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Joint Commissioning Board

Thursday, 16th September, 2021 at 9.30 am

PLEASE NOTE TIME OF MEETING

Council Chamber – Civic Centre

This meeting is open to the public

Members

Stephanie Ramsey
Councillor P Baillie
Councillor Fitzhenry
Councillor White
Dr Sarah Young
Suki Sitaram

Please send apologies to:

Emily Chapman, Board Administrator,

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PUBLIC INFORMATION

Role of the Joint Commissioning Board

The Board has been established by the City Council and Clinical Commissioning Group to commission health and social care in the City of Southampton. It will encourage collaborative planning, ensure achievement of strategic objectives and provide assurance to the governing bodies of the partners of the integrated commissioning fund on the progress and outcomes of the work of the integrated commissioning function

Public Representations

Save where an Item has been resolved to be confidential in accordance with the Council's Constitution or the Freedom of Information Act 2000, at the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Benefits from Integrated Commissioning

- Using integrated commissioning to drive provider integration and service innovation.
- Improving the efficiency of commissioned services
- Increasing the effectiveness of commissioning – across the whole of the commissioning cycle.

Smoking policy – the Council and Clinical Commissioning Group operates a no-smoking policy in all of its buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Fire Procedure – in the event of a fire or other emergency an alarm will sound and you will be advised by lofficers what action to take.

Access – access is available for the disabled. Please contact the Support Officer who will help to make any necessary arrangements.

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the Board are contained in the Council's Constitution and the Clinical Commissioning Group Governance Arrangements.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 4 with a minimum of 2 from the City Council and the Clinical Commissioning Group.

Disclosure of Interests

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

AGENDA

Agendas and papers are now available online at
www.southampton.gov.uk/council/meeting-papers

1 WELCOME AND APOLOGIES

2 DECLARATIONS OF INTEREST

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

3 MINUTES OF THE PREVIOUS MEETING/ ACTION TRACKER (Pages 1 - 4)

4 HOSPITAL DISCHARGE OPERATIONAL AND URGENT COMMUNITY RESPONSE MODELS (Pages 5 - 30)

Lead Jamie Schofield / Donna Chapman	**Item for decision**	**Attached**

5 PERFORMANCE REPORT (Pages 31 - 54)

Lead Stephanie Ramsey	**Item For discussion**	**Attached**

Wednesday, 8 September 2021

SOUTHAMPTON CITY COUNCIL

NHS
Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

Meeting Minutes

Joint Commissioning Board – Public

The meeting was held on Thursday 19th August 2021, 09:30 - 10:30
Council Chamber, Civic Centre Southampton

		INITIAL	TITLE	ORG
Present:	Councillor Daniel Fitzhenry	Cllr Fitzhenry	Leader	SCC
	Stephanie Ramsey	SR	Director of Quality and Integration/Managing Director	HSIOW CCG / SCC
	Councillor Ivan White	Cllr White	Cabinet Member – Health and Adult Social Care	SCC
	Councillor Spiros Vassiliou	Cllr Vassiliou	Cabinet Member – Communities, Culture and Heritage	SCC
	Matt Stevens	MS	Lay Member	HSIOW CCG
In attendance:	Donna Chapman	DC	Deputy Director	HSIOW CCG / SCC
	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Keith Petty	KP	Co-ordinating Finance Business Partner	SCC
	Sandy Jerrim	SJ	Senior Commissioning Manager	HSIOW CCG / SCC
	Councillor Sarah Vaughan	Cllr Vaughan	Councillor	SCC
	Angela Murrell (minutes)	AM	Executive PA	HSIOW CCG
Apologies:	Councillor Peter Baillie	Cllr Baillie	Cabinet Member – Children's Social Care	SCC
	Lee Tillyer	LT	Service Development Officer	HSIOW CCG / SCC
	Matthew Richardson	MR	Deputy Director of Quality and Nursing	HSIOW CCG/SCC
	Beccy Willis	BW	Head of Governance	HSIOW CCG
	Dr Sarah Young	SY	Clinical Director	HSIOW CCG
	Maggie MacIsaac	MM	Chief Executive Officer	HSIOW CCG
	Suki Sitaram	SS	Lay Member for Southampton	HSIOW CCG
	Kay Rothwell	KR	Deputy Director for Finance	HSIOW CCG

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted	
2.	**Declarations of Interest**	
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship No declarations were made above those already on the Conflict of Interest register.	
3.	**Minutes of the Previous Meeting/Action Tracker**	
	The minutes from the previous meeting dated 17th June 2021 were agreed as an accurate reflection of the meeting. **Matters Arising** There were no matters arising.	
4.	**Domestic Violence and Sexual Abuse Service Recommissioning**	
	SJ attended the meeting to present the Domestic Violence and Sexual Abuse Service recommissioning proposals. SJ outlined the highlights of the paper. Cllr Fitzhenry asked if the use of SCC properties for procurement was a new approach or something that is done historically. SJ confirmed that it was historical. SJ stated that one of the properties used within the refuge provision is a SCC lease property and the leasing arrangements are being reviewed. Cllr Fitzhenry asked if there is scope to do more with SCC properties commenting that this would give the SCC more flexibility to provide support. SJ confirmed that we will need to await the outcome of the needs assessment to be able to understand what the demand is and where that sits within the national provision of refuge services. Cllr White commented that it should be recognised that this portfolio should be linked into Adult Social Care/ Safeguarding. SJ reported that the new Domestic Abuse Act will be including children. The Board approved the recommendations outlined in the paper.	

5.	**Quality Report**	
	SR presented the quality report to the Board and outlined the highlights of the paper. MS commented that the extra burden on our care providers to put in place the appropriate equipment support for infection control measures is recognised and do the CCG and Local Authority contribute financially to this? Also will the joint assessment team that was put in place in response to the Covid-19 be kept and if so do we have any long term funding in place. SR commented that funding is a challenge but that additional funding was distributed speedily to all eligible providers. Awaiting national guidance on long term financial commitments SR stated that because patients are being discharged slightly earlier due to the changes in the national guidance and due to the impact of Covid there has been a significant increase on demand of equipment not because of more people but due to people having more complex needs. SR commented that there is an efficient system in place for accessing equipment. DC reported that the hospital discharge programmes monies that comes directly from NHS England is approximately £18 million for Hampshire and Isle of Wight of which Southampton's allocation is £2.5 million guaranteed to the end of September 2021. Anticipating receiving the same amount of money for the second part of the year. DC stated that a paper around what the discharge model will look like will be at JCB in September. MS asked if the survival of the joint assessment team rely entirely on funding or is it the way things are structured. DC commented that additional funding was received to be able to implement the joint assessment team and the funding will be necessary for it to continue. Cllr Vassiliou asked what provisions are in place to alleviate some of the challenges around recruitment within the Health Care sector and are there any apprenticeship schemes in place or consideration for bringing in workers from abroad. SR stated that the NHS are exploring ways at how to attract staff from abroad. Cllr White raised that the density of the care homes within Southampton effects the death rates figures.	

	Cllr Fitzhenry asked if the date all care home staff need to be vaccinated is a fixed date of 11/11/2021. SR stated that this is a date that was set nationally and is valid for all Health Care workers in care home setting. Cllr Fitzhenry commented that as a City there is a public health focus on trying to reach the communities that have a lower vaccination take up. Cllr Fitzhenry stated that from an HR perspective as an employer and partner we are prioritising this matter. The Board noted the Quality report.	
6.	**Date of Next Meeting**	
	16th September 2021 09:30 – 10:30	

SOUTHAMPTON CITY COUNCIL ®

Equality and Safety Impact Assessment

The **public sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the council to better understand the potential impact of the budget proposals and consider mitigating action.

Name or Brief Description of Proposal	This document concerns a proposed Integrated Intermediate Care and Hospital Discharge to Assess (D2A) Model for Southampton that meets the national Hospital Discharge Operational Model requirements as per current government guidance most recently updated 5th July 2021. It highlights the current position, illustrating some of the challenges, with a particular focus on the requirement to move from an over dependency on nursing/residential care home beds to discharging more patients home in line with "Home First" principles.
Brief Service Profile (including number of customers)	A primary government assumption at the outset of the COVID-19 crisis was that acute hospital beds would be in high demand and thus the optimisation of flow out of the hospital would be a priority. In March 2020 as part of the Government's response to COVID, legislation was introduced with immediate effect that changed the timescales and approaches associated with hospital discharge focussing on a "Home First Discharge to Assess (D2A) Operational Model". These changes have undergone further adaptation since their initial implementation and are now the expected ongoing Hospital Discharge and Community Support model as set out in the Government's Policy and Operating model published on 5 July 2021. The key features of the Hospital Discharge Operational Model are:- • An Expected Discharge Date should be established at the earliest point possible in a patient's journey to allow for pre-emptive planning and information sharing to take place. • A "Criteria to Reside" has been developed which describes the clinical scenarios in which a patient would require acute inpatient care. If the patient doesn't clinically meet these scenarios when assessed then the expectation is that they should be discharged from the bed on the same day. • Once a patient is ready for discharge they should be discharged

as soon as possible on the same day.

- A patient's home ("Home First") will be the default discharge destination even if intensive support or 24 hour care is required to achieve this.
- "Discharge to Assess" should be the default approach which requires that functional assessment of need and long term care requirements should take place in the community not in a hospital setting.

The Guidance identifies 4 Hospital Discharge Pathways which include expected demand on each:-

Discharge to Assess model – pathways[2]:

- Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home.
- Pathway 1: 45% of people – support to recover at home; able to return home with support from health and/or social care.
- Pathway 2: 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.
- Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

The expectation is that all patients, regardless of their final eligibility for funding, will follow this process and so the community health and social care system is now managing the assessment and care of self-funders in the same way as all other patients/clients from an earlier stage up to the point that their needs and eligibility for support is confirmed.

On average there are 2733 patients discharged from hospital on a monthly basis (based on May/June 2021 data). The Southampton position when aligned with national expectations is:-

- Pathway 0 – 73% (national expectation 50%)
- Pathway 1 – 16% (national expectation 45%)
- Pathway 2 – 7% (national expectation 4%)
- Pathway 3 – 4% (national expectation 1%)

This particularly demonstrates that we need to shift towards supporting more people to return home within the current discharge guidelines undertaking more homebased (D2A) assessments for onward care.

