Market Impact Statement

Local Adult Care Market

SOUTHAMPTON 2021 – 2022

NHS
Southampton City
Clinical Commissioning Group

SOUTHAMPTON
CITY COUNCIL

Contents

Welcome from Stephanie Ramsey

Over the past year, Covid-19 has forced Southampton's providers of adult care services to face and endure the incredible challenge of continuously adapting and maintaining provision of essential services throughout successive waves of infections and hospitalisations; an experience that has tested the resilience of the city's system of health and care services, and the people delivering these services every day, like no other before it.

This Market Impact Statement, produced by Southampton's Integrated Commissioning Unit on behalf of Southampton City Council and Southampton City Clinical Commissioning Group, represents an initial attempt to establish a shared and broad understanding of the impact that Covid-19 has had on the efficacy of local adult care commissioning arrangements and pre-pandemic commissioning intentions thus far. In doing so, the aim is to support the development of our thinking and plans for how these arrangements and intentions may need to be re-shaped to remain fit for purpose, and to identify what further initiatives will be required to ensure resilience, continuity, safety, and quality in the provision of local adult care services throughout what is expected to remain a difficult and uncertain time in the coming year.

And yet there is also hope for the future – we've already made substantial progress with local implementation of the national vaccination programme, and with this we predict that we will soon be in a position to engage meaningfully with our providers to develop medium to long term plans for the future shape of local adult care services within the context of what will be our 'new normal' going forward.

I hope you find this Market Impact Statement to be of benefit to your organisation and we in the ICU would of course welcome any feedback or questions about it you may have.

Stephanie Ramsey
Managing Director, Southampton CCG &
Director of Quality and Integration, Southampton City Council

Introduction and executive summary

Introduction

Market Position Statements (MPS) normally provide information, intelligence, and analysis of benefit to current and prospective providers of care and support services within a given locality. The structure and format of this document will feel familiar to those who have read MPS's previously, but we have chosen to instead call this one a Market Impact Statement (MIS) to reflect the context within which the city's adult care market has operated for most of 2020.

This year has been one of unprecedented challenge and uncertain times, and despite their experience of COVID-19, care service providers have strived continuously throughout to maintain provision of critical services to some of the most vulnerable members of our community.

The scope of this MIS is inclusive of all adult care services commissioned by Southampton's Integrated Commissioning Unit (ICU) on behalf of Southampton City Council (SCC) and NHS Southampton City Clinical Commissioning Group (SCCCG). It includes allied services, such as Shared Lives, respite and other care environments supporting people in the community. Its purpose is to:

1. Describe the impact thus far of COVID-19 on the supply, demand, and operation of the city's adult care services
2. Review our pre-pandemic commissioning intentions for adult care services, consider the impact that COVID-19 has had on the delivery and relevance of these intentions, and where possible to provide early indication of where intentions may need to be re-shaped to remain fit for purpose within the context of COVID-19
3. Provide a steer for informed business planning and budget setting across the two organisations for the coming financial year
4. Initiate and/or continue a dialogue between commissioners and providers to agree how we will work together to ensure we maintain a sufficient supply of diverse, high quality adult care services in the city, despite the challenges brought about by COVID-19, and to facilitate collaboration between commissioners and providers on the further development and re-shaping of local adult care services to ensure they remain fit for purpose in the long term.

Introduction and executive summary

Executive Summary

All parts of the care sector have been impacted by COVID-19, and care homes for older people have been most adversely affected.

All adult care services have been adversely impacted during the pandemic, leading to significant issues for many users of those services. Services for older people, given the risk profile for this cohort and the role these services play in the city's wider health and social care system, have been particularly compromised and remain so. Further waves of increased infection rates risk adding pressure to services that have been under intense strain. Many providers are reporting that the relatively short period of recovery that has followed the first wave of infections has not provided adequate respite, as COVID-19 operational policies have had to remain in force, which has caused ongoing pressure on staff time and resources.

Complexity of need has been increasing

Across all service areas, there has been a rise in the complexity of client need. Continuing health issues caused by COVID-19, often known as Long Covid, are increasing care needs for some clients. Longer term impacts are still yet to be fully understood, but commissioners will need to re-design future services to ensure these needs can be met.

Changes in hospital discharge policy and practice have led to more and higher intensity care being provided in the community, placing pressure on services and costs. There is currently not enough capacity in community-based services to effectively support the hospital discharge process at the pace required by new national policy. The volume of patients coming through the system requiring intermediate and/or long-term care has increased as has the complexity of need amongst this cohort. Key service types remain locally undersupplied, including long term home care, and nursing care for people with complex needs.

Added to this is the potential for loneliness and physical and cognitive decline faced by many care clients, particularly those who live alone or are in care homes and have been unable to see family for a long time due to lockdown restrictions.

Commissioners are working to increase the number of Discharge to Assess (D2A) nursing care beds in the city to tackle the immediate need for people leaving hospital. We also need to ensure the supply of community care and support services is further developed to provide the assurance that anybody who can be supported at home, with the right services in place, is able to do so. This will include continued developments of housing with care for a range of client groups – from supported living housing through to extra care housing.

There will be further pressure on care providers over winter

The adult care sector is likely to remain affected over the winter. The Discharge to Assess (D2A) of medically optimised patients means that there is likely to be a need for a greater than usual number of nursing home beds throughout the winter months. Factors that might lessen the impact may

include mass testing, development of new treatments, and vaccination. Another factor that might worsen the impact, especially for this second wave and subsequent increase in infection rates, is a possible concurrent influenza epidemic. Co-infection of COVID-19 and influenza interacts to create much higher risk of severe illness. Influenza vaccination should be a priority for all care home residents and staff.

There has been significant disruption to learning disability support, mental health services and other community and day services

Other adult care services, including those for people with learning disabilities, mental health conditions, and day care for older people were also substantially disrupted by the first national lockdown. Pressure on mental health services is now being felt and this is likely to increase.

Provider innovation and the development of COVID-secure service delivery models enabled some of these services to maintain a degree of resilience and continuity. Other services are beginning to adapt, although day service provision for both older people and those with a learning disability remains a significant challenge.

Informal carers have provided considerable levels of support

Where clients have opted to stay at home or with a family member rather than accepting homecare or residential care, friends or family have become informal carers. We have seen a sharp increase in this arrangement during the pandemic, therefore support will need to be provided to these informal carers to sustain and/or replace this care in the future.

The self-payer market has reduced

There is a risk of an adverse impact on the viability of existing independent sector business models and the operating costs associated with the provision of adult care services. The care home sector, for instance, has traditionally relied substantially on income from individuals who fund care themselves, however, self-payer demand for local care home placements has fallen by 18% since the start of the pandemic. There has not yet been any sign of recovery of self-payer demand, and it remains unclear how this segment of the market will adapt if this becomes part of a long-term trend.

