Public Document Pack

Southampton Health and Care Partnership Board

Thursday, 16th January, 2025
at 9.30 am

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Please send apologies to Natalie Johnson email: natalie.johnson@southampton.gov.uk

AGENDA

1 WELCOME AND APOLOGIES

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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

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3 TRANSFORMATION UPDATE - ADULT SOCIAL CARE (Pages 1 - 14)

Report of the Executive Director of Community Wellbeing, Children and Learning (DASS and DCS) outlining progress with Adult Social Care transformation.

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4 BETTER CARE FUND UPDATE - QUARTER 2 (Pages 15 - 20)

Report of the Director of Commissioning - Integrated Health & Care outlining performance and delivery of the Better Care Fund for Quarter 2.

DECISION-MAKER:	Southampton Health & Care Partnership Board
SUBJECT:	Adult Social Care Transformation Update
DATE OF DECISION:	16 January 2025
REPORT OF:	Interim Executive Director of Community Wellbeing, Children and Learning (DASS and DCS)

CONTACT DETAILS				
Executive Director	**Title**	Interim Executive Director of Community Wellbeing, Children and Learning (DASS and DCS)		
	Name:	Rob Henderson	Tel:	
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Author:	**Title**	Adult Social Care Director		
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STATEMENT OF CONFIDENTIALITY		
N/a		
BRIEF SUMMARY		
This update together with the accompanying presentation (Appendix 1) outlines the developments with the Adult Social Care Transformation for Health & Care Partnership Board Members.		
RECOMMENDATIONS:		
	(i)	To note the contents of the attached presentation.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To ensure that the Health & Care Partnership Board is sighted on Adult Social Care transformation developments and plans and can input and support as required.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	None.	
DETAIL (Including consultation carried out)		
	Background Nationally and locally demand for Adult Social Care services is increasing at a faster rate than capacity to meet it. As a result the health and care system is under increasing strain. The new Adult Social Strategy (2024-2029), sets out the ambitions for health and social care and what will be done to achieve them.	

	Update The attached presentation explains to Board Members what has been achieved so far in adult social care transformation via business case summaries, programme summaries, workstream progress and challenges. There will be an opportunity for questions and feedback as part of this agenda item.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	This report is intended as a progress update on the transformation programme and that the capital and revenue implications are captured/monitored through the budget monitoring process and transformation programme governance.
Property/Other	
	N/a
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	Health & Social Care Act 2012
Other Legal Implications:	
	N/a
RISK MANAGEMENT IMPLICATIONS	
	N/a
POLICY FRAMEWORK IMPLICATIONS	
	Adult Social Care Strategy 2024 – 2019 Health & Wellbeing Strategy 2017-2025

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Presentation to Health & Care Partnership Board – 16 January 2025

Documents In Members' Rooms

1.	
2.	
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	No

Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.		No
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.		
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Community Wellbeing Transformation Programme Summary

January 2025

Ambitious Futures – Business case Summaries

In Adults Social Care, we have built on the great work achieved so far within Ambitious Futures programme to create various programmes to support our transformation journey over the next 12-18 months. These programmes embrace the adapt | grow | thrive approach and aim to make further savings across the service.

Living and Ageing Well

Prevention/Demand Management

Aiming to… prevent individuals from requiring Adult's Social Care involvement

Practically… Reducing the number of residents requiring to contact the service.

Long-Term Care Starts

Aiming to… make timely, informed decisions that meet residents' needs and promote independence

Practically… using collaborative forums to reduce the number of starts into nursing & residential homes.

Reablement

Aiming to… maximise the value of the reablement service and reduce home care hours commissioned

Practically… enable more people to finish reablement and improve the effectiveness of the service

Whole Life Pathway

Optimised Packages of Care (Moves, Step-Downs, and Progressions)

Aiming to… provide working age adults with the right level of care to support their independence.

Practically… individual moves to less restrictive settings and reduced care hours, where appropriate.