The proposal seeks to increase our community resources associated with our hospital discharge hub, (Single Point of Access (SPOA)) homecare, reablement and therapies to give the opportunity of greater

	support at home whilst simultaneous reducing our bed capacity to shift resources from one provision into another. This will also be supported through national funding designed to support hospital avoidance and discharge.
• **Summary of Impact and Issues**	The new model outlined in the proposal will improve outcomes for both patients and the system as a whole by addressing the following issues:- • Poor or un-timely discharge planning – meaning that patient needs are not always known soon enough, information is poor, thus driving more risk adverse discharge planning. Estimated dates of discharge (EDDs) are not routinely established or communicated and twice daily ward rounds/reviews are not in place on all wards. The lack of pre-discharge planning also means that patients with particular needs e.g. mental health problems, learning disabilities, homeless potentially may not be flagged as needing extra support until the point that they are due to be discharged. • Again linked to the above point when patients remain in hospital longer than is required they risk hospital acquired infection and also deconditioning which makes recovery more difficult. • D2A capacity is heavily focussed on beds – whilst this was partly due to the need to step up a lot of capacity quickly to respond to the new guidance which came out in March 2020 and demanded immediate action, it has meant that the default position has been to discharge patients with more complex needs to a bedded environment as opposed to exploring alternative options. The majority of patients that access a D2A bed stay in residential/nursing home care following their ongoing needs assessment. There could be a range of reasons for this, including that people tend to decondition whilst in a residential/nursing home environment or they get used to the residential/nursing home environment and do not want to leave (in many circumstances people have moved to non D2A beds in the same nursing homes). The primary concern is that people who may, at the point of hospital discharge, have been able to return home with the opportunity to regain independence may not have the chance to do so. • The current Single Point of Access (SPOA) model is only resourced to provide a reactive response –to onward care referrals. The SPOA is currently not constructed in a way that would enable it to call upon wider expertise quickly in a more proactive response to referrals or “pull” patients from hospital; although some resources are aligned with the SPOA others are not so easily accessible e.g. housing, mental health and homelessness support). There is a need to strengthen links with therapy, Mental Health, Continuing Health Care, Housing and Homelessness services, Voluntary Orgs, and Brokerage to ensure that support is proactive and timely particularly for those

	individuals with increased complexity. • Insufficient capacity in the community to provide the level of support and immediacy of response required to support a more Home First model. Currently the Urgent Response Service, Community Independence Teams, End of Life outreach services and the homecare framework are already challenged in meeting the current demand and would need increased resourcing to meet the demands of this model. 24/7 medical cover also isn't available currently. The outcome is again that patients that may have been able to return home and, in some cases regain their independence, have less opportunity to do so due to the availability of resources. In summary the current system isn't proactive and timely, doesn't consistently support people to be on the discharge pathway that they should be, doesn't uniformly support people with particularly complex needs and can be resource driven rather than person centred.
Potential Positive Impacts	The focus of the hospital discharge model is primarily to ensure that people are only in hospital for as long as is absolutely necessary and that when they are discharged every possible effort is made to get them back to their own home environment. The benefits being:- • People who remain in hospital are at increased risk of contracting a hospital acquired infection it is therefore important that they only remain in hospital for as long as is necessary. This proposal seeks to ensure that people are discharged as soon as they are clinically able to do so reducing these risks. • People who are in bed based care be it hospital, residential or nursing home are at increased risk of deconditioning as they are more likely to be sedentary, less confident or aware of their environment, and more likely to be "cared for" and thus likely to do things for themselves. The proposal aims to get people home to an environment that they know and feel comfortable in and then, where possible, seeks to provide the care and therapy required to actively promote optimum levels of independence. • Ensuring that we have multi-disciplinary integrated systems that support people to be on the correct hospital discharge pathway, such as the SPOA, is important as this reduces the risk that people who can be at home with a level of independence will be able to do so. • People with limited or no capacity and/or communication issues, such as those with learning disabilities, mental health needs or autism are better served through earlier involvement from the community so that the appropriate communication and advocacy support can be put in place to support the discharge and ongoing planning. • People with mental health needs such as dementia, learning disabilities for example autism are more likely to function better if their environment, routines and networks are maintained therefore getting people home as priority to support ongoing

	assessment can help decrease ongoing uncertainty and anxiety. • Symptoms can be exacerbated for people with dementia if they are in an environment that is unknown to them therefore getting people out of hospital back to a “home” environment for ongoing assessment can reduce the level of confusion and associated anxiety. • Having a fully functioning SPOA will also increase the opportunity for people with particularly complex needs or lives (e.g. people with LD, MH needs etc) are supported in the hospital discharge process at an early stage maximising their opportunities to return to an optimal level of independence within the community. • For those people that are at the end of their life the proposal would again seek to get people home to die in an environment that they recognise and feel comfortable in and where possible with their belongings and family around them. • Assessing long term care needs in the environment that people live, unlike a hospital setting, is likely to improve the accuracy of those assessments as individuals respond differently in their own homes and the assessors can gauge their needs in a more realistic context. • Homeless people, particularly those discharging to the street, may require planning that involves developing or established community networks. The early planning will support this and will also help to identify those people who require safe appropriate accommodation on discharge from hospital so that they can receive ongoing clinical care which requires early specialist planning. • People who receive early access to therapy and reablement during a recovery period following a hospital admission are more likely to have reduced or negated longer term care needs. Other agencies, such as voluntary sector, can also be engaged to support people which is less likely when planning is less considered and proactive. • If we are concentrating on people going home then the bed based resources can be utilised for those patients that actually need them and currently might be waiting for a bed whilst patients that don’t need them are utilising them. Using the right resources for the right people will improve outcomes for all concerned. • Currently as resource availability changes so rapidly it is difficult to respond to everybody in a uniform manner. Patients with the same needs and circumstance may leave hospital on differing pathways and then have different outcomes depending on the available resources at any one time. This proposal will reduce this risk prioritising home based discharge for all patients.
Responsible Service Manager	

Date	

Approved by Senior Manager	
Signature	
Date	

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	Older people are at increased risk of deconditioning and loss of independence the longer they remain in an unfamiliar bedded environment. People who are confused or who lack capacity, for example people with dementia need to be supported to understand the hospital discharge process and options open to them.	The proposal seeks to ensure that wherever possible people will have their long term needs assessed in their home environment helping them to remain independent. The proposal seeks to ensure that people's needs are identified as early as is possible through pre-planning and having access to expertise that can support communication and advocacy in relation to hospital discharge and ongoing assessment of long term needs
Mental Health	Hospital admission can generally effect people's mental health and further negatively impact on those people that have established mental health needs. People have established routines, medication regimes, networks and dependencies that need to be accounted for together with the potential for impaired communication and decision making capacity.	This proposal focuses on early planning and where appropriate engaging specialist support and known support networks in an effort to ensure that the patient is as involved as possible in the discharge process. Supporting people to return to the place that they came from on discharge, wherever possible, reduces the

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		impact caused by taking people away from familiar surroundings routines and networks.
Disability	People with disabilities and complex health needs are at increased risk of remaining in hospital as finding alternative care can be difficult to source. Communication can be an issue for some people however it is important that people have a full awareness of the options and processes involved related to hospital discharge. People with autism may require extra support with communication and interpretation together with changes in relationships, environment and routines. This can require focus and can be difficult in a busy environment such as a hospital ward.	The proposal seeks to ensure that people's needs are identified as early as is possible through pre-planning and having access to expertise that can support communication and advocacy in relation to hospital discharge and ongoing assessment of long term needs. Early involvement from the community increases the opportunity to engage with people with autism, identifying appropriate support including advocacy or people's own established networks to increase involvement and reduce anxiety and uncertainty. Discharging people with autism back to the environment that they came can reduce the level of uncertainty and further assessment is likely to be more realistic and appropriate if undertaken in a person's own home.
Homelessness	Homeless people are more likely to have complex needs that require early support. It is important that established support networks (e.g. MH services, homeless healthcare, primary care vol orgs), are involved in supporting discharges particularly for those	Early community planning for hospital discharge is important in engaging the appropriate networks to support homeless people once they have been discharged. The proposal seeks to engage this level of involvement at the

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	people discharging to the street. Homeless people requiring onward care following discharge, for example those who have reduced mobility, require ongoing clinical care such as oxygen therapy etc, will require a safe appropriate accommodation to be discharged too can be challenging particularly if the individual has no recourse to public funds or have behaviours that may be challenging in some environments.	earliest point possible. Securing safe appropriate accommodation requires early planning and coordination which forms part of this proposal. There is currently further work underway to develop the proposed pathways to further support homeless people.
Gender Reassignment	No negative impact	
Marriage and Civil Partnership	No negative impact	
Pregnancy and Maternity	No negative impact	
Race	The hospital discharge process requires that patients and their relatives understand the options and the follow on activity in the community. This requires that where there are language barriers that people are given equal opportunity to understand and ask questions.	The proposal seeks to identify people who need extra support e.g. language barriers, at an early stage and source the appropriate support required to risk assess and pre-plan what is required to support a safe discharge.
Religion or Belief	No negative impact	
Sex	No negative impact	
Sexual Orientation	No negative impact	
Community Safety	No negative impact	
Poverty	No negative impact	
Other Significant Impacts		

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DECISION-MAKER:	Joint Commissioning Board			
SUBJECT:	**Hospital Discharge Operational model and Home First Discharge to Assess (D2A)**			
DATE OF DECISION:	**16 September 2021**			
REPORT OF:	**Director of Quality and Integration**			
CONTACT DETAILS				
AUTHOR:	**Name:**	Jamie Schofield	Tel:	N/A
	E-mail:	Jamie.schofield1@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	N/A
	E-mail:	Stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY

This report sets out a proposed Integrated Intermediate Care and Hospital Discharge to Assess (D2A) Model for Southampton that meets the national Hospital Discharge Operational Model requirements as per current government guidance most recently updated 5th July 2021.

It highlights the current position, illustrating some of the challenges, with a particular focus on the requirement to move from an over dependency on nursing/residential care home beds to discharging more patients home in line with “Home First” principles.

Parallel guidance has been published requiring the development of Urgent Community Response services (“step up” hospital avoidance), which also has a bearing on intermediate care provision. Although this is alluded to in this paper further detail will be provided at a later date on hospital avoidance.

RECOMMENDATIONS:

	(i)	Joint Commissioning Board is asked to support the overall direction of travel in relation to the proposed Hospital Discharge Operational Model, in particular the shift towards more care being delivered in people’s homes “Home First” – noting the breadth of change required to achieve this.
	(ii)	Joint Commissioning Board is asked to support the proposal to allocate the available NHS Hospital Discharge Programme (HDP) funds in 2021/22 in line with the proposed Home First Discharge to Assess model.
	(iii)	Joint Commissioning Board is asked to note the annual estimated costs of the proposed Home First Discharge to Assess Model going forward and that there will need to be a decision later in 2021/22, once the financial position regarding NHS Hospital Discharge Planning (HDP) funds beyond March 2022 is known, in relation to how these costs are met within the Southampton Health and Care System. This will be the subject of a separate report.

