1. Integrated Commissioning Unit (ICU) Summary Performance Report — M10 (Jan) 2019/20

Achieving Transformation Change

↑	95% Target ≥ 92%	% CAMHS routine assessments within 12 weeks
↑	186 Target ≤ 153	Number of Permanent admissions to residential & nursing homes (65+)
↓	45.5 Target ≤ 27	Average Daily Delayed Transfers of Care (DTOC) beds
↓	21,258 Target ≤ 20,272	Number of Non-Elective Admissions
	2,607 Prev Yr = 2,224	Falls & Fraity (65+) Admissions <24hr

Quality

↓	50% Target ≥ 80%	% Full Continuing Healthcare Assessments completed ≤28 days
↑	100% Target ≥ 85%	% Continuing Healthcare Assessments taking place in community
↑	86% Target ≥ 90%	% of placements that are sourced through the Care Placement Team
↑	5.5% Target ≥ 5.3%	% people with common mental health conditions accessing IAPT
↑	30.0% Prev 12 mths = 29.1%	Alcohol - % of clients completing treatment and not re-presenting

KEY

Compared to Previous Year

↑ Better than previous year

↓ Worse than previous year

→ Same as previous year

Compared to Target

Within 10% of Target

Target Achieved

<10% below target

2. ICU Workstream Progress

a. Achieving Transformation Change

Supporting work to further develop integrated team model
Section 75 review of Mental services now complete, recommendations reviewed and accepted by SCC and SHFT. Recommendations have been used to develop an action plan with delivery oversight at future s75 partnership board meetings. CAMHS - Multiagency Single Point of Access with No Limits and Yellow Door in place. The Lighthouse Crisis lounge now open in Shirley High St.
Roll out of SoLinked (community solutions) including development of Southampton fund. New city wide navigation service in place that includes navigation for people living with mental health challenges and dementia.
Consultation underway on deregistration of 3 Dimensions residential homes, will impact 17 clients (estimated saving £150k).
Development of Sufficiency strategy with children's services. CAMHS Local Transformation Plan refreshed. MH Support Teams in Schools commenced Jan 2020 to support schools in managing MH/emotional/behavioural difficulties. Work commenced to develop a more integrated model of pre-school provision for children with complex disabilities.
LD market position statement currently being reviewed.
Ageing Well Framework finalised with wide stakeholder engagement - Peoples Panel Survey completed to inform messaging approach and identify potential priorities.

b. Procurement & Market Mananagement

Number of procurements in train including:
• Joint Equipment Store (max £11,260k for Southampton City) - procuring for both PCC and SCC. Stand still period now completed and contracts with Nottingham Rehab for signing, work has started work on the transition between providers. Service due to commence 01.07.20.
• Direct payment support (£512k) – complete, service to commence April 2020
• Weston Court respite service progressing through tender process
• Southampton Peer support services (£480k) – awarded. To commence April 2020
• Wheelchairs procurement – joint across all CCG's in Hampshire and Isle of Wight. Procurement closed 27 January and now in evaluation phase.
• Home care framework call off– additional hours confirmed following a mini competition off the Framework ,using winter pressures
• 1st anniversary of the reopening Children's residential framework has now concluded and also working with consortium on evaluation of the reopening event for the Independent Fostering Agency framework
• Work commenced on development of a community transport offer – model to be presented to JCB in June.
• Development of vision for making best use of Kentish Road site and agreement to proceed to undertake a feasibility study
• Palliative care – formal notice given to Solent NHS Trust and care will move to Countess Mountbatten from August 2020.
• LD day external service review in progress, to align with internal review.