CHC, DFG, and other health funding

Aiming to… ensure funding packages are appropriate for service users with healthcare needs.

Practically… multi-disciplinary teams mobilised to utilise national and local arrangements to propose funding streams.

Transitions

Aiming to… encourage anticipatory care plans to maximise independence in adulthood.

Practically… alignment with CSC to earlier manage transition pathways into adulthood.

Service Productivity and Redesign

Service Redesign

Continuation of data-led approach to redesign of teams, resizing and adjusting skill mix of teams to fit the new operating model and reflect the efficiencies delivered in Living and Ageing Well and Whole Life Pathway.

Social Care System Procurement

The procurement phase of the programme of work to replace the current Case Management System – CareDirector. Contract award targeted May 25.

Care TEC

Development of a TEC first approach and equipment library to support this.

Commissioning

Tailored approach to negotiation of rate changes with providers, use of Inclusive Lives framework

Living & Ageing Well Programme Summary

Prevention/Demand Management

Aiming to… prevent individuals from requiring Adult Social Care involvement

Practically… Reducing the number of residents requiring to contact the service

Key measurables

- # of contacts made by Connect team /week
- # of cases currently on the connect waiting list.
- Average length of time a case stays on the waiting list.

To drive these measurables, we are:

- Closing down an email account to reduce the avenues in which the front door team can be contacted.
- Reformatting an online referral form to better signpost to alternative community resources.
- Improving communication channels between the Contact centre and Connect team to reduce the number of inappropriate referrals.
- Using an alternative review form for cases that are requesting an increase/decrease in current care.

Long-Term Care Starts

Aiming to… make timely, informed decisions that meet residents' needs and promote independence

Practically… using collaborative forums to reduce the number of starts into nursing & residential homes.

Key measurables

- # of starts into nursing placements
- # of starts into residential placements.
- # of starting homecare hours.

To drive these measurables, we are:

- Improving the visibility and grip around data, better understanding the reasons for long-term starts and making process changes that mitigate the most frequently occurring reasons.
- Setting up case-level meetings to promote positive risk-taking & encourage input from assistive tech/community services.
- Completing an onward referral & hospital escalation process redesign that will reduce length of stay within the hospital, in turn ensuring independence and a home-first approach is prioritised.

Reablement

Aiming to… maximise the value of the reablement service and reduce home care hours commissioned

Practically… enable more people to finish reablement and improve the effectiveness of the service

Key measurables

- # of reablement finishers
- Effectiveness (reduction in weekly care hours)
- Length of stay

To drive these measurables, we are:

- Implementing SMART goals culture training and a digital tool to track residents' progression and work towards residents' greatest independence
- Setting up effective Community referral route to enable more residents to start reablement
- Establishing data visibility and stand-up performance improvement cycles to address blockers and drive positive changes on KPIs
- Setting up multi-disciplinary case-level improvement cycles to unblock any barriers to individuals' progression towards maximum independence

Workstream Progress

Reablement

New Referral Process: A system process change has been implemented where all Connect cases are now referred to reablement. We have seen an increase in community referrals, hence an uptick in the number of finishers is expected in a few weeks' time.

Community referrals/week

SMART Goal Training: All coordinators are now trained on SMART goal setting and they are currently cascading the training down to carers. Conversations have started around developing a digital SMART goals tool to facilitate more productive conversations about service users' progression.

Improvement Cycles: Additionally, new governance structures are in place to best support continuous improvement. They are: thematic-level improvement cycles (ICs) to review performance on a weekly basis; multidisciplinary case-level ICs to enable collaborative and challenging conversations to maximise service users' independence. Ongoing iterations are expected over the next few weeks.

Waitlists

The number of cases currently on the City Wellbeing waitlist is 229 down from 320 last week.
The number of cases currently on the Connect waitlist is 133 (down/up from a peak of 330).