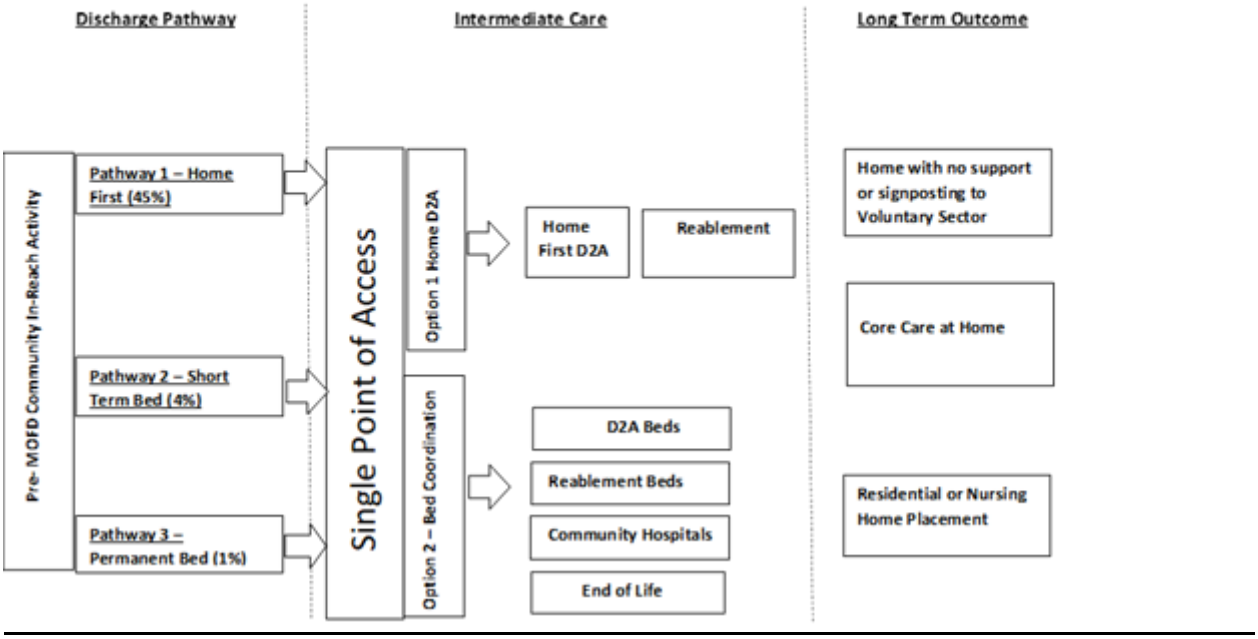
REASONS FOR REPORT RECOMMENDATIONS

1.	A primary government assumption at the outset of the COVID-19 crisis was that acute hospital beds would be in high demand and thus the optimisation of flow out of the hospital would be a priority. In

	March 2020 as part of the Government's response to COVID, legislation was introduced with immediate effect that changed the timescales and approaches associated with hospital discharge focussing on a "Home First Discharge to Assess (D2A) Operational Model". These changes have undergone further adaptation since their initial implementation and are now the expected ongoing Hospital Discharge and Community Support model as set out in the Government's Policy and Operating model published on 5 July 2021.
2.	The key features of the Hospital Discharge Operational Model are:- • An Expected Discharge Date should be established at the earliest point possible in a patient's journey to allow for pre-emptive planning and information sharing to take place. • A "Criteria to Reside" has been developed which describes the clinical scenarios in which a patient would require acute inpatient care. If the patient doesn't clinically meet these scenarios when assessed then the expectation is that they should be discharged from the bed on the same day. • Once a patient is ready for discharge they should be discharged as soon as possible on the same day. • A patient's home ("Home First") will be the default discharge destination even if intensive support or 24 hour care is required to achieve this. • "Discharge to Assess" should be the default approach which requires that functional assessment of need and long term care requirements should take place in the community not in a hospital setting. The expectation is that all patients, regardless of their final eligibility for funding, will follow this process and so the community health and social care system is now managing the assessment and care of self-funders in the same way as all other patients/clients from an earlier stage up to the point that their needs and eligibility for support is confirmed.
3.	In order to support this new discharge policy, the Government introduced a national Hospital Discharge Fund in March 2020 to cover the additional costs to the community health and social care system of supporting hospital discharge. In May 2021, the Government published its finance support and funding flows for 2021/22 which covered discharge funding for the first 6 months of this year as follows: • For the period 1 April – 30 June, eligible costs will be reimbursed from the NHS HDP for the period up to 6 weeks post discharge • For the period 1 July – 30 Sept, eligible costs will be reimbursed from the NHS HDP for the period up to 4 weeks post discharge The funding position for the second 6 months of the year and beyond has not been confirmed but is expected to mirror the first 6 months with continued eligible costs reimbursed for up to 4 weeks post discharge.
4.	In response to the new guidance, Southampton stood up a range of provisions and arrangements to deliver the new discharge requirements. This included: • The Community Discharge Hub which brought together the teams responsible for discharge across the Council (Complex Care and Hospital Discharge Team), CCG (Continuing Health Care Team) and Solent (Urgent Response and Community Independence Teams) to manage the discharge process, including triaging Onward Care Referrals completed by the hospital each day, initiating and overseeing the D2A process, case managing all patients and clients

	as they move through the D2A process, liaising and problem solving with the hospital and community services to maintain flow and capturing data that informs the system. A previous business case for maintaining the Community discharge hub was brought to and approved by the Joint Commissioning Board in April 2021. • A range of additional D2A capacity (over and above the 10 D2A beds the city already had in place under joint funding arrangements) to achieve the aim of assessing all patients, including self-funders, in a community setting. 38 block contract D2A beds are currently commissioned by the CCG from the independent sector. • Additional home care bridging hours to support the Home First principle • Additional spot purchased beds for those patients whose needs cannot be met in the D2A block contracted beds, either because of capacity or their complexity • Therapy support to the D2A process • Additional support to the Community Independence Service • Additional CHC staff to support D2A process • Additional social work staff to support the D2A process • Additional brokerage support
5.	The total costs of this additional provision have been met by the Hospital Discharge Fund. However there was a shortfall of approximately £1M for Southampton (£7.2M for Hampshire, Southampton and Isle of Wight CCG as a whole) between the amounts of funding allocated for the first 6 months of this year and the costs of this capacity.
6.	Whilst Southampton has succeeded in stepping up the additional capacity at pace to respond to the new guidance and has made significant improvements in the length of stay of patients who were previously significantly delayed in hospital (reducing the length of stay by an average of 14 days for those needing nursing home care and by an average of 5 days for those needing rehab and reablement in their own homes), the city has also experienced a number of risks and challenges with the new discharge arrangements, in particular: • **Achieving the 4 week timescale for D2A** which the national discharge fund can be used for – approx. 20% of clients are taking longer than 6 weeks to move on from their D2A placement and the average length of stay in a D2A bed is averaging 41 days (5.8 weeks) as achieving the assessments within current resources is proving challenging. • Delivering the Government expectations around **Home First** – which is that 95% of patients go straight home from hospital. In Southampton the figure is 89%. There is a strong over-reliance on bedded support and it has been estimated that to achieve the 95% expectation, approx. 7 patients a week would need to move from being admitted to a D2A bed to being discharged straight home with the necessary health and care support around them to enable this. This estimate does not account for any additional growth in discharge numbers/demand. • **Increased costs of onward care** which have been shown to be primarily linked to increased levels of complexity but also potentially the over-reliance on D2A beds which could mean that their capacity for reablement and independence is not being maximised. Patients are leaving hospital at a much earlier stage in their recovery than in previous hospital discharge models thus increasing the likely levels of complexity on discharge. The overall demand on community services has increased substantially particularly in relation to increased costs of residential and nursing home packages, “double up” care (both in terms of reablement and

	general homecare), use of equipment and increased therapy. For CHC, numbers of clients were broadly the same between 19/20 and 20/21 but average costs for placements/packages have increased by around 28% in 20/21 (26% increase for both home care and residential; 31% for nursing homes) and for Adult Social Care average unit costs for placements have increased since 19/20 by 20% for residential placements, 21% for nursing home placements and approx. 100% for home care packages. • **Lack of certainty regarding funding** resulting in short term planning
7.	There is therefore a need to both determine a more sustainable model moving forward into the second 6 months of the year and beyond which both complies with the Government's requirements for D2A and Home First and optimises people's independence and provides a positive experience, at the same time as better managing onward care costs.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
8.	The following alternative options have been considered and discarded: • **Do nothing** is not an option for the reasons outlined in Paragraph 6 above. The current over-reliance on bed based care does not meet the Government's expectations of Home First, does not offer best outcomes for local residents and is not sustainable in the long term • **Reverting back to the previous model of discharge** pre Covid where D2A was not the norm and people's long term care needs were assessed whilst still in hospital is also not an option because this would not comply with the Government's Discharge requirements and increased hospitalisation increases rapidity of deterioration and the potential for higher long term care costs.
DETAIL	
	<u>Proposed Hospital Discharge Operational Model</u>
9.	This report proposes a new more sustainable Hospital Discharge model to be implemented during the second half of this year and beyond.
10.	Its key aims are: • To reduce over-reliance on bed based placements with a view to achieving Home First wherever possible • To promote and support people to retain as much independence as possible at the earliest opportunity and maximise their potential for remaining in their own homes • To seek to reduce onward care costs by reducing dependence on bed based and more intensive care wherever possible
11.	The model described in this report aligns with the Home First D2A model being developed for the whole Southampton & South West Hampshire System with colleagues from across Southampton City Council, Commissioning, Hampshire County Council, University Hospital Southampton Trust, Solent NHS Trust and Southern Health Foundation Trust through a series of discussions and a whole system workshop held on 2 July 2021. This vision has also been agreed by the Southampton and South West Hampshire Operational Delivery Group (ODG) in July 2021 and is now in the process of being worked up in detail for both Southampton and Hampshire at place which will include input from the voluntary and community sector, patients and families.

12.	This new model will reflect the national model as outlined in the Hospital Discharge and Community Support: Policy and Operating Model below, which also demonstrates the expected proportion of hospital patients discharged through each of the pathways (45% Pathway 1: Home First; 4% Pathway 2: Short Term Bed and 1% Pathway 3: Permanent Bed) – the expectation being that 50% of patients leave hospital with no support on pathway 0. This new Home First D2A model is shown below. 
13.	Currently Southampton and South West Hampshire are discharging 89% patients straight home on Pathways 0 and 1 (73% and 16% respectively) against a national expectation of 95%, 6-7% into interim beds on Pathway 2 (against a national expectation of 4%) and 4-5% into long term beds on Pathway 3 (against a national expectation of 1%).
14.	The main issues with the current operating model which are driving this over-reliance on bed based discharges and which the new model will seek to address are summarised below: • A need to improve discharge planning – patient needs are not always known soon enough and sometimes there is insufficient information about them, thus driving more risk adverse discharge planning. Estimated dates of discharge (EDDs) are not routinely established or communicated and twice daily ward rounds/reviews are not in place on all wards. The lack of pre-discharge planning also means that patients with particular needs e.g. mental health problems, learning disabilities, homelessness potentially may not be flagged as needing extra support until the point that they are due to be discharged. • D2A capacity which is focussed on beds – whilst this was partly due to the need to step up a lot of capacity quickly to respond to the new guidance which came out in March 2020 and demanded immediate action, it has meant that the default position has been to discharge patients with more complex needs to a bedded environment as opposed to exploring alternative options. The majority of patients that access a D2A bed stay in residential/nursing home care following their D2A assessment. There could be a range of