Increased costs and pressures are reported across the sector

At the same time, COVID-19 has imposed new pressures on the cost of operating adult care services, which have been estimated locally as an average cost of 22% more than pre-pandemic operating costs. Both national and local intervention has provided substantial temporary financial relief from these pressures for adult care providers. However, the absence of a long-term financial settlement that accounts on a recurrent basis for the additional cost of operating adult care services substantially increases the risk of local provider failure and/or system market failure.

Staff in all sectors are under continuing pressure, and have not had adequate time to recover from the pressures felt during the initial pandemic wave

Care staff from all sectors have been under immense strain over this pandemic, both personally and professionally. They have had to work over and above their usual duties to assist whilst also putting themselves directly at risk of contracting the virus in cases where a lack of adequate PPE was available at the

start of the pandemic. Additional to this risk, 10% of care staff are from Black, Asian and Minority Ethnic (BAME) communities, who have been identified to be at higher risk than other groups.

Planning for the future is challenging

Making accurate predictions about the future is always challenging, but perhaps now so more than ever. It is too soon to say with any degree of integrity or authority what the long-term impact of COVID-19 will have on the provision of adult care in Southampton. However, age, ethnicity, and deprivation are all risk factors for COVID-19. In addition, the prevalence of long-term health conditions places people at more risk and older people are more likely to have multiple long-term conditions. We know that:

- Southampton will have 4,000 more residents over the age of 75 by 2025
- Southampton has 19 Local Super Output Areas (LSOAs) within the 10% most deprived in England
- 11% of Southampton's adult care workforce come from a Black and Minority Ethnic (BAME) background.

Given these risk factors, there are important reasons for us to be concerned with the sufficiency and resilience of the city's adult care system in the near future. We know that there is a backlog of people waiting for treatment for a range of health conditions, delayed due to the first wave of COVID-19. Timely treatment for health conditions is key to ensuring people stay healthy and independent for longer, and delays in treatment can lead to more complex care needs in the long term. It has additionally been recognised that some people take much longer to recover from COVID-19, (i.e. Long Covid), which could also lead to growth of a new form of complex care need in the future. All of this may manifest as additional pressures on local demand for adult care in the future.

The impact of Brexit is still uncertain. With 8% of care staff from EU countries, any disruption could have further negative impacts on care services in the city at a time when levels of continuity are most required.

Substantial practical and financial support has been provided to the sector to date

The care sector has received and is continuing to receive substantial financial support from central and local government and SCCCG. However, decisions on long term infection prevention and control support need to be taken as additional financial support is currently only in place until March 2021.

While changes to costs relating to wage and inflation increases can and should be managed through usual change processes, changes to costs relating to ongoing COVID-19 requirements and impacts will require separate consideration and continuous monitoring to ensure sufficiency and diversity in the local supply of adult care for (at least) the next 12 months.

Commissioners are working with the market, including Hampshire Care Association, to develop an independent sector workforce strategy to support the market in the longer-term. It will also need to take account of any impacts from Brexit on the local adult care workforce. This will be in place in 2021, but is already delivering outcomes including wellbeing support, access to recruitment campaigns and setting out joint working opportunities.

There is also work underway to update Southampton's Carer's Strategy and a Carer Friendly Southampton Scrutiny

Inquiry has been convened to establish how carer support in the city can be improved. Alongside this, providers of day care are being supported to re-open safely and to innovate with other support provision where day centres are unable to provide safe care. Providers of homecare were given another opportunity to join the city's homecare framework when it re-opened in December 2020, with the aim of ensuring wider market diversity and sustainability across the city. Commissioners are also committed to providing ongoing practical day to day support in the management of COVID-19 risks and infections including training, guidance and question and answer sessions for providers.

The longer-term impacts on the market are still to be fully understood

There is still much more we need to know about COVID-19 and its legacy and subsequently much more we need to do to support the care market and improve outcomes for users of these services. The pandemic could result in a long-term realignment of care services, hastening moves from residential settings to community settings, including home care and housing with care, but this needs to be managed carefully to ensure care capacity is able to support this.

We need to explore the potential for a new commissioning and procurement approach to the care home market to maximise opportunities and provide more certainty to key segments of the market. For all sectors of the Care Market, the impact on staff recruitment and retention is uncertain given that care work may generally be characterised as both demanding and low paid in relative terms. We continue to develop our understanding of the service user and provider experience of COVID-19, and how we can best commission services going forward.

The shape of our future support to the care market will include co-production of solutions for care and working with our providers to innovate and tackle the challenges that lay ahead. We will also need to continue to listen to those receiving care in Southampton to ensure their voice remains central to the development of future commissioning intentions.

1 Southampton demographic overview and the impact of COVID-19 on the city

Section summary

Southampton is a diverse city with a younger population than the England average. The city's older population is set to increase over the next five years, which along with our growing BAME community and higher percentage of those living in deprivation, carries extra risk factors for the population from COVID-19. For the older population, those with long-term health conditions, and those who live in deprivation, there are many additional risk factors presented by COVID-19. Where we are concerned with impacts on the adult care market, it is important to bear in mind that there are specific risk factors both for those in receipt of adult social care, and those providing it.

RISK FACTORS FOR COVID-19

Age

Age has proven to be a risk factor, with older people more likely to be severely affected by the virus than younger people. The city's population aged 75 and over is forecast to have the largest proportional projected increase between now and 2025 compared to other age groups and this equates to an additional 4,000 residents over the age of 75.

Ethnicity

Since 2001 the diversity of the population within the city has changed, with a greater proportion of residents from a BAME background over time. The biggest change has been seen in the 'Other White' group, which includes migrants from Europe. The percentage of pupils from an ethnic background other than White British has increased and 39% of live births in Southampton were non-White British. This suggests that much of the population from ethnic backgrounds other than White British are younger. A review by PHE highlighted the disparities in COVID-19 related risks and outcomes for BAME groups.[1] These risks are important to bear in mind.

The adult care workforce is reflective of the diversity in the city. In 2019/20 in Southampton there were an estimated 5,800 jobs in adult social care, split between local authorities (9%), independent sector providers (86%) and jobs working for direct payment recipients (5%):

- An estimated 81% of the workforce in Southampton identified as British
- 9% identified as of an EU nationality, and
- 10% identified as a non-EU nationality.

Deprivation

Deprivation is a risk factor for more severe infection and mortality, with the most deprived having twice the risk of death of the least deprived. This is partly because there is already a link between deprivation and a higher incidence of long-term health conditions. The index of multiple deprivation (IMD 2019) highlights Southampton as a city with a relatively deprived population. It is ranked 55 in local authority areas in England.[2] Southampton has 19 Lower-layer Super Output Areas (LSOA) within the 10% most deprived in England and only 1 LSOA in the 10% least deprived.