Online Form Change: The current online form for referrals into the relevant frontline service has been restructured and multiple iterations have been challenged by a working group. The new form is currently in a build phase, with completion expected within the next two weeks.

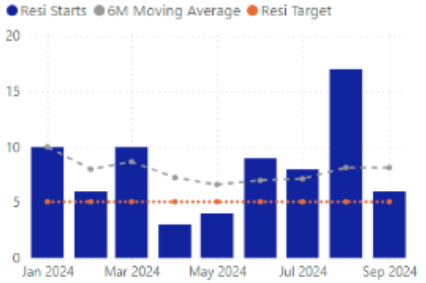
Service Centre Ways of Working: Changes to working relationships between Service Centre and Connect teams, with regular touchpoints established, has ensured a more rigorous signposting approach taken by Contact Centre, resulting in fewer inappropriate referrals to the Front Door team.

Streamlined Reviews: New methods of completing reviews of requests for increased support currently on the wait lists have been considered & implementation commenced, with the aim of fast-tracking cases.

Long-term Starts

The workstream is focusing on reducing the number of residential care home starts. This is due to recent start numbers being significantly above target levels.

Residential Care Home Starts/month



Solution Circles: Collaborative solution meetings have been implemented with the Connect (front door team) to provide additional access to community services and rigour around support planning. This is to ensure that long term packages of care are only provided when necessary. This work also links to promotion of Care TEC

Hospital Discharge Process: Additionally, a revised hospital discharge redesign process to encourage early discharge planning has been discussed

Workstream Challenges

Reablement

Data and Systems: Reablement is currently operating across various IT systems, leading to a clunky process and making it difficult to extract the best data visibility by linking up these systems. This has resulted in limited visibility to drive the right actions. We are working with BI to ensure access to data systems and to create interim visibility where appropriate. Additionally, there are challenges accessing NHS data systems regarding therapists' involvement and case notes, which has made it difficult to obtain up-to-date information on service users.

The work has dependencies on the Social Care System Procurement programme. The initial pass of requirements (including a SMART goals element) has been submitted, but ongoing conversations are necessary to ensure the future system is fit for reablement.

Waitlists

Whole System Alignment: Providing wide-scale change to the inflow of contacts is challenging, and often implementing a solution in one team/area will cause strains on other teams. It is vital to consider the system as a whole.

Changing Public perception
Changes to methods in which members of the public contact social care services without a thorough testing phase may cause initial backlash & public dissatisfaction.

Long-Term Starts

Dependency on Health:
Dependencies on the health care services for earlier data visibility, as well as timely and appropriate referral creates risks around delivering savings to agreed timeframes.

Placement Capacity
A lack of capacity across placement types and competitive market for care beds will inhibit the ability to consistently place residents in what would be their 'ideal' care setting, as well as causing delays when attempting to source care for an individual. A longer term strategy is required alongside short term capacity increases.

Change Fatigue
Change fatigue and high staff turnover means it is difficult to get buy-in to the transformation work across the different seniorities of the teams.

Whole Life Pathway Programme Summary

Optimised Packages of Care (Moves, Step-Downs, and Progressions)

Aiming to… provide working age adults with the right level of care to support their independence.

Practically… individual moves to less restrictive settings and reduced care hours, where appropriate.

Key measurables

- # moves and step downs completed per month
- Change in cost of care package
- Change in number of care hours
- Change in proportion of placement in each long-term care setting

To drive these measurables, we are:

- Setting up a dedicated team of individuals to conduct case-level reviews and determine whether a move or step-down is appropriate for individuals, through engagement with the service user and their network
- TEC, OT, Community Support to optimise avenues of support
- Improving the visibility and grip around data, better understanding trends around transitions and costs

CHC, DFG, and other health funding

Aiming to… ensure funding packages are appropriate for service users with healthcare needs.

Practically… multi-disciplinary teams mobilised to utilise national and local arrangements to propose funding streams.

