The proportion of people who received short-term services during the year – who previously were not receiving services – where no further request was made for ongoing support*	CLD	
2A(1)	**2B**	*The number of adults aged 18 to 64 whose long-term support needs are met by admission to residential and nursing care homes (per 100,000)*	CLD & ONS	
2A(2)	**2C**	*The number of adults aged 65 and over whose long-term support needs are met by admission to residential and nursing care homes (per 100,000)*	CLD & ONS	
2B	**2D**	*The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital*	CLD	Experimental
1G	**2E**	*The proportion of people who receive long-term support who are enabled to live in their home or with their family*	CLD	

ASCOF Measures expected for 2023-2024

Prior Code	New Code	Description	Source	Notes
Objective 3: Empowerment – Information and Advice				
1B	**3A**	*The proportion of people who use services who report having control over their daily life*	ASCS	
3C	**3B**	*The proportion of carers who reported that they have been involved in discussions about the person they care for*	SACE	
3D1 & 3D2	**3C**	*The proportion of people and carers who use services who have found it easy to find information about services and/or support*	SACE & ASCS	
1C	**3D**	*The proportion of people who use services who receive direct payments (split by age: aged 18 to 64; aged 65+)*	CLD	Previously 2 measures
Objective 4: Safety				
4A	**4A**	*The proportion of people who use services who feel safe*	ASCS	
	4B	*The proportion of section 42 safeguarding enquiries where a risk was identified and the reported outcome was that this risk was reduced or removed*	SAC	
Objective 5: Social Connections				
1I	**5A**	*The proportion of people who use services who reported that they had as much social contact as they would like*	ASCS	
Objective 6: Continuity and Quality of Care				
6A	**6A**	*The proportion of staff in the formal workforce leaving their role in the past 12 months*	ASC-WDS	New workforce employee survey from July 2023
6B	**6B**	*The percentage of adult social care providers rated good or outstanding by the Care Quality Commission*	CQC	