[1] https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes
[2] Details of the IMD 2019 is available on the Southampton Data Observatory website: https://data.southampton.gov.uk/economy/deprivation-poverty/

FIRST WAVE OF SOUTHAMPTON COVID-19 CASES

During March to the beginning of October 2020, the total number of laboratory-confirmed cases in Southampton was 1162 (Figure 1). It should be noted that:

- During the early phase of the pandemic, testing capacity was limited to those with the most severe illness requiring hospital admission, meaning the actual number of cases is likely to be much higher.
- Studies have indicated that 30-70% of people with infection have no symptoms at all, suggesting that even when testing capacity became available for the wider population, including for those with mild symptoms, a large proportion of those with infection would not have been identified.
- Finally, the PCR swab test for COVID-19 has a relatively high false negative rate which may be as high as 30%. This means that for every 10 people that have COVID-19, only 7 are identified using the current test.

The peak of the first wave of COVID-19 in Southampton mirrored the national peak towards the end of April/beginning of May 2020 and then cases dropped by late June. Until the end of August, the cases in the city remained low, but notably not zero.

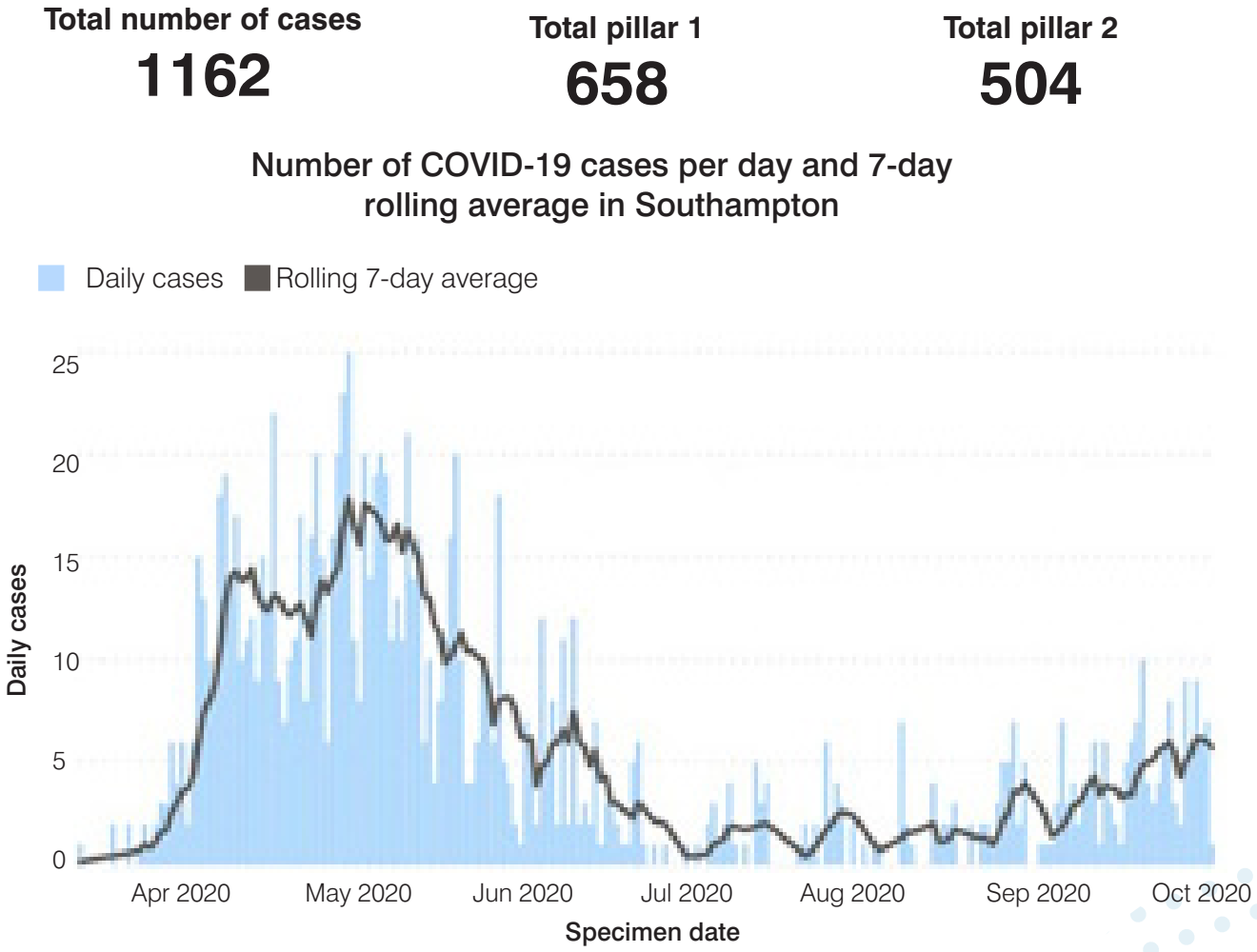


Figure 1: COVID-19 laboratory confirmed cases Southampton to October 2020

From April to June 2020, there were 168 deaths attributed to COVID-19 in Southampton. Most occurred in hospitalised patients (102) and the remainder in the community, with 53 of the 66 deaths occurring in care homes. The peak in deaths mirrored the peak in infection in the city, with a recognised lag associated with the time needed for symptoms to progress prior to death.

COVID-19 can have longer term health impacts. There is the risk of cognitive and physical decline among some elderly people, and other vulnerable people following lockdowns and a resulting lack of contact with family and others. Loneliness is a big contributory factor to this. Many care homes have been concerned at these impacts for some time, and we are expecting this to be mapped more formally than is the case currently as further waves of the virus occur.

In addition, some patients continue to experience symptoms after three weeks (post-acute COVID-19) and some beyond 12 weeks (chronic COVID-19). Exact definitions for these longer-term symptoms are yet to be agreed and it is hard to quantify the effects of this on the health and social care systems in the short and longer term. Since COVID-19 affects older people more severely, those who survive are at higher risk of sarcopenia, malnutrition, depression, and delirium. It is likely that a person already receiving some type of adult care would have higher care requirements following infection, and especially if experiencing some Long Covid symptoms. Several long-term follow up studies are underway to understand more about the impact, which should enable better planning to meet needs.

SECOND AND SUBSEQUENT WAVES OF VIRUS

From September 2020 a second wave developed across England. Southampton has also seen an increase in the infection rate, though this began more slowly.[3] Due to the nature of transmission of the virus, once the rate of infection rises it spreads across age groups. This was demonstrated in those regions with higher rates of infection, which saw a corresponding rise in hospitalisations, use of ITU beds and mortality.

There are several differences that should be considered when predicting the impact on adult care when compared to the first wave:

- Improved PPE supply routes from day one
- Improved PPE training
- Improved infection prevention and control training and support for care home providers that has been embedded in practice
- Routine testing of asymptomatic residents (monthly) and staff (weekly) in care homes
- Routine testing to be expanded to some supported living and extra care settings
- Routine testing being piloted in home care settings and may be rolled out if effective
- Routine testing of healthcare staff at University Hospital Southampton
- Infrastructure now in place for expansion of intensive care beds
- NHS Test and Trace to act on positive results, inform cases, and identify contacts

[3]Weekly data on Southampton rates:
https://data.southampton.gov.uk/health/disease-disability/covid-19/covid-19-updates/

- NHS tracing smart phone App
- Social distancing starting to become the social norm
- A greater public awareness of the things that can be done to prevent individual infection (Hands, Face and Space), onward transmission (isolate with symptoms or when a contact), and contain outbreaks
- Further national lockdowns and tier restrictions
- Better understanding of how to treat COVID-19 when individuals require hospitalisation.