Key measurables

- # of individual care packages with shared funding contributions between Health and the Council.
- Proportion funded by Health compared to the Council for each reviewed care package.
- Success rate of funding split change proposals.

To drive these measurables, we are:

- Setting up a dedicated team of individuals to triage and review cases where funding contributions look to be appropriate for challenge
- Ensure the multi-disciplinary team receives the appropriate upskilling, support, and material to review and address funding split changes successfully

Transitions

Aiming to… encourage anticipatory care plans to maximise independence in adulthood.

Practically… alignment with CSC to earlier manage transition pathways into adulthood.

Key measurables

- # of long-term care starts in LD and MH
- Effectiveness of care package reviews in driving independence into adulthood (reduction in weekly care hours)

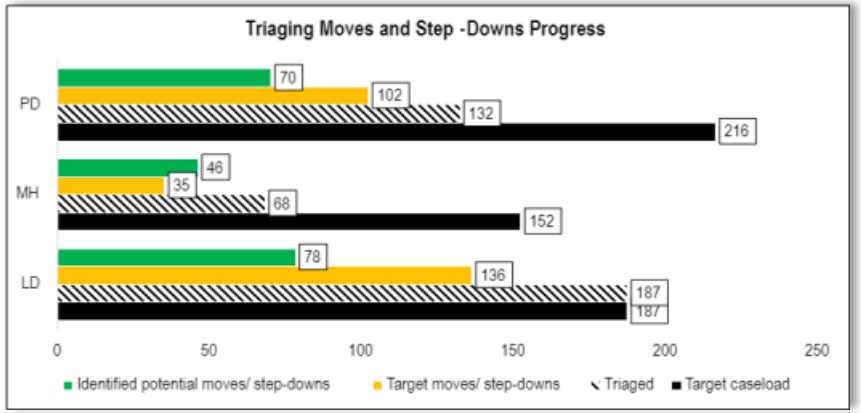
To drive these measurables, we are:

- Improving the visibility and grip around data, better understanding trends around transitions, care packages, and associated costs
- Centring around outcomes-based communication between CSC and ASC teams, with knowledge-sharing and cross-challenge to obtain the best outcome in adulthood for older children through early intervention Implementing SMART goals culture training

Whole Life Pathway Progress Update

Optimised Packages of Care (Moves, Step-Downs, and Progressions)

- A **Live Data tracker** has been implemented with the relevant teams, and co-designed to ensure intuitive and impactful use. The tracker is used to coordinate prioritised triage and reviews, alongside monitoring of financial savings delivered.
- This tracker now incorporates savings achieved by the **LD** colleagues through dedicated transformation activity commencing earlier in FY24/25.
- A **dedicated full-time team** is being stood up to coordinate upcoming activity relating to the engagement of service users, their networks, and external providers. Initial upskilling and support will be incorporated in the kick off.
- We have worked with the **Commissioning and Placements team**, to ensure the impact of Inclusive Lives and the new framework on Supported Living placement availability is fully understood, and the demand on settings quantified.
- Other dependencies, such as those on Housing through Extra Care placements and adaptations, are being quantified, to enable improved collaboration with those teams in driving best outcomes.
- We are building a **system-wide visualisation of data** from CareDirector, helping teams to understand trends in total caseloads and average costs.
- We have begun to capture best practice and known solutions across Southampton and other local authorities, to implement into longer term process design.



Whole Life Pathway Challenges

Optimised Packages of Care (Moves, Step-Downs, and Progressions)