Commissioning Performance

March 2024

Social Care Provider Quality

9 Nursing Homes
78% rated Good or above by CQC (no change)

23 Older Adults Residential Homes
83% rated Good or above by CQC (no change)

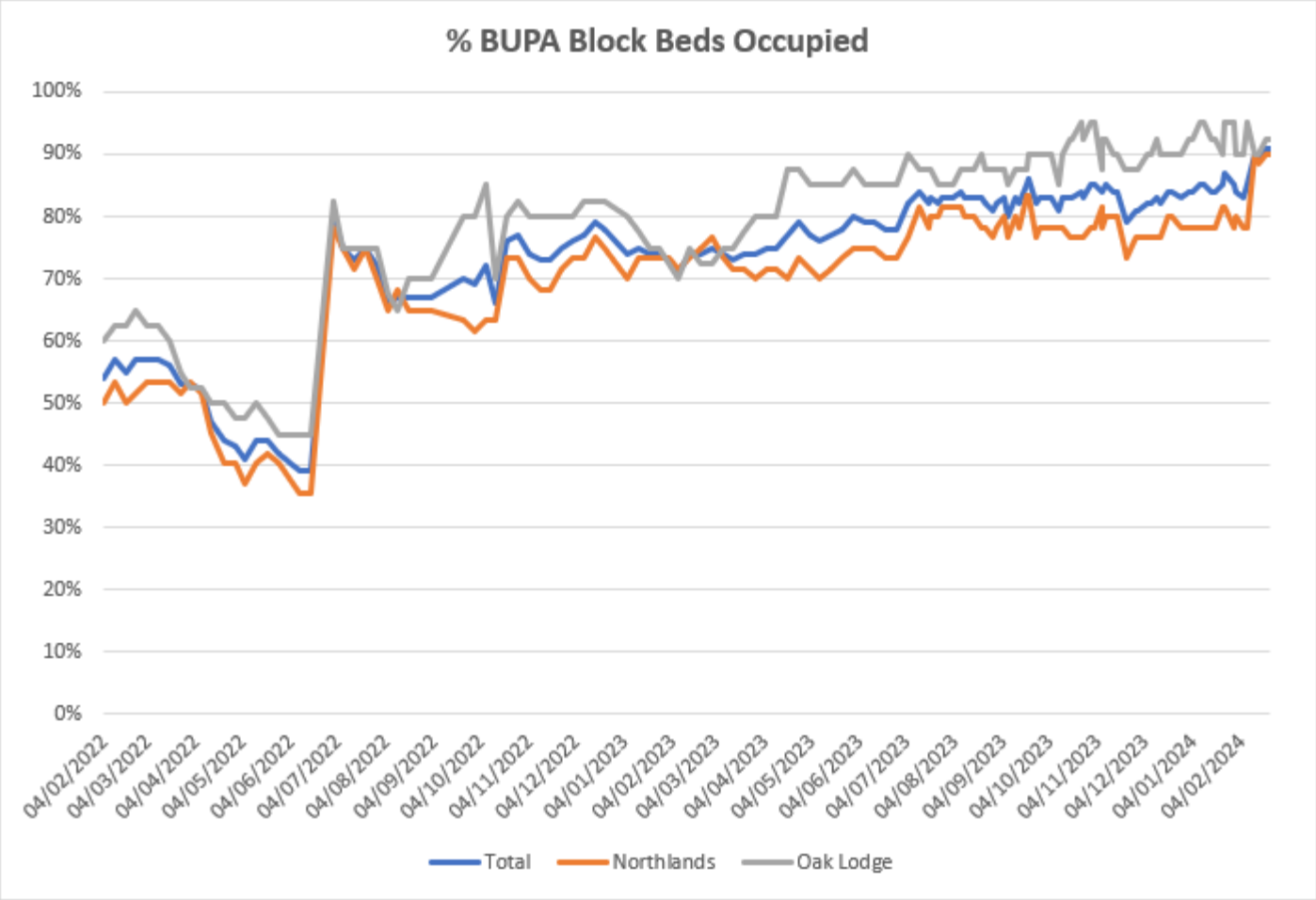
24 Mental Health / Substance misuse / Learning Disability providers 88% rated Good or above by CQC (no change)

43 Home Care providers, including Extra Care 90% rated Good or above by CQC (slight improvement)

Care (nursing, residential, home care)

- Southampton has 78.1% of Nursing and Residential Care rated as Good or above. This is similar or slightly lower than the local, regional and national averages (82.1%, 79.3% and 78.5%, respectively). Due to the relatively small numbers of providers in Southampton, a single provider downgrading to Requires Improvement has a disproportionate impact on percentage changes.
- At present, Southampton has an above average proportion of providers rated as Requires Improvement but a lower proportion rated as Inadequate.
- The Care Quality Commission have changed the way they assess providers. Where a provider has previously been rated Requires Improvement but there are no ongoing quality concerns (i.e., the provider has completed their improvement actions, and the Integrated Commissioning Unit has been working closely with the provider to monitor) they are no longer a priority for reinspection. This means that most of the providers in Southampton rated as Requires Improvement no longer have active quality concerns affecting their service.
- No residential homes have received a negative rating within the last nine months with the exception of one home which subsequently closed.
- On average, Southampton Nursing and Residential Homes are waiting 16 months for a re-assessment with the longest wait currently 39 months.

BUPA Block Contract Occupancy



- Occupancy now 92% across both home as of 12/03/24
- Northlands – 92% (5/60 Vacancies)
- Oak Lodge – 93% (3/40 Vacancies)
- Active monitoring of all referrals in place between commissioners and Placements team to escalate and challenge any responses outside of KPI timescales.
- * Contract variation live from July 2022 across both homes
- ** Northlands changes re: bed bandings kick in Jan 2024