Management of this current wave had already begun, but consideration is now also being given to the potential impact of subsequent waves of increased infections on the health and care system. There are risks to the sustainability of staffing in the sector as they face continued pressure both managing the new requirements for wearing protective clothing, but also on the increased time required to support clients, many of whom are unaware of the restrictions in place, and whose condition is such that they require constant reassurance.

COVID-19 and staff absence

Gathering good data on staffing issues has presented challenges, but since June 2020, the COVID-19 Adult Social Care Tracker has been providing better quality data on staff capacity. There is no comparable data available before this date.

Since summer 2020, COVID-19-related absences in the local care sector workforce have reduced but remain significant for some providers, particularly as many parts of the care system run on both low margins and low staff ratios. Providers are once again

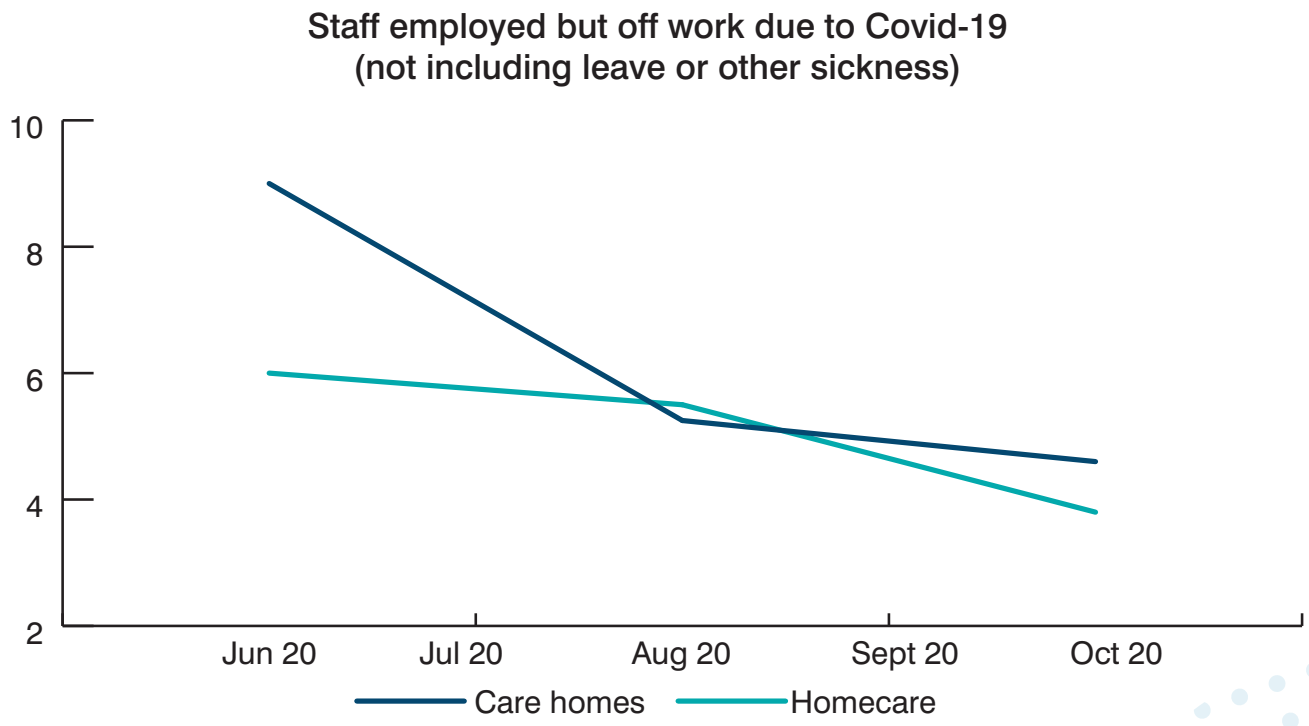


Figure 2: Staff employed but off work due to COVID-19

now identifying a slight increase in infection rates' rates among staff, particularly within care home services as testing has become the norm.

The impact on adult social care from the effects of the first, current and subsequent waves of the virus is likely to fall into a number of categories, and the current responses are required to identify, support and limit these impacts, which include:

- Direct short-term effects of COVID-19 infection such as increased morbidity, enhanced care needs, reduced workforce, adverse effects on informal carers and an increased incidence of mental health conditions. These are already being felt and are likely to result in longer term pressures in the health and care system
- Direct long-term effects of COVID-19 infection (Long Covid) such as post-acute or chronic COVID-19, for many vulnerable clients
- Impact on care staff resilience, resulting from prolonged use of PPE, time spent soothing and supporting clients, and burnout for staff and informal carers
- The impact of COVID-19 on BAME groups and carers in the city is likely to be greatest, and providers are encouraged to provide additional support for these staff and clients, including reducing contact with people at highest risk of infection
- Indirect effects of COVID-19 such as changes in accessing health services, delays in detection and treatment for new conditions, exacerbation of long-term conditions and general deconditioning due to prolonged lockdown. This includes the loneliness and potential cognitive and physical decline of some individuals with care needs, due to the lockdown restrictions.
- Support is being provided through additional funding for infection prevention and control measures to keep both staff and clients safe, by ensuring staff only work in one home or with a limited number of clients in the community, residents who must isolate can still receive appropriate care and support, and to enable visits to care homes to take place safely, enhancing resident wellbeing.

2 Local COVID-19 impact on demand for intermediate care

Section summary

Intermediate care provides support for people when they are first discharged from hospital, while they are assessed to determine if longer-term support is needed. Changes to discharge policies have supported hospitals, but there are impacts on community provision including an increased volume of patients being discharged and requiring support, increased complexity of patient's needs and a lack of capacity in community-based services to cope with this.

There are several issues related to intermediate care which need to be addressed:

- The city is not achieving the target for enabling people to leave hospital within the required timescales
- Community-based services do not have adequate capacity or the necessary skills base to support the levels of complexity of need and speed of discharge from hospital
- Independently provided discharge service types, including to D2A nursing home beds, Designated Accommodation, and homecare services continue to be needed and able to deal with increased complexity of need. This capacity is being put in place, but there remains a need to focus on more support for this group in the community and outside of care home settings. In this way, the potential to ensure individuals can remain as independent as possible will be maximised.
- Further research is needed to understand readmissions to hospital following the usual 28-day reporting period after the discharges. We can map impacts on complexity as clients are readmitted but understanding if these can be managed more appropriately will be key.