c. Quality

Overall quality of social care providers in Southampton continues to be good, a recently held provider event, focused on supporting care homes in avoiding admissions to hospital was attended by over 40 providers.
Continued work with the current wheelchair service provider to ensure that challenges are being addressed.
Monitoring the quality of care at UHS continues with a particular focus on cancer pathways, ophthalmology and the emergency department.
Workforce concerns continue in mental health services in Southampton, particularly at Antelope House (Adult Mental Health) and the Western Hospital (Older Persons Mental Health)
Improvements in infection prevention and control at Countess Mountbatten Hospice have been seen, with 97.5% compliance with the required standards.
Southern Health NHS Foundation Trust have been rated good by the CQC, a clear demonstration of the progress they have made over the last few years.

d. Strengthening Commissioning Integration

To Promote strengthening Integrated Commissioning there have been eleven proposals developed with leads identified from across the Integrated Commissioning Unit, Clinical Commissioning Unit and the Council. These include - Maximising the potential of our existing arrangements and benefits; shift in approach so that joint projects are centred around key issues; promoting joint working of teams/services working on areas of common interest; development of best practice standards for citizen and staff engagemen; JCB practices and best possible uses of insight; innovation in procurement to promote the best use of the Southampton '£'; contribution from health organisations to the Council's priorities and vision; and the role of Southampton 'place' within the wider ICS development.
Each of these schemes are progressing with project plans outlined and work initiated in a number of areas: Clear process for taking forward the functions and benefits of pooled fund arrangements; engagement resource developed with partners and service users and undergoing testing; planned joint ways of working group; and desk top exercise to highlight opportunity for joint working in addition to those already in place. Some areas will progress at a later date in order to reflect the context surrounding them, including the contribution of health organsiations to the Council Priorities and vision, making the best use of insight and the role of Southampton 'place' within the wider ICS development. Each of these are seeking to ensure that they compliment other key developments existing timelines e.g. setting of the Council priorities and vision and the ICS plan.

3. Key Performance Indicators

a. Integrated Care (Better Care)

	RAG Summary	
	Last Yr	Target
Green	3	4
Amber	4	1
Red	5	6
n/a	6	7

			Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M8	Average Daily DTOC beds	46	37	8	22%	27	19	70%
M8	Average Daily DTOC beds rate (per 100,000)	23	19	4	22%	13	9	70%
M1-8	Total Non-Elective Admissions	21,258	20142	1116	6%	20,272	986	5%
M1-8	NEL Admissions (under 18s) - UHS only	2,190	2224	-34	-2%			
M1-8	NEL Admissions (18 - 64 yrs old) - UHS only	9,899	8775	1124	13%			
M1-8	NEL Admissions (65+ yrs old) - UHS only	7,832	6760	1072	16%			
M8	Long Stay Admissions - Number of Patients 21+ days	66	0			77	-11	-14%
M8	Long Stay Admissions - Number of Patients 50+ days	12	0					
M8	Long Stay Admissions - Number of Patients 100+ days	2	0					
M1-8	Permanent admissions to residential homes aged 65+	186	198	-12	-6%	153	33	22%
Q3	% of People with Learning Disabilities receiving a Physical Health Check	36	38	-2	-4%	45	-9	-20%
Q3	Childrens Wheelchairs - 92% seen within 18 weeks by Q4	40	46	-6	-13%	79	-39	-49%
M1-8	CAMHS - 92% of routine assessments within 12 weeks (YTD)	95	0			92	3	3%
Q3	60% of people with an SMI receiving a full annual physical check	26	0			46	-20	-43%
M7	% of people experiencing psychosis will be treated within 2 weeks of referral (YTD)	95	100	-5	-5%	57	37	65%
M9	% of adults open to LD social care team who have had a Care Act assessment/review in the past 12 mths.	40	31	9	29%			
M8	Number of new Enhanced Health in Care Homes	18	0			18	0	0%
M9	% of clients in rehab/reablement who do not need ongoing care	70	70	0	0%			