Transformation

Impact on performance and budget

Completed transformation projects 23/24

Delivered Project	Impact of delivery (Benefits)
Launch of redesigned IAG & Southampton directory **Launch of EquipMe** **Launch of Online self-assessment**	Significant reduction in calls Increase and improvement to self-serve capability/demand management
Charging Policy	Clear, fairer and transparent policy delivering estimated £200k increased income
CIS Social workers brought into front door team	Strengthened team, more requests resolved at first contact
Sec75 Mental Health workers brought in to SCC Community Mental Health team	Improved compliance with the Care Act and our s117 duties under the Mental Health Act.
Service Redesign - Restructure Phase 1	£100K saving, robust and clear structure to enable Phase 2
Care TEC Trial	£100K+ cost avoidance, protected independence
Direct payments (Phase 1)	Implemented 'virtual wallet' from April 2024 an online platform to streamline administration of direct payments.

In-progress transformation projects 24/25

Project	Expected impact of delivery (Benefits)
Sec75 OTs unified into an SCC specialist team	Adult Social Care Occupational Therapists will support evidence-based goal and outcome focused preventative approach and ensure promotion of independence through the provision of equipment and functional assessment.
Service Redesign - Restructure Phase 2	Strengthened team and greater mix of skills available at the front door, more requests resolved earlier. Streamlined Processes, reduced waiting lists
Workforce development	Skilled and confident workforce
Launch of ASC strategy	Clear and shared strategic aims, clear performance measures
Direct Payment Phase 2	Increased uptake in DP, simplified process and improved outcomes
ASC Commissioning Service redesign	Closer alignment of commissioning to operations, improved outcomes
In-house services redesign	Improved outcomes and savings

Finance

Update on budget and savings proposals

Community Wellbeing Scorecard – Month 11

Adult Social Care BUDGET MONITORING MONTH 11 (February)									
CURRENT POSITION	**Current Budget 2023/24 £M**	**Forecast 2023/24 £M**	**Forecast Annual Variance at Period 11 £M**	**Variance P10 £M**	**Variance Movement Compared to P10 £M**	**Significant Forecast Variance Indicator**	**Improving ↑ / Deteriorating ↓ Movement**	**Actual to date £M**	**Actual Outturn 2022/23 £M**
Service Area									
Adults - Adult Services Management	1.16	0.87	0.29 F	0.34 F	0.05 A	Green	↓	0.69	1.69
Adults - Long Term	45.14	48.19	3.05 A	3.56 A	0.51 F	Red	↑	37.67	43.28
Adults - Provider Services	4.29	3.85	0.44 F	0.46 F	0.01 A	Green	↓	3.68	4.61
Adults - Reablement & Hospital Discharge	8.80	7.88	0.92 F	0.87 F	0.05 F	Green	↑	8.84	8.21
Adults - Safeguarding AMH & OOH	14.02	13.64	0.38 F	0.08 F	0.30 F	Green	↑	12.04	13.69
ICU - Provider Relationships	14.94	14.59	0.35 F	0.24 F	0.11 F	Green	↑	11.72	13.70
ICU - System Redesign	1.63	1.62	0.01 F	0.01 F	0.00	Green	-	2.80	2.03
Public Health - Health Improvement	1.70	1.70	0.00	0.00	0.00	Green	-	0.80	2.18
Public Health - Health Protection and Surveillance	9.80	9.80	0.00	0.00	0.00	Green	-	7.42	9.88
Public Health - Management & Overheads	(15.28)	(15.28)	0.00 F	0.00 F	0.00	Green	-	(17.16)	(15.82)
Public Health - Non-ringfenced	0.19	0.19	0.00	0.00	0.00	Green	-	0.16	2.40
Public Health - Population Healthcare	3.77	3.77	0.00	0.00	0.00	Green	-	0.31	3.76
Total Adult Social Care	**90.17**	**90.82**	**0.65 A**	**1.56 A**	**0.90 F**	Red	↑	**68.97**	**89.60**