- **Commissioning dependency:** The full effects of Inclusive Lives and the new procurement framework on the availability of Supported Living placements, and the cost of these placements, will not be fully understood until the framework is live towards the end of October 2024.
- **Housing dependency:** The work has dependencies on the Housing teams, including Extra Care placements, which we expect to be limiting. Supply will need to be prioritised against potential financial savings, which are projected to be greater for older adults.
- **Data availability**: CareDirector (current case management system) doesn't allow for analysable capture of all relevant data points, such as funding split information. Changes to the case management system coincide with this transformation work, meaning that changes implemented to support with this may not be set up to sustain. Interim visibility toolkits will be stood up where appropriate, alongside shaping the user requirements for longer-term tools. Providing wide-scale change to caseload across LD and MH in challenging without visibility of system performance as whole.
- **Reputation:** Changes to care packages may cause initial backlash and dissatisfaction.
- **Scale of cultural change:** Changes incorporated to practice and culture with a small, dedicated team will support move and step-down activity in the short-term, but doesn't enable wider cultural shifts, without a defined approach to the wider workforce, and this will need to be considered in workforce strategy.
- **Staff capacity and morale:** There is a risk of staff experiencing change fatigue and increased workplace anxiety through the pace and scale of the transformation work, whilst aiming to balance this with BAU responsibilities. This may drive decreased buy-in, increased staff turnover, or impact the sustainability of change.

Thank you.
Any Questions or Comments?

January 2025

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DECISION-MAKER:	Southampton Health & Care Partnership Board
SUBJECT:	Better Care Fund (BCF) Delivery & Performance Quarter 2 update
DATE OF DECISION:	16 January 2025
REPORT OF:	Director of Commissioning – Integrated Health & Care

CONTACT DETAILS				
Executive Director	**Title**	Executive Director of Community Wellbeing, Children and Learning (DASS and DCS)		
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	E-mail:	robert.henderson@southampton.gov.uk		
Author:	**Title**	Deputy Director, Southampton Integrated Commissioning Unit		
	Name:	Donna Chapman	Tel:	023 80
	E-mail:	d.chapman1@nhs.net		

STATEMENT OF CONFIDENTIALITY		
N/a		
BRIEF SUMMARY		
This report provides an update on the Better Care Fund Quarter 2.		
RECOMMENDATIONS:		
	(i)	To note the contents of this report.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The primary purpose of BCF quarterly reporting is to ensure a clear and accurate record of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. It also provides insight on local progress, challenges and highlights on the implementation of the BCF plans and progress on wider integration across health and social care.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	N/a.	

DETAIL (Including consultation carried out)

1. Performance against BCF metrics

Metric	Assessment of progress against the metric plan for the reporting period:	Commentary:
Avoidable admissions **(Rate of Admissions per 100,000 adult population)**	**Not on track to meet the target.** **Q2 Target = 215.8 per 100,000** **Q2 Actual = 240.4 per 100,000** **Year to date Target = 470.9 per 100,000** **Year to date Actual = 500.7 per 100,000** **(Local data showing a slightly more favourable position than the national data and actual discharges in Q2 being 7.6% less than in Q1)**	**Performance remains challenging due to increasing demand and complexity in the community and the capacity in community services.** **Mitigation for recovery:** • INT – proactive care capacity March 2025 onwards • Strengthening of community pathways out of A&E, aligning frailty processes linking to SDEC priority pathways, optimising therapy teams to work collaboratively for admission prevention. • Social worker in SCAS call centre and development of pathways into UCR and virtual wards • IV frusemide in the community project being explored • Rapid hospital at home equipment services • Virtual ward utilisation • Single point of access
Discharge to normal residence	**On track to meet the target** **Q2 Target = 95.2%** **Q2 Actual = 95.1%** **Year to date Target = 95.2%** **Year to date Actual = 95%**	**HIOW Proportionate Care roll out to Reablement teams, home care bridging and staff working in community is supporting achievement. We will continue to seek to improve upon our position through:** • Continued focus on our home first messaging within the hospital • Implementation of Advanced Assessment Team to assess people earlier in their hospital stay • review of Pathway 1 processes and improvement opportunities – including pilot of D2A bridging for new packages of care • Standardisation of discharge standards • Review of patient transport, particularly aimed at reducing cancellations/aborts to make better use of capacity
Emergency Admissions due to falls **(Rate of Admissions per 100,000 for 65 and over population)**	**No longer on track to meet the target** **Q2 Target = 675.1** **Q2 Actual = 699.8** **(NB local data showing 658.6)** **Year to date Target = 1350.2** **Year to date Actual = 1423.2** **(NB local data showing 1348.5)**	**Whilst we were on track to meet target, performance figures received since the original Q2 submission on 31 October, are showing that performance has deteriorated and there is a significant difference between local and national data. This may be due to late data input.** **Whilst there has been a significant improvement on previous year's performance, Southampton remains an outlier and despite being on track at the beginning of the year, is now showing to be off track.** **Work continues to strengthen the falls pathway. The Saints Foundation falls exercise scheme is a particular strength that we would like to build on.** **We are also looking to strengthen our pathways between SCAS and Urgent Community Response to**