Summary

DTOC - main issues affecting performance are:
- Overall increased complexity of patients: Actions to resolve include Bespoke work is carried out to support complexity and secure complex care, community OT in-reach to hospital to joint assess patients and greater consideration of how equipment and care technology could support people in the community to reduce levels of dependencies.
- Discharge and community provision: trusted assessors are ongoing training to support Pathway 1, more investment in pathway 2 to increase reablement and invested in home care to increase capacity. Pathway 1 more established, Pathway 2 increased investment in home care to support “bridging” care.
- Hospital processes: UHS is developing an action plan to create greater consistency in hospital and CCG quality team are working with UHS to develop reporting to encourage grater transparency
- Delays attributed to care and nursing home acceptance assessments is a constant challenge – we have invested in a hospital based Trusted Assessor pilot designed to work alongside homes in the first instance with a long term view to undertaking the assessments on behalf of the homes (the homes would still make the final decision). The expectation is that this will be a slow piece of work as the homes need to build trusting relationships with the assessor.
- Community resource pre admissions - commissioners are working with Providers to become more preventative, community clusters are working with voluntary sector to develop 'social prescribing'

% with LD receiving a Physical Health Check - The primary care team will be promoting the importance of health checks throughout Quarter 4 and Becky is working with those practices that require support to increase their %. 16 out of 26 practices are reporting below 50% and therefore the focus will be on supporting these practices.
Under Enhanced Care in Care Homes SPCL have contract to undertake assessments and will be completing AHC if patients have LD – commencing in Quarter 4; already done 17 to date; Primary Care have reminded then that this needs to be coded to pull through into our figures.

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

SMI full annual physical check - Q3 the overall performance increased from 18% to 26%. Enhanced service contract with primary care in place, although not all practices have signed up to the offer. Pilot developed for Q4 implementation, community wellbeing team/health facilitator role to increase take up of physical health assessments for individuals who have historically not engaged/less likely to present for their health check appointment. Support requested from NHSI/E to provide standard ‘queries’ to ensure all areas measuring the same data from GP clinical systems

Wheelchairs - In January 2020 a refreshed Improvement plan has been established with the provider. This will be monitored monthly with 2 weekly telephone conference calls with the Regional manager and CCG Associate Director. The plan focuses on Pathway improvements for low need, specialist seating and MND, Clinical Productivity - triage, adherence to criteria, DNA policy, increased allocated clinical time to 60% and MECC, Community Provision - integration into OT networks, identification of existing wheelchair trained staff in community, engagement with care homes, Communication and Engagement, Workforce - explore joint post opportunities, Digital - connect local service with national spine and support automated triage process, explore options for satellite clinic, development of mini equipment store and Care Home Project - in development

In response to the workforce challenges, Millbrook are introducing a new staffing model, exploring whether therapy support can be brought in from other contracts, approaching suppliers for additional capacity, targeting locums outside the area with an agreed pay package to cover travel and accommodation costs, recruiting into apprenticeships and implemeting an improved recruitment system

b. Prevention and Early Intervention

	RAG Summary	
	Last Yr	Target
Green	4	4
Amber	2	0
Red	3	0
n/a	0	5

			Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M1-7	Falls and Frailty (65+)	2,607				2,224	383	17%
Q3	IAPT - % with common mental health conditions accessing IAPT	5.5	5.3	0.2	4%	5.3	0.2	3%
Q3	IAPT - % who complete IAPT moving to recovery	50	51	-1	-2%	50	0	0%
M8	% LARC (all 4 methods) at Integrated Sexual Health Service (YTD)	43	42	1	2%	35	8	23%
M8	% of HIV tests completed as part of an STI screen (YTD)	84	85	-1	-1%	75	9	12%
Q3	% of pregnant women who cease smoking time of delivery (YTD)	17.5	18.4	-0.9	-5%			
M8	Alcohol - % of all clients completing and not re-presenting	30.0	29.1	0.9	3%			
M8	Opiates - % of all clients completing and not re-presenting	3.3	6.7	-3.4	-51%			
M8	Non-opiates - % of all clients completing and not re-presenting	27.8	30.7	-2.9	-9%			