	reasons for this, including that people tend to decondition whilst in a residential/nursing home environment or they get used to the residential/nursing home environment and do not want to leave (in many circumstances people have moved to non D2A beds in the same nursing homes). • Lack of capacity within the home care market – resulting in difficulties sourcing home care, particularly for people needing two-carer packages and multiple calls a day. The home care market has been under particular pressure in terms of recruiting and retaining workforce whilst other business sectors reopen following the lockdown. • Insufficient capacity in community health and care services to provide the level of support and immediacy of response required to support a more Home First D2A model. Currently the Urgent Response Service, Community Independence Teams, End of Life outreach services and the homecare framework are already challenged in meeting the current demand and would need increased resourcing to meet the demands of this model. 24/7 medical cover also isn't available currently.
15.	The new model will address these current issues by providing: • A stronger focus on earlier discharge planning, at the point of admission and within the first 12 hours: to be led by the hospital supported by In-reach from the community where appropriate (Adult Social Care, housing/homelessness support, Mental health and voluntary sector support) • Strengthened Single Point of Access/Community Discharge Hub with additional Social Work and CHC capacity: to more proactively promote and coordinate pre-discharge planning, receive and rapidly process onward care referrals, in-reach into the hospital as appropriate, rapidly mobilise the appropriate resources required to get people out of hospital and achieve the 4 week D2A timescales. . • Promotion of Home First principles with a strong focus on reablement and promoting independence: ensuring all patients are discharged back to their home whenever this is practicably possible with reablement support to meet their level of need. Once a patient has transferred out of hospital a rapid community assessment should determine the next steps e.g. D2A or CHC assessments, therapy, reablement, no further care required etc. A time limit will be established to support this (e.g. within 48 hours). • More flexible use of interim beds, particularly community hospital beds, to provide interim bed based care when a patient is unable to return straight home. The new model would require fewer interim beds; however those beds that remain will need to be more flexible according to the current needs in the system. This will include a review of the community hospital bed model with a view to managing a greater proportion of rehabilitation patients at home which will release community health beds to be used for direct rehabilitation pathways and for other reasons including higher acuity step down with unresolved social issues. • Strengthened health and care services in the community with the agility to respond quickly and flexibly to greater levels of complexity and acuity in people's own homes at any time of the day 24/7. This will require ready access to Reablement care, Homecare, Therapy, Overnight care, End of Life Care, and 24/7 medical cover.
	Benefits of the Model
16.	The non-financial benefits of the new model are outlined below: • Patient's needs are assessed from a person centred perspective with a view to maintaining

	them at home wherever possible. • Improved information sharing at an earlier stage of the discharge pathway will enable a more accurate understanding of a patient's needs, thereby ensuring that they are discharged to the most appropriate setting. • Long term health and functioning is improved through a greater focus on timely reablement particularly in a home environment that people are accustomed to and feel comfortable in. • A focus on home based care as the default position will reduce the numbers of people unnecessarily placed and subsequently remaining in bed based care. • Greater flexibility in the use of bed based interim care for those who need it will ensure that these resources are utilised more effectively. • There will be improved flow out of hospital as a result of earlier discharge planning, improved information and increased ability to mobilise resources rapidly into people's home across a full week. • Demand and Capacity are coordinated from a single hub - Opportunity to bring data together from system gives a shared version of the "truth". • Stronger Multi-Disciplinary Team approach and system wide ownership of hospital discharge
17.	In terms of financial benefits, there is an expectation that delivery of a Home First D2A model could potentially reduce the long term costs of onward care. The early feedback from areas that are further ahead in implementing the government guidance (Somerset, Swindon) is that getting patients on the right pathway early in their recovery has better outcomes in terms of the provision of long term care. Somerset, who are furthest ahead, audited their 2020/21 (April – April) cases and identified a 14% reduction in long term care packages and a 5% reduction in long term placements against their forecasted activity.
18.	Hampshire County Council undertook some analysis when developing their Home D2A and Single Point of Access business case and were projecting a 5% reduction in long term care costs. These were primarily associated with keeping people mobile in their own homes through timely reablement and therapy at the point of discharge and thus either negating or reducing the need for long term homecare and and/or residential care costs.
.	**Resourcing the New Model**
19.	The table below shows the average monthly discharges by pathway from University Hospital Southampton Trust based on the last two month period (May – June 2021). This is for all patients discharged from the Trust, around 50% of whom will be Southampton residents. The table also shows the percentages being discharged down each pathway and how this compares to the national expectation. It then goes on to calculate the distance from the national expectation in terms of how many patients a month would need to move onto or off each pathway. Focussing on pathway 2, there would be a need to shift approx. 70 patients each month from short term bed based care to support to recover in their own homes. This equates to roughly 2 patients a day and based on Southampton patients making up 50% of the overall numbers would mean 1 patient a day (7 a week) for Southampton.

DISCHARGES BY PATHWAYS - TOTAL DISCHARGES FROM UHS (REGARDLESS OF LOCAL AUTHORITY OR FUNDER)

Sum of Number	Column Labels				
Row Labels	0 - Simple Discharge	1 - Support to Recover at Home	2 - Short Term Bed Based	3 - 24 Hour Nursing Care	Grand Total
Average monthly discharges over last 2 months (May & June)	1992	438	180	123	2733
% Discharges by Pathway	73%	16%	7%	4%	
National Expectation	50%	45%	4%	1%	
Difference between acutal activity & national expectation	**-626**	**792**	**-71**	**-96**	

The table shows that we are above the national guidance on Pathway 0 (73% as opposed to the national expectation of 50%) which we would seek to maintain.

20. In order to resource the new model, there would need to be an increase in home care and wrap around health and care support to enable one additional patient a day (7 a week) with complex needs to return to their own home. Therefore the following additional support would need to be commissioned.

- 296 additional hours of home care a week
- 393 additional hours of night care a week
- 295 additional hours of reablement care a week
- 49 additional hours of therapy a week

Appendix 1. Shows how the Additional Resource was calculated.

21. In addition to the additional home care and wrap around health and care support identified above, it is proposed that the following are also developed to support the Home First approach:

- Voluntary Sector involvement at every stage of the hospital discharge process – including ongoing investment in the Welcome Home Scheme which is delivered by Communicare and has been funded up until now from a one off CCG grant which has now expired
- Additional capacity in the SPOA to support increased numbers of discharges home, increase in-reach into the hospital to pull patients out sooner and achieve the 4 week D2A timescale
    - Social work capacity 3 x wte social workers (these will be temporary appointments whilst funding is short term)
    - 2wte x Band 6 CHC nurses
    - Voluntary Sector – Communicare
- Ongoing increased costs for community equipment on discharge that directly relates to the increased complexity of patients being discharged from hospital will also need to be accounted for within the financial model.

22. <u>Shift in Resources from Bed Based Care</u>

The Southampton system currently has 37 community rehab beds at the Royal South Hants Hospital (average Length of Stay 3 weeks) and 38 D2A interim beds block contracted from the nursing home market (average length of stay 6 weeks), giving a total of 75 beds. Allowing for an optimum occupancy rate of 85%, this would give a capacity level of 64 beds. On top of this block commissioned capacity, we are also spot purchasing interim D2A placements in the care home

market – on average a further 10-25 beds at any one time.

The new model will require fewer D2A beds and it is proposed that the savings achieved from disinvesting in interim care home beds are reinvested in home care and community health and care wrap around support.

Based on the monthly discharges shown in the table at Paragraph 19 (2733 a month), of which approx. 50% will be Southampton City residents (1367 a month or 309 a week), the table below shows the total number of interim beds required with 7% going down pathway two (Short Term bed based care) as per the current model in comparison to the 4% going down Pathway Two as per the national expectation.

Patients on Pathway 2	**Numbers per week**	**Number of beds required based on 4 week LOS**
@7% (current position)	**21**	**84**
@ 4% (national expectation)	**13**	**52**

[*NB. The number of beds required in the above table is based on the national expectation of a 4 week D2A period. Based on the current proportion of patients being discharged on Pathway 2, 84 beds are required at any one time. Given that Southampton is currently block contracting 75 beds, 38 D2A beds from the care home sector and 37 community hospital beds from Solent NHS Trust, this would suggest we are only spot purchasing a further 9. However the number of spot purchased beds is in reality higher than this because the majority of the D2A care home patients are remaining up to 6 weeks in an interim bed*.]

By reducing the proportion of patients discharged on Pathway 2 to 4% as outlined in this report, the number of beds required would reduce to 52, a reduction of 32 beds. Using the average weekly nursing home bed rate of £1,200, this could generate savings of up to £38,400 per week, releasing as much as £1,996,800 per annum.

In practical terms, it would be recommended that most of this reduction is made from ceasing to use spot purchase beds and a smaller proportion from the block contracts, with double running built into the system initially whilst home care support is developed and the new ways of working embedded.

Mobilisation Timetable

23. The aim would be to move towards the Home First D2A model described in this report gradually over the next 12 months to avoid destabilising the current system. Particular care will need to be taken moving into the Autumn and then Winter period when demand is expected to increase and so it is recommended to commence gradually, working with the home care market over the next 6 months to develop capacity and capability, whilst commissioning some additional bridging hours and bolstering the reablement offer, with a view to de-commissioning the surplus bed based capacity and ramping up home care and wrap around community support from March 2022 onwards.

24. This is shown in the table below:

Mobilisation Period	Plan	Comments
Sept 2021 – January 2022	Focus on improving processes with particular focus on first 12 hours and earlier discharge planning Ensure that the data captured is	This would include increasing the level of in-reach into the hospital. Data should reflect the whole pathway including patient outcomes

		meaningful and owned by the system	(not just length of stay (LOS and discharge delays).
		Maintain steady state with D2A capacity going into and over Winter period	Maintaining Steady State D2A is likely to involve continued investment in nursing home care over the winter.
		Work with Home Care sector to begin to develop capability and capacity – support with workforce challenges	Recruitment needs to be continuous – ideally this would be for permanent positions to attract staff.
		Commission some additional bridging capacity	
		Commission some additional reablement capacity	
		Work with Voluntary Sector to scope opportunities to support hospital discharge and ongoing care.	We need to include the voluntary sector in our pathway planning at the earliest opportunity.
	February – June 2022	Decommission surplus bed based capacity	This is dependent on having adequate homecare/reablement therefore agreeing target capacity in line with decommissioning beds.
		There needs to be a continuous effort to shift the culture to focus on "home first" and then ongoing assessment.	A key element of this is ensuring that the community increasingly takes responsibility for determining the patient destination and "get home" requirements.
		Ramp up Home care capacity	Need to ensure that capacity is new and not shifting from elsewhere in the system.
		Ramp up Reablement and wrap around care and support	Continuous rolling programme of recruitment is required.
	July 2022 onwards	Further embed Home First D2A model	
	July 2022 onwards	Review ongoing financial impact on stakeholders, including the potential long term impact on social care, with a view to ensuring that ongoing funding is in place to financially support the new operational model.	

RESOURCE IMPLICATIONS

Revenue

25. The table below provides a comparison of the ongoing annual costs of the new Home First D2A model once fully implemented with the ongoing annual costs of the current predominantly bed based model. This shows that the costs are very similar with the Home first D2A model being only

marginally more expensive (£30.5K).

However this does not take into account the expected benefits of the Home First D2A model in reducing long term care costs through a more strengths based model of D2A – as outlined in Paragraphs 17 and 18.