Prior to COVID-19

Priorities prior to the pandemic included a focus on ensuring discharge to assess capacity was sufficient to meet needs, and to ensure individuals were able to leave hospital in a timely manner. In addition, appropriate move on services were needed to continue to enable this through-flow of patients from hospital to the community.

Hospital discharge

The COVID-19 Hospital Discharge Service Requirements[4] were put in place in March 2020 to help the NHS prepare for COVID-19, and this has required rapid, large scale transformation within the local health and social care system. The system changed again from 1st September 2020, to the national Hospital Discharge Service Policy and Operating Model[5], to allow for assessments to be undertaken to determine responsibility for ongoing financial support - from CCGs or local authorities, or if individuals would need to fund their own ongoing care.

In line with the policy, patients are now being discharged from hospital when they are Medically Optimised for Discharge (MOFD). This means they are ready to leave when they have received the required clinical support from the hospital but excluding any recovery

[4]https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements [5]https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model

period. All assessments of on-going needs that can take place in the community should do so. This results in many more patients leaving hospital at an earlier stage in their recovery. Many consequently have a higher level of need and require more community-based input to their recovery. This has led to demand for a greater volume of support, and more complex packages of support when patients return home or are referred to care homes.

Where people who are MOFD and do not require an acute hospital bed but may still require care, services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. A policy of Home First, supporting the individual's ability to return home with the appropriate support in place, is the first option to be considered. If this is not possible, other bed-based options are considered. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. This is the Discharge to Assess (D2A) process.

To support this rapid discharge process, four patient categories have been established:

- PATHWAY 0: simple discharge, no formal input from health or social care needed once home.
- PATHWAY 1: support to recover at home; able to return home with support from health and/or social care. This includes restarts of former care packages.
- PATHWAY 2: rehabilitation or short-term care in a 24-hour bed-based setting.
- PATHWAY 3: require ongoing 24-hour nursing care, often in a bedded setting but could also be an intensive homecare package, such as live-in care. Long-term care is likely to be required for these individuals.

Acute hospitals are responsible for ensuring the discharge of the first group (Pathway 0). Providers of community health and care lead on the other pathways, working with adult social care and the independent/ voluntary care and support services supply chain. While home is the default discharge destination (Home First), many people with higher needs require specialist support either for the short or longer terms.

Due to the pace at which discharges are being undertaken, patient and family choice is often restricted, and this may be further compounded by what can often be a limited supply of local care homes and home care providers able to meet the needs of patients discharged from hospital at short notice. This is likely to have an adverse impact on both the sustainability and average price of such placements, and if families are unable to visit this could undoubtedly be a source of distress for both the individual and their family.

Hub service supporting the discharge process

A Hub has been established to coordinate access to the community services required to support the discharge process. This consists of:

- The Adult Social Care Hospital Discharge Team.
- The Urgent Response Team (URS) providing rapid community health and reablement. This is an integrated health and social care rehabilitation and reablement service for patients requiring ongoing support.
- The SCCCG Community Health Care Team (CHC).

- The Community Independence Service (CIS)
- Further support is then offered through two brokerage services
  - Care Home Select who support the D2A route into nursing home beds
  - The Placement Service which supports the routes into all other services.

Referrals are made in real time to the hub, and hospital staff undertaking ward rounds endeavour to act pre-emptively to give the community as much advance notice of an imminent discharge. As well as supporting the hospital discharge process all the community services who are part of the hub also have 'step up' activity which plays a crucial role in preventing new hospital admissions.

Urgent Response Service (URS)

URS provides a range of services in the community for people leaving hospital, from homecare to therapeutic support. The service receives between 150 and 170 referrals each month. This has fluctuated in 2020 due to the changed processes in place to support hospital discharges, including referral direct to community services.

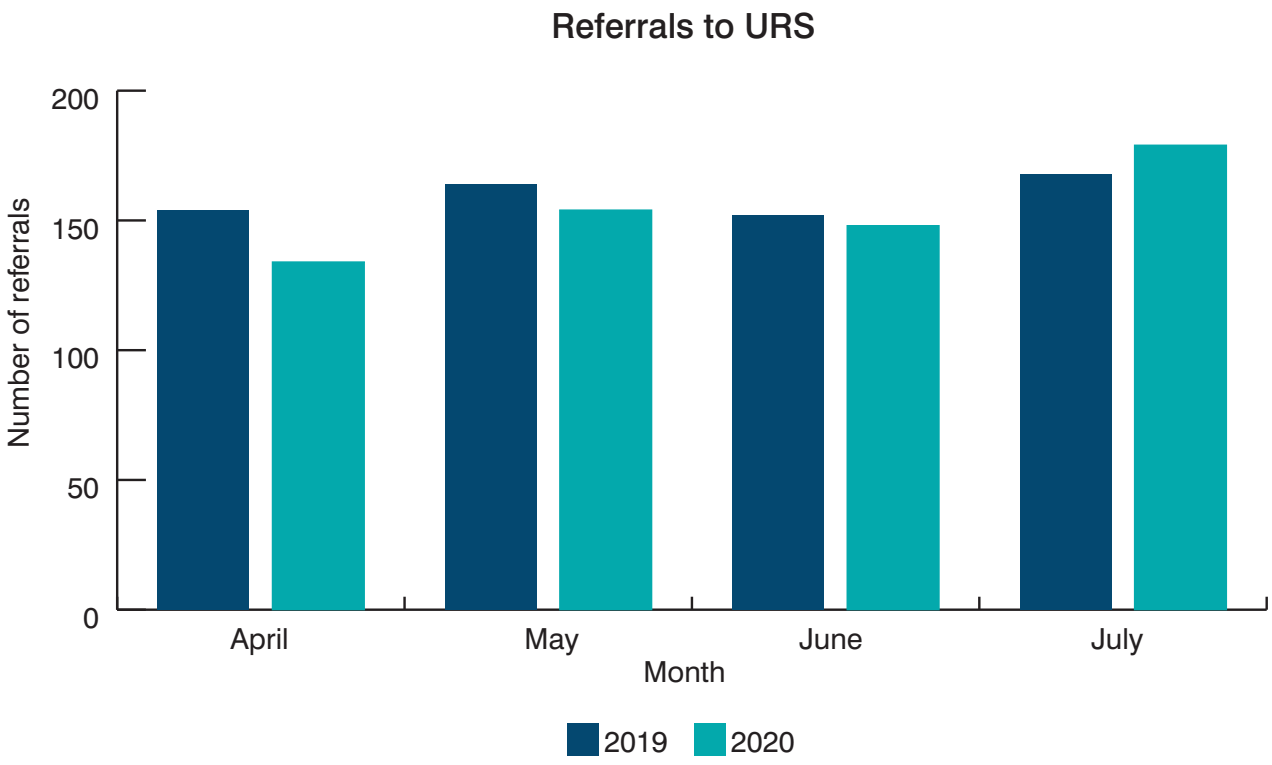


Figure 3: Comparison of referrals to URS between April and July in 2019 and 2020

Evidence from URS also shows that average complexity of client need has risen by 53-54% during the COVID-19 period, placing more pressure on the capacity of both this and other community services. Figure 4 shows the increase in support required by URS clients over a 2-month period in 2020 when compared to the same months in 2019.