Summary

Falls – work is ongoing to reduce the numebr of admissions for falls and fraility. This includes:
• UHS has appointed a therapist to lead the Fracture Liaison Service/pathway. Work will commence to implement the agreed standard operating procedure.
• The Pilot Community Alarm (Gold) and Telecare service commenced on 1 May offering a 6 month to patients with a falls risk and socially isolated. 90 people signed up and have accessed the pilot to date. Analysis is taking place to evaluate the impact on ED attendances & NEL admissions.
• To improve the identification and management of patients who have a falls risk, 4 practices piloted the use of Keele University Tool. A number of appraoiches where trialled. The Wellbeing Team have agreed to work with practices/PCN's across the City to roll out the adoption, working with the Saints Foundation to promote access to the falls prevention exercise offer.
• With additional investment into Community Independence Team (5WTE) waiting times for assessment have reduced and the number of assessments completed have significantly increased.
• The Saints Foundation will be working with a Public Health registrar to evaluate take up and maintaining falls prevention exercise participation. This will involve evaluating national best practice and gathering local qualative information from users and people referred to the service.
• SCiA have since September 2019 been providing a Community Transport offer to patients being discharged from ED, CDU, AMU and SDEC. Approximately 50/60 patients are supported home every month. Work is underway to increase the numbers accessing service by providing UHS volunteers to escort people home.
• The pilot scheme of a Urgent Response Service clinician in SCAS call desk to support call handlers in diverting to more appropriate community pathways that avoid hospital conveyance has been viewed as a success. A new QIPP plan has been developed as a result of the pilot to expand the service from the current Mon- Friday (8.00- 1.00pm) to 7 days (8am – 6.00pm), with enhance support available via the URS Team and access to the good neighbours network being developed by Communicare. Funding for this scheme needs to be approved by the CCG.

Substance Misuse -The new Substance Use Disorder Service contracts commenced on 1st of July 2019. This data reports the proportion of all people in treatment, who successfully completed treatment and did not re-present within 6 months. The figures presented in this table evidence activity from our previous contracts / system i.e. Successful completions that took place between the beginning of April 2018 until the end of March 2019 and Re-presentations up to the end of September 2019.
It is positive to note the improvement in performance for people with a primary alcohol use disorder, particularly, as this improvement has been made in line with a significant (87%) increase in the number of people with an alcohol concern accessing treatment and support over the same period. Commissioners are aware of the poorer performance for other cohorts and have been working jointly with the provider, an improvement plan is in place and this work is being overseen by Commissioners and CGL Directors. CGL are working on their improvement plans and delivering the service during a time of change. The service is working towards an improvement trajectory that will take some time to see performance fully recover to historical levels and matching our LA comparator performance levels.

c. Commissioning Safe & High Quality Services

RAG Summary	Last Yr	Target
Green	3	2
Amber	0	0
Red	2	2
n/a	0	0

				Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M8	≥85% of CHC assessments taking place in an out of a hospital setting	100	88	12	14%	85	15	18%
M8	≥80% of Full CHC assessments completed within 28 days	50	80	-30	-38%	80	-30	-38%
M1-8	<44 cases of Healthcare Associated Infections (Community): Cdiff (cumulative)	16	21	-5	-24%	18	-2	-11%
M1-8	Zero cases of Healthcare Associated Infections (community): MRSA (cumulative)	1	2	-1	-50%	0	1	-
M9	% of Providers with a CQC Rating of good or above published in month (cumulative)	71	81	-10	-13%			

Summary

CHC Assessments within 28 days - this target remains challenging to achieve. As we have moved through the year, the use of Care Track as our new record keeping and reporting tool is ensuring that our reported figures are more accurate than with the previous system. Data quality continues to be refined and we are meeting with Care Track in February 2020 to ensure that we are using the tools to effectively and accurately. The CHC team have also begun an evaluation and refinement process to ensure that all decision making is compliant with the National Framework for CHC. Framework compliant decision making challenges the 28 day compliance target particularly with regards the completion of DST's for FNC patients where social work capacity with the Local Authority challenges the ability to complete assessments in 28 days. This is a national challenge with regards CHC and the CHC team are working with Local authority partners to try and mitigate the issues.