			reduce conveyance rates, including "call before convey", "dial before dispatch" and triage processes
	Residential admissions **(long term support needs of older people met by admission to residential or nursing care homes per 100,000 of population aged 65 and over)**	**On track to meet the target.** **Annual target = 648 per 100,000.** **Annual forecast actual = 543.9 per 100,000**	**Local data is showing a significant improvement with reductions in permanent admissions to both residential and nursing homes.**

2. Capacity and Demand

Estimates of capacity and demand have not changed significantly in quarter 2, since the BCF plan for the year was submitted. However, demand is exceeding capacity for Hospital Discharge pathway 1 Rehab and Reablement. Wherever possible short term home care capacity to bridge people at the start of their Reablement package is being utilised to prevent delayed discharge.

Within the community BCF funding has been used to increase capacity in the Urgent Response Service (URS) so that the workforce can be pulled from other community teams during peak periods to continue to support people in the community and avoid hospital admissions.

Demand for Hospital Discharge, pathway 1 short term domiciliary care is higher than expected but there is sufficient capacity to manage this. In the community referrals to the Community Independence Rehabilitation Service are lower than expected, we will continue to monitor this and investigate whether this is a data quality issue.

3. Expenditure

As part of the BCF quarterly report, expenditure to date for each scheme supported by the BCF is provided. Please see below the overall summary of the position as at month 6, quarter 1 & 2.

	2024-25			
Running Balances	Income	Expenditure to date	Percentage spent	Balance
DFG	£2,741,399	£1,047,233	38.20%	£1,694,166
Minimum NHS Contribution	£23,080,574	£11,612,525	50.31%	£11,468,049
iBCF	£10,704,789	£5,352,395	50.00%	£5,352,394
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£2,501,325	£1,250,662	50.00%	£1,250,663
ICB Discharge Funding	£2,270,958	£1,137,156	50.07%	£1,133,802
Total	**£41,299,045**	**£20,399,971**	**49.40%**	**£20,899,074**

The overall balance is close to expectations for month 6, with 49.40% of the budget spent. The main variance against the expected position is on the Disabled Facility Grant (DFG) where there remains an underspend.

4.	**Next Steps** Due to the late publication of the Quarter 3 reporting template, the submission date for the quarter 3 return has been extended to 14th February 2025. Prior to the submission, the draft return will be signed off by both NHS HIOW Chief Financial Officer and Chair of the Health & Care Partnership Board.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	N/a
Property/Other	
	N/a
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	N/a
Other Legal Implications:	
	N/a
RISK MANAGEMENT IMPLICATIONS	
	N/a
POLICY FRAMEWORK IMPLICATIONS	
	The Better Care Finance and Performance Group provides assurance to Southampton Health and Care Partnership Board on the delivery of the Better Care Fund against the plan. Areas of concern are escalated as appropriate and in line with the governance and assurance process.

KEY DECISION?	**Yes/No**
WARDS/COMMUNITIES AFFECTED:	
SUPPORTING DOCUMENTATION	
Appendices	
1.	None.

Documents In Members' Rooms

1.	None.
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Data Protection Impact Assessment	

Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.		
2.		

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