Community Wellbeing Savings

Head of Service	Ref	Description	Sum of 2023/24 £000	Sum of 2024/25 £000	Sum of 2025/26 £000	Sum of 2026/27 £000	Agreed
Adult Social Care	23S97	Adult Social Care - reduce agency staffing budgets/freeze vacancies	-850	-850	-850	-850	Feb 23 Report
Adult Social Care	23S92	Use the results of the Association of Directors of Adult Social Services peer review to reduce costs for Adult Social Care continuing healthcare/S117 aftercare	-100	-150	-150	-150	Feb 23 Report
Adult Social Care	23S95	Adult Social Care - shift to home first policy, avoiding need for residential placement	-134	-473	-473	-473	Feb 23 Report
Public Health	23S98	Proposal for Public Health Grant to be invested in activities delivering wider public health outcomes (with Director of Public Health oversight)	-500	-500	-500	-500	Feb 23 Report
Adult Social Care	24S235	Following consultation on the closure of Holcroft House residential home and reprovision for occupants elsewhere.		-1300	-1300	-1300	Nov Report
Adult Social Care	24S259	Savings arising from negotiations on inflationary uplift applied to care provision costs	-1380	-1380	-1380	-1380	July Report
Adult Social Care	24S407	Wellbeing & Housing agency review	-200	-200	-200	-200	July Report
Adult Social Care	24S415	Additional Government funding to meet Adult Social Care cost pressures (Market Sustainability Grant)	-1687	-947			Oct Report
Adult Social Care	24S449	ASC charging policy changes		-200	-200	-200	Nov Report
Adult Social Care	24S511	Repurposing of public health grant for employment support in delivery of public health outcomes (resulting in saving for ASC)	-38				Nov Report
Adult Social Care	24S512	Repurposing of public health grant for employment support in delivery of public health outcomes (resulting in saving for ICU)	-138				Nov Report
Adult Social Care	24S513	SCC Mental Health Team not using NHS Southern Health accommodation		-93	-93	-93	Nov Report
			-3,443	**-4,120**	**-3,173**	**-3,173**	