Care Home Beds - Overall quality of social care providers in Southampton continues to be good, a recently held provider event, focused on supporting care homes in avoiding admissions to hospital was attended by over 40 providers.

d. Managing and Developing the Market

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

				Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
Q1	≥90% contract reviews on schedule	95	92	3	3%	90	5	6%
M9	Care Placement - ≥90% placements are sourced via Team	86	83	4	4%	90	-4	-4%
M9	Avg days from referral received to placement start date (Home Care)	10	13	-3	-24%	14	-4	-31%
M9	Avg days from referral received to placement start date (Res/Nursing)	5	5	0	-2%	14	5	-68%
M9	Total number of home care hours purchased per week	22,942	21,953	989	5%			
M9	% Home Care clients using a non framework provider	19	22	-3	-14%	20	-1	0%

Summary

Care Placement: 'We continue to work with stakeholders to improve the use of the Placement Service however please note that this target does not take into account emergency placements sourced outside office hours. The number of these placements would have been higher towards the end of November and beginning of December due to the winter/ Christmas pressure period. This is the likely reason for the reduction from 92% - 86% for this period. We will continue to monitor this closely.

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

Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Delayed transfers of care	Increasing complexity of clients will increase DTOC resulting in failure of plans, BCF targets and QIPP savings and this could compromise quality of care and outcomes for clients	V High	DC	DTOC remains a high priority and is closely monitored. Main challenges remain: o increasing levels of complexity amongst patients being discharged. There has been a strong push within the hospital to discharge patients earlier with higher levels of need which are more difficult to meet. o workforce capacity in the domiciliary care market particularly to support higher levels of need e.g. requiring calls at specific times or double up calls 3 or 4 times a day. o nursing home capacity to take more complex clients o access to specialist rehab beds, in particular Snowden but also specialist spinal rehab beds commissioned by NHSE - Mental Health delays at SHFT Recent actions include: - further extension of the dom care retainer with a specific focus on facilitating timely discharge and working with URS to reduce extensions and thereby free up capacity in reablement - commissioning additional dom care capacity over the winter period, including Live In Care placements - commissioning additional reablement bed over the winter period - increasing bed based capacity within the Pathway 3 D2A scheme - Roll out of low level health needs care (with the exception of diabetic care) from Dec - extension of rehab/reablement inreach to 7 day service - recruitment of an OT to review double up care with a view to freeing up capacity - budget issued to IDB to provide dedicated transport and other support to facilitate discharge e.g. deep cleans, handyman - where's best next campaign - launched 20 Jan Other schemes currently being scoped/mobilised include: - voluntary sector support within the IDB and brokerage service to help families make timely decisions - deep dive review and process mapping of key pathways - particularly pathway 3 CHC/Fast-track - Trusted Assessment to care homes - Review of specialist rehab provision - joint with West Hampshire