26. Comparison of Annual Running Costs

Resource	Current bed based model £000	New Home First D2A Model £000	Difference £000	Comment
Spot purchased D2A placements/packages	2,904.0	907.2	(1,996.8)	Reduction in use of beds (see Paragraph 22)
Block contract D2A beds	2,500.2	2,500.2	0	
Brokerage	316.8	150.0	(166.8)	Review of current outsourced approach
SPOA & Assess capacity (CHC/SW)	624.7	989.7	365.0	Additional CHC & SW capacity for inreach and additional D2A assessment work to meet 4 week standard
Home Care D2A capacity	640.5	1,246.3	605.8	Increased capacity to support more complex patients at home
D2A Therapy support	455.0	818.3	363.3	Supporting rehab and reablement in people's own homes
Additional Reablement (incl health and care)	815.0	1,285.0	470.0	Increased reablement in people's own homes
Vol Sector support to D2A	0	90.0	90.0	
Additional equipment to support D2A	0	300.0	300.0	
TOTAL	**8,256.2**	**8,286.7**	**30.5**	

27. During 2020/21 and 2021/22 the Government has allocated additional funding to CCGs for delivery of the hospital discharge arrangements as set out in the national model. This has been outlined in Paragraph 3 of this report. Whilst the actual allocation for 1 October 2021 – 31 March 2022 is yet to be confirmed, the CCG is expecting an allocation of £2,701K for Southampton for this period, mirroring the allocation for the first 6 months of the year. Whilst this allocation was uplifted by NHS England in the first 6 months of the year – by approx. £1M for Southampton (to approx. £3,701K)– in recognition of cost pressures, it is not expected to change for the second 6 months of this year.

In addition the CCG has been allocated additional "Ageing Well funding" for hospital admission avoidance in 2021/22. Some of the increased investment in teams like the Urgent Response Service which provides both step up and step down urgent response and reablement has been badged against this budget - totalling £815k per annum.

Together these two streams make up the budget that is available in 2021/22 and comes to £6,217K (£5,402k HDP plus £815k Ageing Well) for the full year - £3,108.5K for a 6 month period.

The national position on NHS funding for discharge for 2022/23 is as yet unknown.

28. In addition to this, the CCG, in anticipation of a shortfall in 2021/22, transferred a non-recurring budget of £950K to the Council via the Better Care Fund Section 75 Agreement to be used as a one off investment to support delivery of the hospital discharge arrangements. This will support developments in the second 6 months of this year.

29. The table below shows the costs of mobilising the new Home First D2A model during the second 6 months of the year from 1 October – 31 March 2022 alongside the investment available in 2021/22 through the various funding sources outlined in paragraphs 27 and 28. It should be noted that the plan would be to phase in the new model, whilst still maintaining the same level of bed based capacity until the home care and additional wrap around support is fully in place – as per the mobilisation plan in Paragraph 24. This therefore assumes some double running of old and new models until at least February 2022, hence why the costs for this 6 month period are more than 50% of the full year costs shown in Paragraph 26.

	1 Oct 21 – 31 Mar 22 (6 months) **£000**	**Comment**
COSTS (Mobilising new Home First D2A model whilst still maintaining bedded capacity to ensure flow)	4,613.0	Includes most of the bedded capacity currently in place
BUDGET Assumed NHS HDP Budget NHS Ageing Well Budget **Budget Total**	 (2,701.0) (407.5) **(3,108.5)**	
SHORTFALL	1,504.5	
Non Recurring BUDGET CCG NR Hospital discharge transferred fund (in BCF)	 (950.0)	
REMAINING SHORTFALL	**554.5**	

30. The above table shows that for the financial year 2021/22 the majority of the costs are met by the NHS HDP funding and NHS Age Well funding with the £950k non recurrent budget transferred from the CCG into the Better Care Fund to support with any shortfall on the hospital discharge arrangements. This leaves a residual £554.5k shortfall (13.7%) which the CCG is expecting to pick up from additional "Surge investment" for surge cost pressures and slippage in recruitment.

31. The budget position for 2022/23 and beyond is however unclear and guidance on NHS investment is not expected until Quarter 4 of this year at the very earliest. There will therefore need to be further work undertaken later in the year when the future financial position is clearer to confirm how the ongoing annual costs as outlined in Paragraph 26 will be met in future years. This will be the subject of another report.

Property/Other

32. The main property implication relates to the base for the SPOA. The Urgent Response Service is currently working with SCC and Solent Estates Departments to identify a long term collocated base for the SPOA and the intermediate care teams.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

33.

- In March 2020 many assessment and care planning duties that had previously applied to hospital discharge (as laid out in the Care Act 2014) were suspended as a result of the emergency Coronavirus Act 2020 and the Covid 19 Hospital Discharge Service Requirements.
- From 1st September 2020 the "Hospital Discharge: policy and operating model2 has been in place setting out mandatory "Discharge to Assess" (D2A) that must be followed by Health and Social Services
- July 5th 2020 the "Hospital Discharge: policy and operating model" was further updated.

Other Legal Implications:

34. NOT APPLICABLE

CONFLICT OF INTEREST IMPLICATIOINS

35. NOT APPLICABLE

RISK MANAGEMENT IMPLICATIONS

36. Learning from other areas and based on local intelligence, the table below sets out the key risks and challenges along with plans that would be put in place to mitigate them:

Key Risks and Challenges	Plans for Mitigation
Unanticipated increases in demand/surge at a time when the model is being implemented could outstrip the capacity.	Implement the new model gradually, ramping up from Spring 2022 onwards. Some "double running" along with closely monitoring and forecasting demand will help to ensure we don't decommission bed based capacity until we are confident that we have the required level of homecare and support in place to meet the demand.
Continued failure to turn D2A assessments around within 4 weeks resulting in cost pressures above those we have anticipated within our HDP spend.	Strengthening the SPOA to undertake CHC and social work assessments with the 4 week timescale.
Recruiting homecare, reablement and therapy staff is difficult in the current market therefore sourcing the necessary resources to progress the new model is challenging.	Gradually implementing the new model from Spring 2022 onwards and ensuring we don't decommission bed capacity until we have the appropriate support in place. Ensuring that we have recruitment and retention processes in place that attract and retain care and therapy staff which would include:- • Rolling recruitment drives • Recruiting reablement and therapy staff

	on permanent contracts • Supporting the homecare market through access to training and support, engagement in strategic development including helping to design flexible and sustainable commissioning arrangements and access to information and communication forums.
Unless systems are in place for community staff to prioritise and identify potential "home first" patients at an early stage suitable patient planning won't have taken place and patients will still continue to be discharged to D2A beds by default resulting in continued use of spot purchase beds at the same level alongside increased investment in home based care.	There is a work stream in place, led by UHS, that is looking to ensure that all patients have an EDD in place to support appropriate pre-planning. Having community staff in-reaching into the hospital will also allow for more proactive planning identifying those patients requiring extra support at an early stage and also ensuring that patients are on the correct hospital discharge pathway wherever possible focussing on a return home.
It is important that performance is measured not just in terms of numbers of discharges or length of stay but also in terms of outcomes. Unless this is measured effectively the effect of shifting focus, in terms of early discharge, increased early community activity and the concentration on keeping people in their own homes the full impact won't be understood	Shared data systems will be developed that equally capture whole system demand, capacity and outcome.

POLICY FRAMEWORK IMPLICATIONS

37. This proposal reflects national hospital discharge guidance (updated on 5th July 2021) and key principles associated with Better Care and the Southampton Health and Care Strategy by:-

- promoting person centred/strength based interventions that support people to remain be independent
- greater joined up whole person care
- proactive planning and intervention
- reducing permanent inappropriate admission to residential care
- ensuring people receive reablement care following discharge
- reducing unnecessary hospital delay

KEY DECISION?	**YES**
WARDS/COMMUNITIES AFFECTED:	**ALL**
SUPPORTING DOCUMENTATION	

Appendices	
38.	1. Calculating the additional Resource Requirements

Documents In Members' Rooms

39.	N/A	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**YES**
Privacy Impact Assessment –		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		**NO**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)		
40.	N/A	

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2021/22 Integrated Commissioning Unit (ICU): Monthly Summary Performance Report

Month: Q1 21/22

1. ICU Summary

a. Achieving Transformation Change

Significant work is underway in a range of areas. This includes a number of recent, active or planned procurements including Improving Access to Psychological Therapies which has now been concluded and is at the stage of confirming the provider, Housing Related Support and Domestic Violence services which will be going out later this year and the Mental Health Network and Service User Network which has been recently awarded to a collaboration led by Comunicare. The ICU also continues to work with partners across Hampshire and Isle of Wight to collaborate on joint procurements where this delivers best value for our local population - e.g. working with the OPCC to procure Sexual Abuse Services and with the rest of Hampshire, Portsmouth and Isle of Wight for Bereavement Support Services. Other key headline areas of work for this Quarter have been:

- Supporting the Scrutiny Inquiry and development of a new Carers Strategy - the ICU has facilitated much of this work, co-producing the strategy with carers and a range of partners - due to go to Cabinet this Autumn
- Applying for and mobilising grants which have brought considerable additional investment into the city - particular areas this quarter have included Rough Sleepers Initiative, support for Rough Sleepers with Mental health problems and Rough Sleepers with Substance Misuse problems and Substance Misuse support for people in the Criminal Justice System
- Progressing the Learning Disability housing project to support more people with learning disabilities access more appropriate housing solutions which promote their independence
- Continued development of the Mental Health Teams in Schools initiative, with the second two teams now taking their first referrals
- Supporting the Children's Destination 22 programme, including co-developing the Early Help locality offer, reviewing early intervention support for children with SEND and reviewing CAMHS provision to support a more locality based preventative model
- Securing recurring funding for the Discharge Single Point of Access and now beginning to consider development of the Single point of access model moving forward, encompassing both step down and step up pathways of support
- Continued development of the hospital discharge model, working in partnership with colleagues from the wider Southampton and SW Hampshire area, as well as exploring options for a more "home first" Discharge to Assess model - proposals being prepared for JCB in September
- ongoing development of integrated care teams, continuing to develop and evaluate the initial two pilots with the Living Well Partnership and West Southampton Primary Care networks and planning a workshop to engage the other East PCNs

b. Procurement and market management

All planned procurements are progressing in accord with procurement project plans. The market management and development segment of the ICU work plan is progressing well overall, however, substantial risks remain regarding the sustainability of the local care market. The new home care framework has increased capacity and additional hours are purchased from a 'retainer service' which provides rapid access and responds to peak need. The local market has responded favourably to growth in demand, with sustained and substantial growth in the number of hours per week of home care that is being purchased over the last 18 months. 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. The new framework allows an annual re-opening to encourage new entrants to the market and ensure any potential loss in capacity is mitigated. The establishment of 'lead provider' roles across the 5 areas in the city and provides a platform for further developmental work and sustainability in the city. These lead organisations are in a position of relative strength with both capacity and recruitment to take on additional packages of care, though recruitment remains insufficient to meet demand and waiting list numbers are increasing as a result. Winter planning is underway, and the retainer service is being transferred to an alternative provider to secure better performance and value, and manage the conflict of interest risk associated with the current provider being successful in their bid to be the lead provider for 2 city clusters. 'Right to work' issues are being investigated and managed through safeguarding and provider failure processes. Part time workforce commissioning lead appointed to support with independent sector recruitment and retention efforts. Capacity Tracker and provider survey being used to identify providers at risk from staff vaccination mandate to enable targeted support to be provided. Cost of care exercise underway to support 2021-22 budget planning.

c. Quality

Currently across Southampton social care providers in the care home and home care market are considered overall to be providing good care. The Care Quality Commission continues to undertake focused inspections based on an assessment of risk and local intelligence with the option of carrying out a comprehensive inspection as necessary.
Over the past months, several home care providers have de-registered from the market whilst others have been established and are awaiting Care Quality Commission inspection. The Integrated Commissioning Unit has ratified a process to safely manage quality assurance of off framework providers so that they can be safely commissioned under spot purchase contract arrangements.