Month	Average minutes of care per client per day - 2019	Average minutes of care per client per day - 2020	% increase in level of care required
June	52	80	**54%**
July	53	81	**53%**

Figure 4: Comparison of average hours of URS provided care per day per client over two months in June and July in 2019 versus 2020

Therapy services

Timely access to therapy is important in keeping people as independent and active as possible, reducing the need for care or further hospitalisation. 16 packages of therapeutic support are commissioned at any one time. Figure 5 shows that therapy was undersubscribed in April and May, but that since June 2020 demand for therapeutic support has sharply increased and exceeded the originally commissioned supply. This has required additional investment to be made to meet the demand.

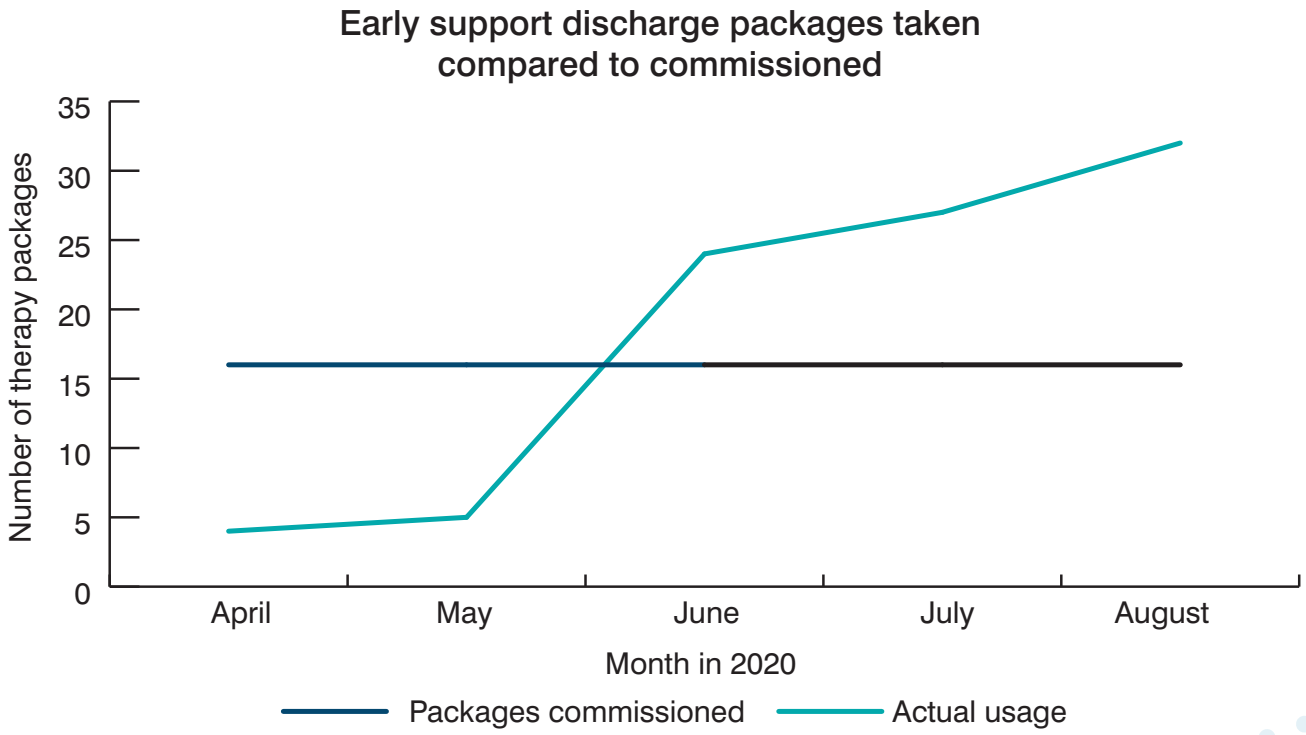


Figure 5: Numbers of therapeutic support packages provided compared to those commissioned between April and August 2020

The service is assessing all patients in the commissioned discharge to assess beds within 72 hours of admission to homes to assess the levels of need, as therapy assessments are no longer routinely completed for all patients while in hospital. Failure to initiate timely therapy for patients in a care setting will increase the risk that patients with the potential to return home may not be able to do so, requiring longer stays in care homes.

Community Independence Service (CIS)

The CIS is made of locality-based Community Rehabilitation Teams. While these teams support clients at all need levels, they are focused primarily on lower-level needs people returning home. As with the URS, there has been a significant increase in activity for these teams over the COVID-19 period. Figure 6 shows the increase in referrals to CIS from hospital, though not all are hospital discharges as some are instead hospital avoidance referrals from the Emergency Department.