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

Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Make Care Safer	There is a risk that the sustainability of high quality Mental Health services in the City via Southern Health Foundation Trust (SHFT) and Solent NHS Trust will not be maintained	High	CA	CAMHS waiting times for first contact showing consistent improvement, but secondary waits still a challenge for some specialities. Waits for services for ADHD and Autism, as nationally, remain long. Solent NHS Trust CAMHS have recruitment challenges Southern Health have significant workforce challenges which is impacting on bed availability and opening of the Crisis lounge and S136 suites. Detailed recruitment and retention plan being implemented. Higher use of bank and agency staff who do not have direct access to recording systems - new leadership team are addressing this. Serious incident on Saxon Ward. External thematic review of whole of Antelope House Transfer of Eastleigh Southern Parish patients from the East Community Mental Health Team taken forward. Evidence that caseloads are now starting to reduce Autism Services waiting list improvement now slowing due to increased referrals; further investigation underway The risk in relation to staffing continues at Antelope House, impacting on bed availability and opening of Crisis Lounge, and recent leadership changes have led to a further period of instability. Higher use of bank and agency staff, improvement in direct access to recording systems . Older Persons Mental Health service has recruitment challenges which may impact on bed capacity SHFT Contract Review meeting in July 2019 changed to a focused meeting on Antelope House staffing concerns ,to review again and ascertain the impact of actions being taken. Specific Workforce Clinical Quality Review Meeting (CQRM) was held with SHFT in September 2019. Overall assurance was provided around the strategic activity being undertaken across the Trust. Serious incident on Saxon Ward, external thematic review ongoing. Southern have CQC unannounced visit in November Most providers have elements of challenge with recruitment of specialist roles. Retention and recruitment plans are being implemented and monitored for impact

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Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Wheel Chair Service	Waiting lists - financial, clinical and reputational risk. Risk of long waiting lists - leading to individuals at risk of harm in delay in service and reputation	V High	DC	Despite ongoing efforts to improve performance, including a waiting list initiative specifically targeted at children, the service continues to be challenged and as at Nov 19 the average waiting times (from ref to case closed) for Children was 24 weeks and for Adults 34 weeks. The main reason for performance remains workforce challenges associated with recruiting and retaining experienced clinical staff. In response to the workforce challenges, Millbrook are undertaking the following: - introducing a new staffing model - approaching suppliers for additional clinical capacity - targeting locums outside the area with an agreed pay package to cover travel and accommodation costs - recruiting into apprenticeships - improved recruitment system In January a refreshed Improvement plan has also been established with the provider. This will be monitored monthly with 2 weekly telephone conference calls with the MB Regional manager. The improvement plan focuses on: - Pathway improvements for low level need, specialist seating and MND - Maximising Clinical Productivity - triage, adherence to criteria, DNA policy, increased allocated clinical time and MECC - Building stronger relationships with community therapists including networking and exploring the potential for joint posts - Engagement with care homes to ensure recycling opportunities are maximised - Communication and Engagement - establish local strategy for identified key areas to improve communication - Digital - connect local service with national spine and support automated triage process - Identifying key hotspots where provision could be localised to improve access e.g. via satelite clinic, development of mini equipment store

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Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Home Care	Risk that dom care market is unable to keep pace with increasing demand resulting from growing complexity (e.g. more QDS double up clients) and strategic drive to keep people independent. Risk of provider exits from the market adding to challenge around capacity. This is key system enabler and where there are sustainability, capacity and quality issues this impacts on patient choice, quality of care to clients, DTOC, use of residential care and ability to support other priority work areas such as the expansion of extra care housing	Moderate	CB	Action plan developed to address both short-term and long-term requirements has been implemented and has resulted in improvement. The new framework has increased capacity and additional hours are purchased from a 'retainer service' which provides rapid access and responds to peak need. The potential for short-term exits is a constant risk but the process for dealing with this is now well established and we also continue to see strong interest from new providers in entering the care market in Southampton, either through joining the framework or acting as a spot provider. The new framework allows an annual re-opening to encourage new entrants to the market and ensure any potential loss in capacity is mitigated. Whilst there remains high risk due to this market fragility and increasing complexity/demand , this is well managed through the action plan which is updated as the situation changes. . 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 strong position with both capacity and recruitment and are able to take on additional packages of care, reflected in the placements waiting list numbers being lower. However, we are mindful that although we are in a stronger position we need to be always alert to seasonal peaks and trends. At this time one winter pressures project has been implemented and a further project is being scoped - both aiming to stimulate additional capacity development during the winter period and into the spring.

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