The Integrated Commissioning Unit has been proactively supporting the care home and home care sector throughout the pandemic. The bi-weekly video conferencing sessions run by the Quality and Safeguarding and Infection Prevention and Control team continue and have been adapted to include training sessions on a range of relevant topics and engaging speakers from outside of the area.

The Digital Care Team are currently working to roll out RESTORE2 digital to residential and nursing homes, an initiative shown to help carers to identify when a resident may be becoming unwell and to access timely intervention with a view to preventing unnecessary escalation/transfer and improving quality of life. The scheme has also been shown to significantly improve carer confidence and role satisfaction levels, key elements of retaining a highly training, stable and motivated workforce.

The ICU has been working with care homes and partners like the Hampshire Care Association and UHSFT to promote vaccination ahead of the introduction of mandatory vaccination and to answer questions and provide reliable information. Southampton's vaccination rate for first doses in care home staff has improved at end August although Southampton remains below the national comparators in this measure. For second doses, improvements have been made against comparator Local Authorities (rank 8 out of 16 (4 better than reported 2 weeks ago), 0.1% higher (better than) the Comparator Average of 79.2%). However, Southampton remains 3.1% lower (79.3%) than the England average of 82.4% for all Local Authorities (first dose) although the ranking has improved to 109 out of 151 (31 better than reported 2 weeks prior). All ICU/CCG teams facing care homes with staff who require double vaccination in order to gain entry are reviewing their business continuity and resilience arrangements.

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
A. Project Milestone Monitoring: Integration						
1. Rehab and Reablement and timely hospital discharge	Jamie Schofield		G	**Community Single Point of Access** Agreement reached at Joint Commissioning Board in April to fund the additional costs of the Discharge Single Point of Access (SPOA) model for Southampton on a recurring basis. The next step is to consider the long term vision for a Community Single point of access which brings together the hospital discharge functions and urgent community response and reablement care. This will require substantial development of intermediate care, streamlining the hospital discharge pathways out of UHS, ensuring that the SPOA is responsive and ensuring that we have the mechanisms and capacity to respond at speed in supporting people to go back to their own homes on discharge for further assessment or support people to remain in their own homes. We currently have an initial draft model structure which needs sharing and ratifying over the next month. it will also need to take account of wider conversations across the Southampton & South West Hampshire (SSWH) system on the discharge model. **7 Day Working – Hospital Discharge** 7 Day working continues to be a challenge and is dependent on whole system change. Next steps to be informed by conversations across the SSWH system on the future discharge model - workshop planned for 2 July. Aiming to have proposals in draft by 20 July which will inform future work on development of 7 day working **Discharge to Assess** Work is underway to develop a more "home first" model of Discharge to Access (D2A) going forward, taking stock of what had been implemented rapidly in response to the Covid pandemic, how we can support the majority of people going forward to return home (in line with the Government expectations for Pathway One) and the need to improve independence and long term onward care outcomes. Discussions have taken place with the LGA and other Local Authorities who have implemented a more home first model to inform local thinking. Wider conversations across the SSWH system on the discharge model will also help to inform the model. On track to present proposals to Joint Commissioning Board in September. **Specialist Rehabilitation Review** We are looking to develop a business case that gives Southampton the opportunity to utilise the Hampshire Acquired Brain Injury (ABI) Teams skills and buy into their established specialist provider framework.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Hospital Discharge – homeless and housing Paper under development looking at a homeless pathway and potential for interim/bridging beds.		
2. Shape & support new models of care (One Team Development)	Moraig Forrest-Charde		G	**Support the development of integrated care teams** Work with community providers and Primary Care Networks (PCNs) to identify next steps in one team development continues to build on the two pilot areas - Living Well Partnership (East) and West. Workshop for the East planned to promote this further and identify the next steps. **Personalised Care Models** Early focus on - S117 aftercare Personal Health Budgets (PHBs) through the development of service user and project group with early design work underway. Stock take of implementation of the personalised care model is underway and expected to take 3 months to complete. Refreshing the work undertaken ahead of the pandemic and informing performance reporting at place and HIOW level.	Jun-21	
3. Enhanced health support in care homes (EHCH)	Jamie Schofield		G	**Roll out of EHCH model in partnership with PCNs** Still meeting with the PCN's regularly with a view to establishing a uniform model across the City. The Contract with Southampton Primary Care Limited (SPCL) has been extended to April 2022.	Jun-21	
4. Adult mental health	Amanda Luker		G	**Perinatal Mental Health** Quarterly meetings continue to discuss access and transformation plan and investment. **Adult Common Mental Illnesses (IAPT)** Service continues on trajectory to meet access targets alongside providing developing Covid-19 specific treatment. Service is actively managing high levels of referrals and acuity and is engaged with No Wrong Door approach to community mental health transformation in the city. Step 3.5 groups operational. **Adult Common Mental Illnesses (IAPT) Procurement** Tender issued in March 2021, but paused to take account of emerging HSIOW CCG. Tender re-commenced June 2021, with evaluation due to take place in August/September 2021.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Adult Severe mental illness (SMI) community care Progression through dedicated Southampton City Mental Health Partnership Board, with collaboration between CCG, PCNs, Providers (SHFT, DHUFT - IAPT) and Voluntary, Community and Social Enterprise (VSCE), some recruitment of new Enhanced Primary care Mental Health roles completed. 'Cope Comprehend and Connect' model discussions with PCNs, a model that provides formulation-driven goal-based activities through assessment, emotion focussed formulation and group/individual based intervention. **Comprehensive physical health checks** Progress underway is in line with milestones **Individual Placement Support** Individual Placement Support Team continue to work towards Centre of Excellence status, with assessment due in Qtr. 4 2021/22. **Rehabilitation and Reablement** This work has not yet started, timescales yet to be agreed **Personality disorder** Secondary care personality disorder pathway transformation work underway **Bereavement Support Services** Tender in development for Bereavement by suicide support service across Hampshire and the Isle of Wight. **Housing for people with severe mental illnesses (SMI)** Market Management Team continue to work on Needs Assessment with final document expected Autumn 2021. **Mental Health Network and Service User Network** Service has commenced and is working towards key outcomes to support Southampton becoming a Mental Health Friendly City. **Rough sleeping mental health support** Implementation of the agreed model/workforce delayed, but good progress is now being made with recruitment of new roles due to commence **ADHD CYP** Progress underway is in line with milestones **Dementia diagnosis – pre/post diagnosis support** Progress underway is line with milestones		

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Impact of Covid 19 Being led by Hampshire Southampton and Isle of Wight CCG. All age Mental Health Needs Assessment commissioned to report on prevalence and inequalities of Mental Health conditions and Mental Health wellbeing with a particular emphasis on specific at-risk groups whose mental health and wellbeing has been affected disproportionality by COVID-19.		
5.Child and Adolescent Mental Health Services (CAMHS) transformation	Phil Lovegrove		G	**Mental Health Support Teams (MHST)** The MHSTs are now fully recruited to, Study has been fully virtual since COVID. Wave 2 teams are in the process of submitting their cases for graduation. Wave 4 teams have now commenced accepting referrals - based on their study programme. Timescales are still on track aligned to NHS England and Southampton University timetable **Mental Health Services Data Set (MHSDS)** Delayed due to COVID **Early Intervention** A draft proposal has been written - this is aligned to the City Council's Destination 22 programme - and comprises 3 clinical leads from CAMHS to be attached to the locality teams (one for each locality). This outreach model was agreed in principle as the preferred option at the Destination 22 Board on 25 June. Next steps are to better understand the interface between the Early Help locality teams and school based team, particularly Mental Health Support Teams in Schools. Also to develop a costed business case for the outreach model, including additional resource within the Building Resilience and Strength (BRS) service to better manage crisis and therapeutic workloads.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Care for the most vulnerable and reducing health inequalities Work not due to commence until October 2021 - however discussions have re-started within the Integrated Care System (ICS) regarding the need for a short term assessment unit/safe space for young people with a combination of complex social and mental health presenting in crisis. Link between these discussions and the development of short term residential children's home provision in Southampton is currently being explored - potential for co-location - and will conclude over the coming weeks. In addition review of the BRS has also identified a need to bolster the crisis offer - this will be included within the above business case **Eating Disorders** Shared Care Protocol is still going through Solent's Clinical Governance. An eating disorders tutorial is being delivered to GP's on the 29th June and will be recorded for the webinar. NHS England are supporting this work stream by helping to map need across the ICS footprint. A working group including commissioners, providers and other stakeholders across the ICS is meeting regularly to progress the Avoidant Restrictive food intake disorder (ARFID) work stream. **Improving crisis care** Closer to Home team launch has been delayed until late Summer/early Autumn Acute Psychiatric Liaison team has now been recruited to and due to commence in July/August **Improving the transition to adulthood** Work continues with HIOW around the 0-25 offer **Improving the neurodevelopment mental offer** Task and Finish Groups in place Funding secured for Outsourcing of Autism Assessments. 50 have been outsourced to date and a procurement exercise for remainder is in progress. Invest to Save proposal for an enhanced Early intervention offer in SEND including the support offer for families at the "Getting help" and "Getting more help" levels to be presented to MACB by end August **Local Transformation Plan (LTP) Refresh** Draft Plan written		