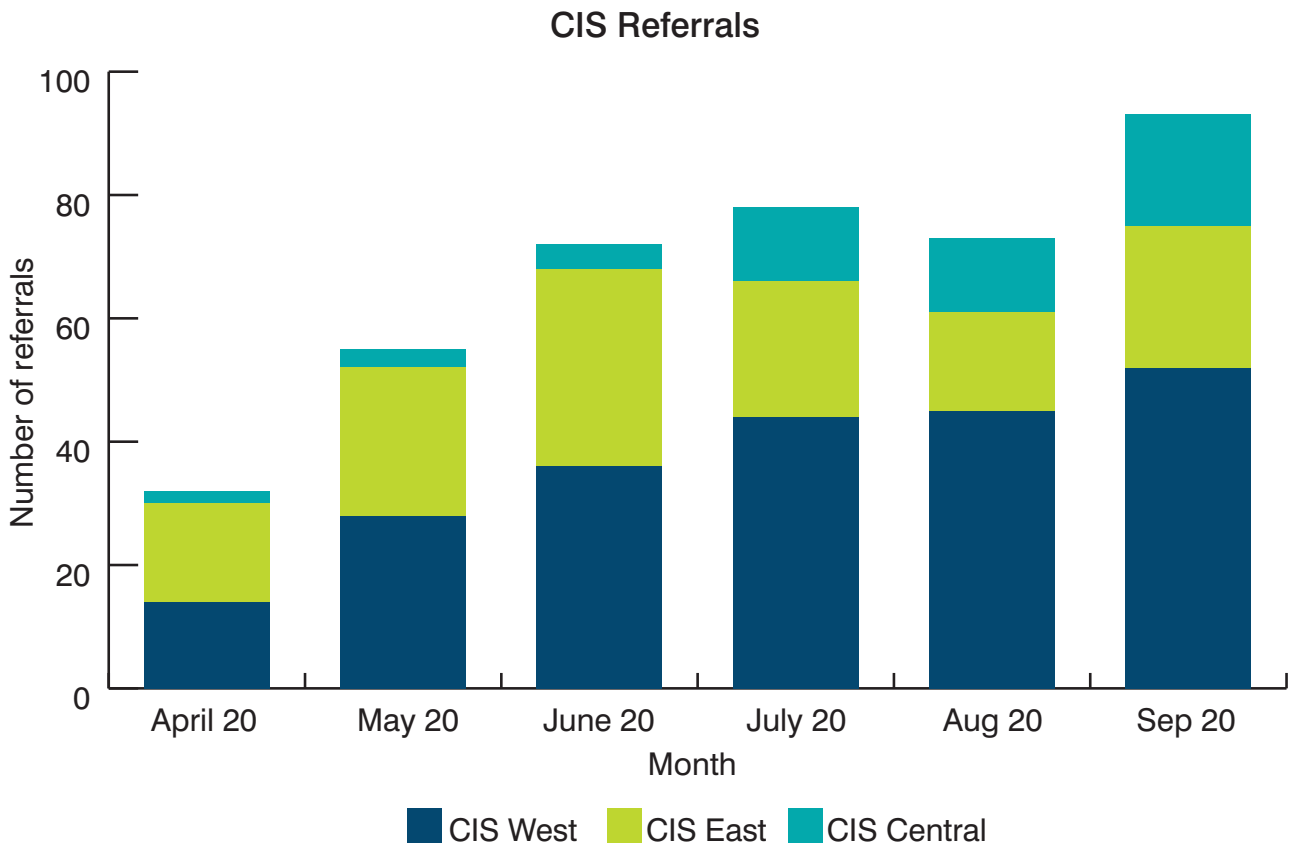


Figure 6: Number of CIS referrals per month and per team

Impact of COVID-19 and the national policy response on discharge performance

There is a significant mismatch in the patients ready for discharge and those who can be supported in the community. Figure 7 shows the gap in demand, which is cumulative, and capacity of the range of services in the community to deliver.

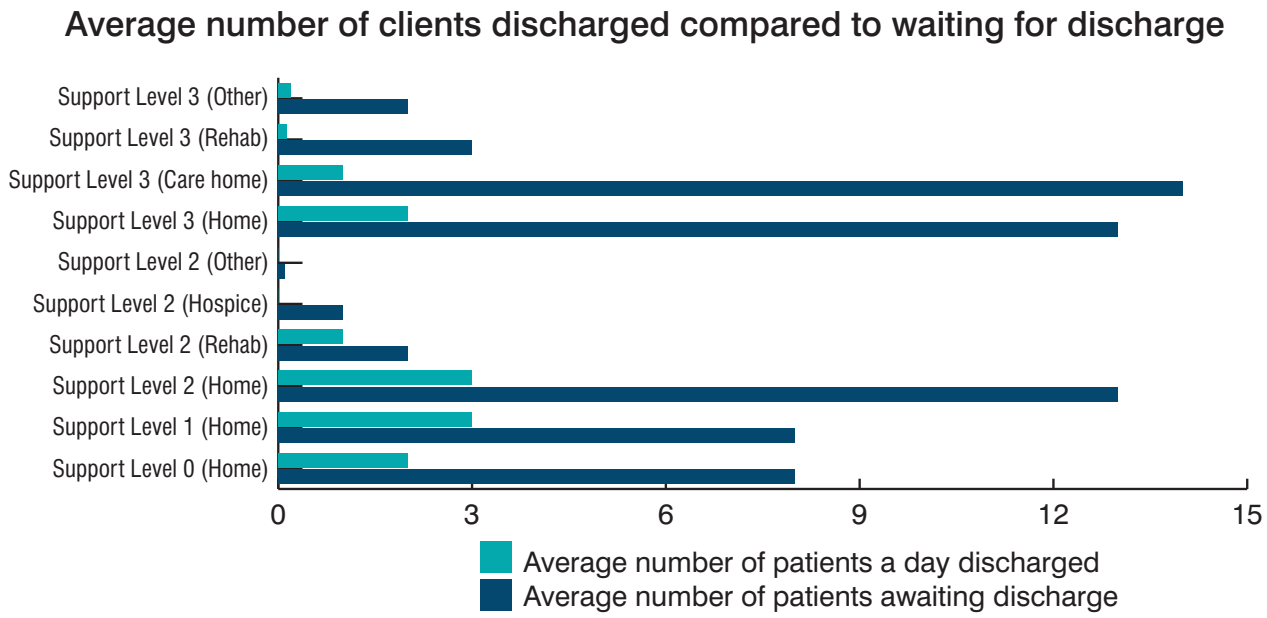


Figure 7: Number of clients declared MOFD and awaiting discharge compared to average number of discharges per day for each Pathway, for the period 16th to 29th September 2020

Readmission data

Readmissions to hospitals, (as measured by returns with 28 days of discharge), have not significantly altered from past periods despite the change to MOFD status of patients. However, there are impacts being felt in the wider system from people who have had to return to hospital beyond 28 days.

SCC's adult social care services are beginning to observe some of these longer-term changes to client needs. Between April and September 2020, 371 clients known to adult social care services have been admitted, discharged and subsequently returned to hospital. This included clients already known to social care and supported to live at home or in care homes, and those new to social care following discharge from hospital (on the COVID-19 pathways).

Of this group, 44% were discharged back to the community and have not returned to hospital. Of the remaining clients, 43% had to return to hospital and a further 13% had to be return on more than one occasion.

Admitted once only	162
Readmitted once	161
Readmitted twice	37
Readmitted three times	8
Readmitted four times	2
Hospital Avoidance	1
Total	**371**

Figure 8: Hospital readmissions for patients MOFD and known to adult social care – April to September 2020 (SCC tracking of funded clients in the community)

It is difficult to know the reasons for this currently – it may be the longer-term needs of clients changing as a result of Long Covid, or it may reflect the system's ability to support clients' short-term but not longer-term needs.

There is a need to further understand the reasons for these readmissions in all cases. In most cases the needs of clients increased following subsequent admissions and discharges. In addition, we still need to track these clients to assess the full levels of need and complexity when leaving hospital. There is emerging research from across the world that patients with existing respiratory problems and hypertension are more likely to be readmitted. Given the air pollution issues in the city and higher levels of respiratory disease this may be a factor, but further work is needed to understand this in Southampton and to understand what co-morbidities these individuals may have and how that is impacting on their recovery.

Equipment

The number of patients discharged from hospital requiring equipment is no higher than in previous years. However, the type of equipment and number of items per patient again indicates a much higher level of complexity. In the three months of operating, August to October 2020, the city's new joint equipment store has supplied:

- **78 more profiling beds** when compared to the previous 4 years
- **13 more hoists**
- **99 Dynaform dynamic mattresses,** which represents a 618% increase in the demand on previous year's average. These are only prescribed for highly dependent patients who are unable to move themselves or have severe pressure damage.