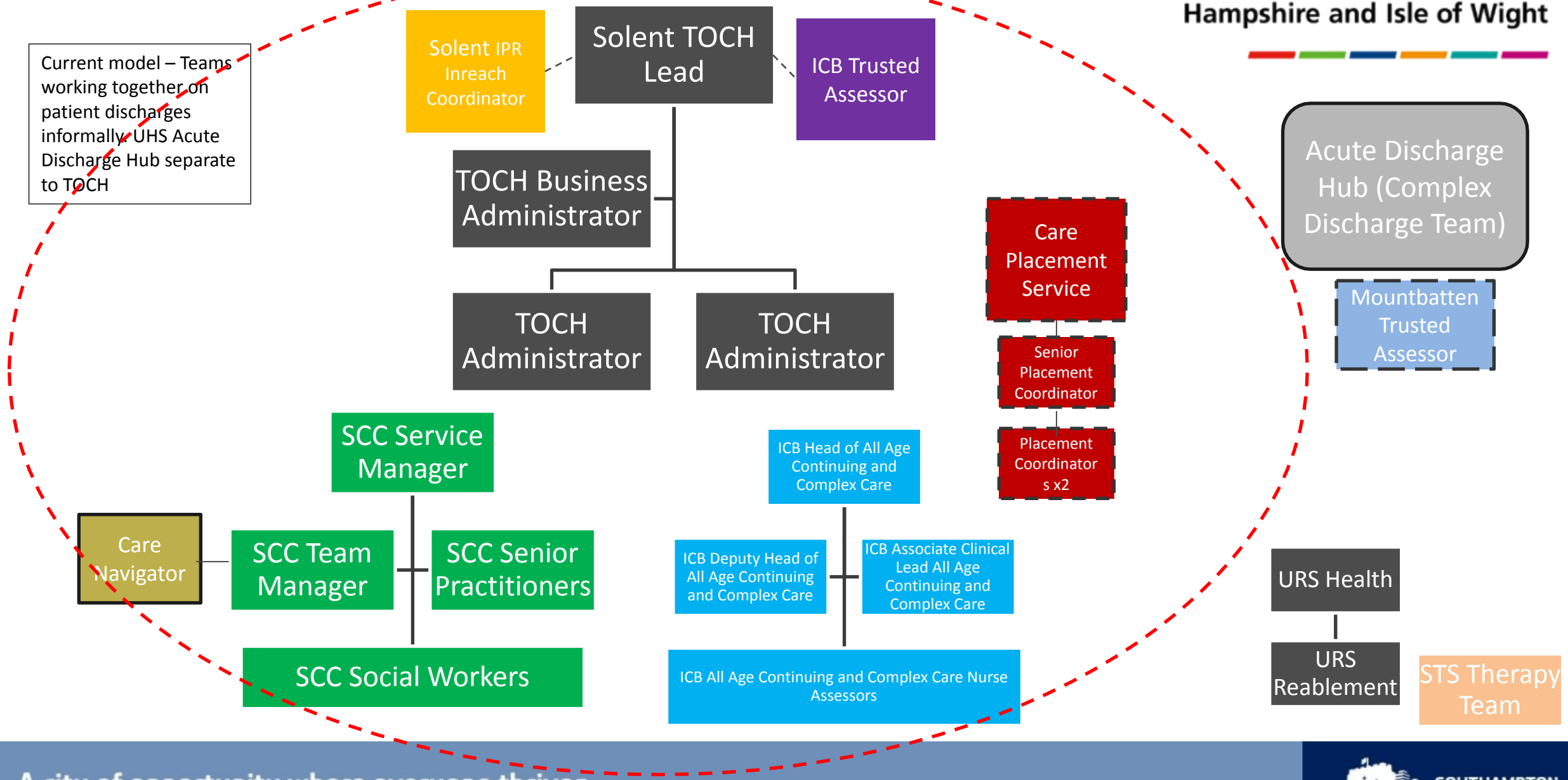
Hospital

UHS and SCC working together to improve hospital discharge

Our Transfer of Care Hub

NHS
Hampshire and Isle of Wight

Current model – Teams working together on patient discharges informally. UHS Acute Discharge Hub separate to TOCH



Southampton – Onward Care Model

as of Nov 23

UHS Southampton
Southampton General Hospital

UHS
Acute Discharge Hub

Transfer of Care Hub
Virtual Multi Disciplinary Teams ASC, reablement, CHC – Mon-Fri (weekends Reablement, Admin, ASC)

Pathway 0

Re-admission avoidance support

- VCSE – Welcome Home & Warm Hubs. Community Navigation.
- Urgent Community Response
- Telemedicine Support to Care Homes
- Virtual Health and Care

**includes 'restarts' of existing care at home*

Pathway 1
Support to recover at home

Capacity type

- Reablement (URS)
- Bridging Home Care Support
- Home Care
- Hospice @ Home

Pathway 2
Rehabilitation or short-term care in a bedded setting.

Capacity type – per month

- RSH Rehab beds (Solent) = 43 beds
- Snowdon Neuro Rehab (Solent) = 14 beds
- Short Term Services Beds = 10
- Mountbatten Hospice beds = 13 beds

Therapy team for Short Term Service
P2 also includes Mental Health beds, Specialist Regional Rehab

Pathway 3

Capacity type

Care Home

**includes 'returns' to care home*

SSWH Discharge Transformation

NHS Hampshire and Isle of Wight

1. Agree Discharge Operating Model and Principles in order to reduce length of stay
Secure cross organisational agreement on discharge principles and model of practice
Deliver a Discharge System Reset with all operational teams involved in complex discharge
Create a rolling way of reinforcing discharge reset key messages. Develop and implement a rolling training programme on complex discharge in place for all UHS and TOCH teams
Develop the model of practice for TOCH Teams and UHS ward teams functioning as an MDT for complex cases - focusing on high referring wards
Regular team building for complex discharge teams to be put in place