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
6.Crisis care	Amanda Luker		G	**Crisis resolution** Progress underway is line with milestones **The Lighthouse** Work underway with results from patient survey being used to develop the 2 site offer within the city (West already in place, additional site on the East) **Southampton Enhanced Partnership Worker** Funding secured for continuation of role for further 12 months **Core Mental Health Liaison Services 24/7** Work underway with UHS and SHFT to develop model to meet acute hospital and patient need	Jun-21	
7.Domestic Violence	Sandy Jerrim		A	Developing commissioning intentions for Domestic Abuse (DA) service in Southampton is progressing well. Aligning the work with the requirements of the new DA Act continues and impacting on completing the final papers. With national consultation planned around the new DA Act it is envisaged local commissioning intentions will include scope to expand contract(s) to accommodate expansions or new service developments identified through the needs assessment.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
8.Transforming care for people with learning disabilities	Kate Dench		G	**Southern Health service review** 5 workshops have taken place to support the development of the core functions in the services. Work with Hants LAT is progressing to meet the end date. Finance investment process lacks clarity. Learning Disability Transformation Manager has not been approved, however, increased capacity linked to Community & Social Inclusion (which will bring benefit to working in integrated ways) is being further explored **Respite** Draft monthly monitoring tracker of demand vs activity on all 3 respite schemes in place - meeting with respite providers 22nd June to review **LD housing** Monthly project group established - confirmation required of Senior Governance arrangements. The Project Approach document is being reviewed jointly with operations, who are leading what operational resource requirements are needed. Deregistrations continuing with draft report for DMT expected in July/August with a view to transfer to Supported Living in the following quarter post approval. In addition, providers are coming forward with new deregistration opportunities that we are scoping jointly with HCC due to shared commissioning arrangements. New housings are schemes in development/and build phases that will afford us the option to repurpose 1/2 and 3 bed properties that are no longer fit for purpose (environmental work is taking place with providers) and inefficient in terms of care delivery. Further RP/developer routes being explored. Voids management work is now demonstrating a decrease in spend, in addition officers are working to develop a Voids Minimisation Policy that will further impact this work. Savings verified (P2) show 91k achieved to date, with robust plans in place to meet the budget proposal requirement for 21/22. **Learning Disabilities and Autism (LDA) Delivery Plan** Approval given for resourcing the Hants central operational team - meeting set up for 13th July to ensure Sotons workforce gain the benefit of skills development through this work as well as ensuring contract monitoring is robust. Revision of some key elements within the JSNA to support wider understanding of potential future need has taken place. Work currently in train with the Data Team to track Learning Disability (LD) trend data (draft LD caseload/provider monitoring established).	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Learning Disability (LD) Integration This area will need review based on LD moving to a localities model, as well as One Team opportunities. **Learning Disability Quality Improvement (QI)** A workplan to support the LD QI is currently being developed jointly with SHFT and Primary Care Commissioners to improve access and uptake of Annual Health Checks, health action plans and flu vaccinations **Autism** Service review of Autism Support Service delivered by Autism Hampshire complete. **Community and Social Inclusion** Vision developed and work commenced on scoping key elements of the new model. Agreement in principle for additional capacity of Service Development Officers working across commissioning and localities established for 2 out of the 3 localities (current work is developing role/function) to support wider project milestones. Delay in obtaining additional capacity may impact on milestones. Provider workshop taking place 12th July, with day service providers to explore the model.		
9.Aids to Independence	Rachel Burden		A	**Development and Reprocurement of Wheelchair Service** New service is in place and commenced in April 2021 **Wheelchair and Repair Service** The launch of the new service has gone well. The clinical lead for the service has now been appointed and clinical work plans have been reviewed and are now in place. The service is fully staffed. New Community Engagement Officer also appointed Waiting times especially for children are still a concern but Millbrook is engaged in this process and they are decreasing month on month. There are concerns around equipment delays due to EU Brexit conditions, complexity of the equipment being ordered via a limited number of suppliers. **Implementation of the Disabled Facilities Grants (DFG) Review** Following agreement at Joint Commissioning Board, a DFG Project Lead has been identified and is setting up the project groups in relation to Workstream 1 which is focussed on transforming the systems and processes. Workstream 2 in relation to utilising the underspend has been established and is currently being tested. This is being managed through the Better Care Finance Group	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
10.Addressing the needs of high intensity users (HIUs)	Georgina Cunningham		G	**Persistent Physical Symptoms (PPS) Service** PPS Evaluation completed demonstrating good outcomes for patients and a 60% reduction in Emergency Department (ED) attendances and a 65% reduction in Non Elective admissions for the group of patients supported by the service. The report has been shared with senior management. Consideration is being given to build on the model to include UHS High Intensity User (HIU) Group proposal for a dedicated Clinical ED based HIU lead, supported by the HIU Co-ordinator to further improve support for this complex group of patients. **Two Saints Intensive Support Programme** Two Saints Intensive Support Programme continues to engage with wider health and social care agencies to share best practice and learning from the intensive support provided by the team. **High Intensity Users (HIU) Clinical Lead Oversight** Work has been ongoing on developing the overall oversight of the High Intensity User programme and a proposal has been put forward for additional clinical sessions to work alongside the co-ordinator liaising with Emergency Department (ED) staff and other clinicians to strengthen clinical leadership to the project. This has been fed into the Southampton & SW Hampshire Recovery and Restoration Board as part of the overall prioritisation exercise for future funding.	Jun-21	
11. Improving the outcomes for children with SEND	Sam Nicolaou		G	**Reimagining the Special educational needs and disabilities (SEND) offer** A draft Cost to Save Proposal has been developed which outlines the proposals for a Continuum of Early Intervention Support for Children/YP with SEND. It has been presented to SEND Partnership Forum for information and feedback. Refinements are being made to the model and the invest to save elements are being worked out.	Jun-21	
12.Personal health budgets (PHBs)	Leela Hunt		G	**Section 117 (mental health)** This whole area has been delayed with the Covid response. The project group has since met and reset of the plan is underway.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
13.End of life and complex care	Moraig Forrest-Charde		G	**Out of Hospital End of Life (EOL) Care Coordination** Significant progress has been made in the early part of this year with the EOL out of hospital coordination centre opening - including a 24/7 telephone response line and crisis visiting service. **Develop and enhance hospice provision** The first stage of providing bereavement support for services outside of Countess Mountbatten House will start with the aid of Improved Better Care Fund (iBCF) funding for social care provider bereavement support. Nurse led beds is in the early stages of development. **Early Identification** Project due to commence in October **Personalisation** Project due to commence in October **Education** Plan to pick up findings shared through the ICS driven piece of work to understand the 6 ambitions self assessment.	Jun-21	
14. Substance Use Disorders	Amanda Luker		G	**Rough Sleeping Drug and Alcohol Treatment Grant** The Rough Sleeper Drug and alcohol team has commenced work from 24.6.21. The team has some key posts still to recruit to (i.e. Nurse Prescriber) but this is currently underway and mitigation if recruitment is unsuccessful (agency) is planned for. An implementation plan has been shared and discussed with commissioners. A multi-agency strategic steering group and an Operational group are in place and will be overseeing the implementation of the new service. KPI's have been finalised and monitoring of the team is already underway. There has been no announcement regarding continuation of funding to date. **Substance Use Disorder within the Criminal Justice System** Bid for funding successful and recruitment of team is underway. Work is taking place with partners and stakeholders to develop specialist criminal justice interventions. **South Central Ambulance Service (SCAS) Pathway Development** Project due to commence in September 21 **Substance Use Disorder (SUD) Services: Impact of Covid 19** Commissioners are working with SUDS providers to develop and implement service recovery plans	Jul-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Alcohol Care Team and InReach NHS England and NHS Improvement (NHSEI) money is being implemented to achieve a 7 day a week service. **Substance Use Disorder Services (SUDS)** Work with adult and YP SUDS providers is underway to analyse Covid 19 impact on access and recovery standards. Services are re-opening following the gradual lifting of lockdown and performance issues are being addressed by commissioners with provider services. **Alcohol Brief Intervention Telephone Line** Alcohol Brief Intervention telephone line has been reviewed and funding is agreed and in place until March 22. **Co-occurring Conditions (Mental Health and Substance Use Disorder)** Pathway development and integrated working between substance use disorder services and mental health services is being led by the strategic steering group. Self assessment of services is still underway with a view to completing the improvement action plan in the autumn.		

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
B. Project Milestone Monitoring: Prevention & Earlier Intervention						
15. Community Solutions	Adrian Littlemore		G	**Embedding Community Solutions Contract** Continuing to work with the provider on a range of initiatives / elements within the contract, including development of Community Navigation network which brings together community navigators from across the city, local community conversations around specific areas of need, including supporting the Children's Destination 22 agenda to develop Early Help for families. Review of Community Navigation capacity underway with a view to shift resources into Volunteer Bureau functions. SO:Good Giving launched offering Local Lotto and Crowd Funding Platform. The Home Welcome and Hello Southampton Communicare schemes are currently being reviewed for ongoing funding - funding source needs to be identified. **Carers** Work to commence in Q2	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Partnerships Commissioning engagement within the Stronger Communities work established. **Development of Living Well activities offer** Service recovering from impacts of pandemic. 50% of service costs comes from self funders, all of which have ceased attending. Adjustment to payment structure proposed and authorised to promote sustainable delivery. Initial discussions with living well service and other related parties regarding development of activity scheme in June. **Development of Eat Well Offer** Increased volume of users are accessing the service since pandemic **Development of integrated community transport solution** Joint work with SCC Transport Team underway to scope joint commissioning options **Development of Exercise offer** Work to commence in Q3 **Promoting the use of telecare for people at risk of falling** Work planned for later in the year. **Fracture Liaison Pathway** Timescales to be confirmed		
16. Maternity	Jeanette Keyte		G	**Development of Smoking in pregnancy pathway** Southampton Smokefree Solutions in place **Development of LARC pathway in maternity** Draft proposal has been developed. Ongoing discussions with Maternity regarding implementation and funding **Develop and monitor plans to support actions from the Ockenden review** Baseline review of Ockenden recommendations in place - action plan developed **Support service in continued roll out and embedding of continuity of carer** Continuity of carer embedded into UHS/Local Maternity System (LMS) plans	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
17. Sexual health & teenage pregnancy	Sandy Jerrim		A	**Implementation of the sexual health improvement programme** Sexual health Improvement plan agreed and being monitored. A new dashboard is being developed to support monitoring. The L3 contract with Solent has approval to extend for 2 x + 1 years, but subject to agreement from Solent to conditions around the use of Pathway Analytics and System Thinking work. Discussions are led by Director of Public Health (DPH) in HCC with input from DPH's in Southampton & Portsmouth and commissioners.	Jun-21	
18. Prevention and early help for children and families	Jeanette Keyte		G	**Breastfeeding support re-procurement** Currently consulting on revised service specifications. Specification will be finalised by end of June with a view to tendering shortly after for new contract from 1 April 2022 **Early Help review including development of Extended Locality Model** Early Help Review is part of the wider Destination 22 Programme. Working towards proposals and deliverables developed in workshops over Spring. Early help assessment forms modified, case allocation process under review, evidence based programme in development, outcomes and evaluation processes being developed. Job profiles for parenting lead and No Recourse to Public Funds (NPRF) worker developed **Support the development of Family Group conferencing (FGC)** Options appraisal for future commissioning intentions completed with children's services and under consideration. Being presented to the Children's Strategic Commissioning Exchange and Contract Life Cycle Management Committee (CLCMC) in July 2021. Strategic aim is to work towards embedding FGCs into social work practice, with support/training/advice from a commissioned provider - this is a shift from the current position where FGCs are purchased via a contract. The options appraisal considers the best way of achieving this from a contractual perspective.	Jun-21	
19. Supporting Children and Young People with complex needs	Jeanette Keyte		A	**Develop a pilot model of community support for adolescents with complex needs, including** Project plan in place, key partners on board. Three 12m fixed term roles currently out to internal recruitment. Project delayed due to delayed funding allocation and recruitment, now planned to start by September 2021 **Children's Hospital at Home / supporting children in the community** South West Restoration & Recovery requirement for specified changes complete - returns to Restoration & Recovery on 22 June for decision on options provided	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Development of end of life provision Met recently with commissioners and service provider colleagues from the region to benchmark services. Plan to set up a managed clinical network across the ICS which will further outline activity required. **Supporting vulnerable young people** In progress as part of Destination 22 Programme		
20. Housing related support (HRS)	Sandy Jerrim		G	**Develop commissioning intentions for Adult and YP Housing related support (HRS) Services** An in-depth review undertaken and informing the development of commissioning intentions for single adults, young people and young parents HRS service. **Rough sleeper initiative (RSI)** Year 4 funding has been secured. Significant challenges with awarding contracts due to procurement rules overcome and services have been able to continue. Uncertainty around future funding poses challenges when developing commissioning intentions and potential risk of losing valuable services if RSI funding ceases. Unable to cover with existing commissioning budget as presents equal risk around loss of other valuable services. **Quality and Safeguarding** Engagement with quality and safeguarding teams completed. Capacity needed to ensure requirements are embedded into future contracts, specification and monitoring approaches	Jun-21	
21. Behaviour Change	Sandy Jerrim		G	**Expansion of smoke-free offer in targeted settings** Developing a smoke-free offer in PCNs, Maternity and other settings **National Weight Management programme (WMP) – understand requirements, implications** Tier 2 weight management forum has been set up and will run monthly initially. New funding for services awarded to Southampton. Work is underway to identify opportunities to develop services. Risks identified with short term funding offer (21/22 only) and mobilising services to address targeted need.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
C. Project Milestone Monitoring: Safe & High Quality Services						
22. Quality Improvement in Health Providers	Helen Eggleton and Theresa Gallard Antony Shannon (Primary Care)		G	**Quality improvement and assurance** This work continues, although some activity undertaken virtually, due to limitations of Covid; this includes participation in Providers quality initiatives/events. Quality visits continue to be undertaken, but proportionately and appropriately risk assessed in relation to Covid. Quality Framework completed and shared for feedback with Commissioning Managers. Quality Managers continue to participate in Provider led governance meetings - now on a regular basis for the majority of Providers. **Quality Reporting** Being reviewed in line with new CCG governance arrangements. **Patient safety** Patient Safety Leads in place and working with regional team in relation to Patient Safety Strategy. Appropriate tools support patient safety work and Quality Managers involved in Provider Safety Committees / Groups. **Patient Experience** Quality Managers working with Providers in various ways to promote service user, family and carer involvement in quality improvement activity, including Quality Improvement (QI) projects andSerious Incident (SI) investigations. System wide learning facilitated through the Learning & Sharing Forum. **Health Inequalities** Monitoring and identification of inequalities continues via harm review outcomes / contract quality measures. **Covid-19** Quality Managers involved in various meetings where 'reset' is discussed and issues escalated. Also, supporting relevant associated work streams (system-wide) and seeking assurance from Providers on staff health & wellbeing activity.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Primary Care The CCG has a responsibility for improving and developing the quality of primary care general practice, reducing variation and in supporting member practices. A Quality Assurance and Improvement Framework designed in such a way to address quality assurance, support improvement in general practice and provide and systematic process for managing unwarranted variation continues to be in development. Part of the agreed process currently is that Practices will receive an annual visit by a member of the Quality Team and the Primary Care Team. It is envisaged that, whilst offering a level of assurance to the CCG, this will also be in part a supportive visit. The CCG will review the visit as part of a Primary Care Quality Group action, this will hopefully include a GP without conflict to that practice and a decision will be made regarding any escalation processes as required. Much of the work was put on hold during the current COVID pandemic as practices reduced normal practice activities and their focus on the vaccination effort.		
23.Antimicrobial prescribing	Andrea White		G	Progress underway is line with milestones	Jun-21	
24. Quality of internal providers (SCC)	Matthew Richardson		G	Progress underway is line with milestones	Jun-21	
25. Embed safeguarding across the ICU	Cressida Zielinski		A	All elements of this work stream are in progress and part of a continued programme of improvement and awareness raising for commissioners s part of the contract and procurement cycle.	Jun-21	
26.Continuing healthcare (CHC)	Shelley Lewis		A	**Continuing Health Care (CHC) Assessment in the Community** Good joint working with SCC and CCG and UHS to facilitate timely discharges from acute trusts and fund placements/packages under Discharge to Access (D2A) or joint funding until community assessments in place. Governance and monitoring processes in place but require refining as government guidance changes and local processes adapt accordingly. Work on PHB's in increasing with joint working across HSIOW CCG working to reduce inequity in the PHB offer across the whole **Continuing Health Care (CHC) QualitY Improvement** The NHSE Strategic Improvement Programme (SIP) is currently suspended however the SOUTHAMPTON area CHC team has strong links with the NHSE regional team and works to ensure current and best practice is followed. The CHC teams across the HSIOW CCG have established a weekly Leads meeting that is exploring how CHC can best be offered in the new organisation and are drafting a position statement. The HSIOW CHC leads have liaised with NHSE to ensure that benchmarking and Continuing Healthcare Assurance Tool (CHAT) tool reporting is completed as an HSI whole rather than as separate CCG areas. Challenges remain in overall staff capacity and this is limiting completion of some areas of work such as the CHAT tool completion. However as joint work across HSIOW footprint progresses it is hoped that some benefits of a larger team can be realised.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
27. Digital Support for Social Care providers	Alex Boucouvalas		G	The Digital Care Team service established in 2019 hold responsibility and progress workstreams related to digital health and social care at a place-based level in Southampton. A need for the service was identified with ever increasing digital social care mandatory workstreams having been delegated to local systems by NHS England and the Department of Health and Social Care to project manage and deliver. The team is unique in that it brings together a multitude of digital health/social care workstreams originating from both the local authority and CCG. These workstreams are then managed centrally by the team. This approach differs from neighbouring systems where work has been scattered across different organisations and then different parts within organisations. The service started with one Project Manager tasked with the implementation of the NHS Data Security and Protection Toolkit and NHS Mail rollout across social care providers in Southampton. Additional workstreams were identified (detailed below) and some further resource allocated to the service to enable recruitment and additional capacity. The service is currently resourced with 1.8 FTE across three staff members. The current service model was developed from temporary Improved Better Care Funding / CCG funding and is managed within the Integrated Commissioning Unit. All three staff members are fixed term appointments, with Southampton City Council contracts, with current funding arrangements ending 31/03/22 but are due to adopt some permanent health funding and remain in the ICU. The team have demonstrated a gap in the market for this line of work and have had a successful 18 months of impact. The team are keen to expand their digital support offer to primary care and are seeking to develop this area of work, and increase overall capacity. Many of the projects implemented are now adopted into business as usual such as NHS Mail, but remain managed and maintained by the team. This on-going maintenance this reduces capacity to adopt new workstreams and allocate staff to new digital projects.	Jun-21	
28. Support for People with Learning Disabilities	Helen Eggleton and Theresa Gallard		G	**Learning Disabilities - Standards** Achieved though oversight of Provider contracts (quality elements) and review of self assessments and action plans, along with attendance at relevant Provider internal meetings / groups. **Learning Disabilities - Contracts** Achieved through attendance at relevant governance meetings.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Learning Disabilities - Quality Improvement / Assurance Quality Team participation in the Learning Disability Transformation Group Information gathering exercise to inform future service design. **Learning Disabilities - Service Redesign - Learning Dis** Quality Manager ongoing involvement in the LD service re-design work and participation in the Learning Disability Transformation Group Information gathering exercise to inform future service design.		
D. Project Milestone Monitoring: Managing & Developing the Market						
29. Home care implementation	Lin Churches & Abi Benham		G	**Developing the framework** Lead provider for clusters 3 and 4 awarded, with contract commencing 21/06/21. General provider forums established - lead provider forums will recommence at the end of June/beginning of July. **Quality Reporting** Process development for monitoring underway. Awaiting information to understand current picture. KPIs being reviewed. **Bridging Service Review** Service review completed. Decision to renegotiate the current contract and extend by six months. Further work on the shape of a new contract to replace current arrangements to be carried out. **Review of placement team processes** Discussions continue to align KPIs across partners, and integrate working more effectively. Resource impact of Care Director being established. Skills analysis will commence as part of Q1 monitoring.	Jun-21	
30. Housing with care	Matthew Harrison		G	**Managing access to Potters court** Housing Development Officer is now in post and work is underway **Planning for housing with care capacity in the future (RSH and other sites)** A needs assessment for extra care provision is underway and due to be completed by the end of July 2021. **Housing needs assessment for mental health** Housing Development Officer is now in post and work is underway with plan to complete by end of July 2021	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
				Housing need update for other client group areas ICU Housing working group has commenced monthly meetings and will be reviewing needs assessments for all areas in July and August to identify commonalities and differences in housing needs. **Develop Market Position Statement (MPS) for housing, together with commissioners** Once the needs assessments have been completed procurement options will begin to be explored as well as internal SCC housing development opportunities through 1000 Homes or other means.		
31. Nursing home and complex residential care market capacity	Matthew Harrison		G	**Understanding need and a fair price for care** Needs assessment is underway and aiming for completion by end of July 2021. This will then feed into a 'Cost of Care' exercise. **Developing the commissioning strategy for care homes** Once needs assessment is complete, specifications will be reviewed and options for future residential & nursing procurement considered. **Options for new capacity** Meetings being held with existing providers about capacity and opportunities for service development to better meet needs.	Jun-21	
32. Children's residential care	Lin Churches		G	The consortium agreed to extend the current framework by three years.	Jun-21	
33. Market sustainability assurance	Matthew Harrison		G	**Developing the understanding of the ongoing issues related to the price of care** Meetings are being held with providers to discuss current provision, future business plans and how well this fits with local needs. These will also include discussion of Covid-19 impacts. **Develop the business case for future uplifts to sustain the market** Once needs assessment complete, a Cost of Care exercise will commence. Funding for pilot work with Hampshire Care Association has been agreed and a draft agreement is being negotiated.	Jun-21	

2. Project/Programme Portfolio						
Project/Programme	**Lead**	**RAG: Prev Mth**	**RAG: Current**	**Summary Narrative**	**Date Updated**	**PID Approved**
34. Independent Sector workforce development	Matthew Harrison		G	**Secure funding for post** Funding is available, currently discussing options for recruitment. **Engagement with Independent Sector** Information being collated from commissioners to gain overall view of current market issues around staffing. **Recruitment Support** Work will commence when post is recruited to. **Provide strategic support** Work will commence when post is recruited to.	Jun-21	
35. Kentish Road PMLD Housing Development	Matt Harrison		G	Working with finance, capital assets and legal colleagues to find resolution to outstanding issues. View of external auditors around HRA funding is being sought.	Jun-21	
36. Digital Capability Improvement	Sue Nash and Aleks Burlinson		G	**Contributing from a commissioning perspective to the CareDirector development and** ICU have input into service and commissioning needs from CareDirector. **Contributing from a health & care commissioning perspective to the development and** Working with Supplier Management colleagues to prepare for go live date and impact on upcoming tenders.	Jun-21	
37. Independent Foster Care	Lin Churches		G	This project is currently on track, with the tender due to go out in mid-July.	Jun-21	
38. Procurement Policy and Strategy	Sue Nash		G	Not due to commence until August/September 2021	Jun-21	

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