2. Reduce nCTR position by remodelling to a proactive discharge system
Confirm the same discharge terminology across HIOW (EDD, MOFD, Discharge Ready, nCTR) and implement this locally
Bolster credibility in the MOFD/nCTR/Discharge Ready date to allow system confidence to move to proactive referrals
Agree Test and Learn model for proactive referrals
Develop Front door processes for early identification of patients and admission avoidance

3. Reduce length of stay by streamlining operational processes and improving information sharing
Implement an editable OCR that is quality assured, with regular OCR reviews post submission
Standardise use of the complex discharge system app in UHS and ensure access to key systems for teams involved in complex discharge
Improve timely information sharing so that discharge teams are working with live information
Review key operational processes and streamline where possible
Agree and implement an operational Escalation Framework for the system, saving potential cancelled discharges

4. Reduce length of stay by optimising flow in short term services provision
Optimise flow in Generic IPR bedded settings and Reablement to ensure capacity is available for hospital discharge
Reduction in bedded STS LOS to 4 weeks through case management and improved processes

5. Transfer Of Care Hubs Transformation to improve efficiency and reduce length of stay
Review the TOCH and Acute Discharge Hub model of working with a view to integrating where appropriate to do so
Develop roles working across TOCHs and ADH where appropriate to do so
Review and maximise Trusted Assessor model
Complete a TOCH benchmarking exercise across HIOW to share good practice

6. Maximise capacity by ensuring patients are on the least restrictive discharge pathway
Maximise Care Navigation resource across the system
Implement a community/hospital Therapy collaborative to develop risk appetites

System Transformation Story so far….

- ✓ Discharge principles and key messages agreed
- ✓ Discharge Reset delivered across the system
- ✓ Proactive referrals - work commenced on Medicine and Older People wards. Focussing on the credibility of the Predicted Discharge Ready Date. Initial cohort is Restarts and Returns across all 6 wards. Target for 50% of patient to be discharged on their MOFD/Discharge Ready Date (current performance 0%)
- ✓ Therapy Collaborative bringing together hospital and community therapists to develop shared risk appetites, therapy shadowing programmes, and models for therapy handover at admission and discharge
- ✓ Transfer of Care Hub benchmarking across HIOW completed
- ✓ Intensive Discharge System Analysis currently underway with UEC colleagues (SSWH version on 'Breaking The Cycle/MADEs) to review day to day operational structures, identify what works well and where there are gaps/further support is needed
- ✓ Patient and carer feedback – consideration of how to build this in discussed in Governance

Discharge Principles

Start on Admission: What's gone before? What's important to the person? Why not discharge today?

Home First: Why not home?

Everyone has a role: How can I help progress the discharge?

Early discharges: How can I line up discharge for the MOFD date? Can I get home the person home for lunch?

Patient involvement throughout: Have you made a decision about the person without them?

Southampton Specific Developments

NHS
Hampshire and Isle of Wight

- Homeless Advice Officer – new role working with patients in UHS, based within the hospital but part of the Street Homeless Prevention Team
- Work on Essential Clean contract with Pest Control
- Introduction of Care Navigation SO:Linked workers within the Hospital Discharge Team
- Single Handed Care Pathway – development of a discharge pathway involving UHS and URS/CIS therapists, and training SCC Reablement staff in single handed care delivery
- Reablement Bridging – use of existing bridging contracts to enable earlier discharge where there is a wait for a Reablement start date
  Development of Reablement community capacity and therapy oversight of reablement cases
- Development of the Transfer of Care Hub (TOCH) – Solent IPR (Inpatient Rehab) and Trusted Assessor roles coming under TOCH oversight
- Development of Community Hospitals discharge support including creation of Discharge Facilitator roles and regular MDT Huddle focusing on discharge progression
  Development of clinical discharge pathways to RSH beds (spinal, ICU)

Further Transformation

- Newton-Europe consultancy to identify further opportunities for cross organisational transformation
- April – May 6 weeks diagnostic analysing evidence from data and stakeholder meetings
- May – June deeper dive with case reviews, benchmarking, national best practice
- July onwards business cases and transformation plans developed and implemented