These figures, compared with several years of data, suggest that COVID-19 is a contributory factor in the increase in spend as it is the only variable. Again, it will be important to continue to monitor this as this will have a long-term impact on the types of services required to meet needs and on the costs being faced by both organisations in meeting these requirements.

Complex clients

For the most complex clients, there are a range of responses including returning home, in line with the Home First policy, community hospital rehabilitation services, neurorehabilitation and specific support for discharges within the community. The complexity of needs for this group, can mean that a number of services are required to provide the necessary level of support. This is not always readily available in the community, and sometimes there is a reliance on a care home placement, normally in a nursing home, to provide the required level of care in the short term whilst the assessment of their long-term need is undertaken. To effectively implement the Hospital Discharge Service policy at a local level, there is a need to stimulate further growth in the local supply of the right services both in and around the city. This will include nursing home placements, higher intensity levels of home care and therapy support, and the option of live-in care to resolve the short and potentially longer-term requirements of the most complex groups.

The greatest gaps in demand and provision have occurred for the most complex patients requiring the highest level of ongoing support once leaving hospital. Prior to the pandemic, a review established the level of demand for D2A as 10 beds. By November 2020, this had increased to 23 and with an aim to have

more available in the next two months. There is a further review planned using data up to January 2021, when true demand may be clearer.

For this group, the current demand is approximately quadruple that of the pre COVID-19 position. This means the need to find further bed spaces within care homes is essential to support these complex clients more appropriately. These places in care homes must come with the right levels of care and support provided. This is not always available, although both SCC and SCCCG continue to work with providers to increase the levels of complex support on offer to help meet this demand. The increased complexity of need has also led to an increase in costs. This is discussed in detail in Section 8.

The Adult Social Care Winter Plan[6] sets out a commitment to deliver a designations scheme with the Care Quality Commission (CQC) for premises for people leaving hospital who have tested positive for COVID-19 and are transferring to a care home. Southampton has secured 19 beds in designated accommodation, shared with Hampshire, but further beds may be required according to needs identified over the winter period.

[6]https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021

3 Homecare

Section summary

Homecare services support people in their own homes and within extra care housing schemes, enabling them to stay independent for longer. There are currently 5 extra care housing schemes in the city, supported by 3 framework providers. The key impacts identified in this section are an overall increase in volume of clients, an increase in the complexity of client's needs, an increase in the use of 'off-framework' providers and increased costs for providers.

Despite signifcant increase in demand and complexity of need the market has responded well to the pandemic; the implementation by providers of their contingency plans was effective and providers were proactive. Feedback from providers has indicated the support they were given by Southampton's Integrated Commissioning Unit (ICU) was well received, relevant and appreciated. This is due to the regular communications and accessibility of the Infection, Prevention and Control (IPC), Quality, and Placements Service teams.

The homecare framework reopened in December 2020, and will be changed from April 2021. The city encouraged providers who were delivering services in the city but were not on the framework to apply to be on the framework. Currently the city still does not have the capacity of homecare provision to meet all needs and demands, and are not always able to meet the complexity levels required. Commissioners will work with the market to address this.

Prior to COVID-19

Homecare provision commissioned by SCC/ SCCCG is delivered through a framework agreement. The current agreement runs from April 2019 to April 2023. It is designed to provide -

- Delivery of personal care and support within a client's own home or residence (including those within housing with care settings).
- Delivery of complex care which is either wholly or partially funded by CHC or Continuing Care for Children (CCC), governed by SCCCG.

The principles which underpin this commissioning approach are –

- A strength-based approach to care, this involves working collaboratively with clients to draw on their strengths and assets, both in their home and in their community, to achieve an outcome that maximises their independence and allows them to remain in their own home for as long as possible
- Reducing demand on other service provision, including residential care and reablement care
- Co-operation / collaboration with other health providers, including home care providers and health providers in the community and in acute settings, in support of the clients
- Person centred and responsive delivery. Placing the person at the centre of their care planning, ensuring they are recognised as the expert in their own experience

- Skilled staff that meet the requirements of the care provision and can provide continuity of care for individuals
- Innovative approaches to meeting the demands of delivering care in Southampton

The intention of the framework is to deliver on all the expectations set out in the Unison Ethical Care Charter[7], noting that stage three of the Charter remains developmental for all providers in the city.

The framework is subdivided into three lots that support adults – Lots A and B are for adults that meet SCC criteria and Lot C is for adults and children that meet NHS criteria[8]. Whilst the total number of homecare hours commissioned in the city varies over time, on average in excess of 23,000 hours per week are required to meet the current demand, this is made up of approximately 19,000 care hours for Lots A and B, with Lot C seeing activity of approximately 4,000 care hours a week.

Lot A has the additional element of 'lead providers', who are allocated in a geographical area in the city for which they have additional responsibilities, including providing the onsite care for extra care facilities within the area, and acting as a lead for homecare within health and care system discussions and forums.

The development of the lead provider role is intended to promote opportunities to develop stronger relationships between homecare and the wider group of health and care providers in the city. It also provides opportunities for Adult Social Care and CHC to develop closer working with homecare providers through initiatives such as trusted assessment. Finally, the terms of this framework enable commissioners and providers to test new ways of delivering care which will inform future commissioning arrangements.

The process of how packages of care are procured encourages market sustainability and vibrancy by setting out the parameters for which providers are offered packages of care, following a clear escalation route depending on the referral pathway. This allows opportunities to be spread across lead providers (currently 5) and tier 2 providers (currently 19), whilst allowing for the possibility of flex to off-framework during periods of pressure. The framework and escalation process ensure that no one provider has too big a share of the market, while still recognising the position of the leads.

Home care lot A market share

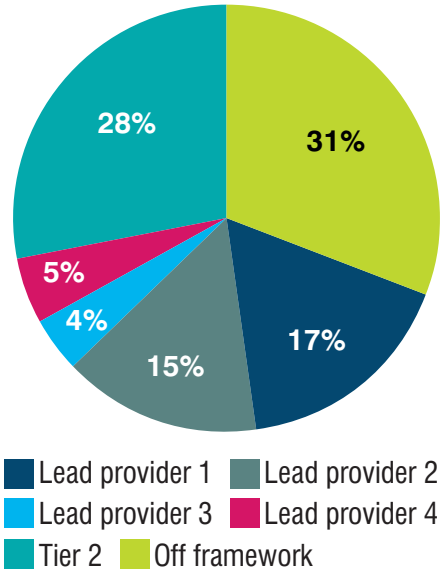


Figure 9: Homecare Lot A market share

In addition, there is a 'bridging' service in place, which can provide short term care while a longer-term package is agreed. This enables patients to be discharged from hospital with support prior to their care package starting. For the other lots, the picture is slightly simpler, with approximately ¾ packages of care placed with the 23 providers on Lot B. There are an additional 18 providers on Lot C.

[7]Link to Ethical Care Charter - https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf
[8]There is also Lot D for children that need support but are not included under Lot C, but that falls outside the remit of this report.

Complexity

Homecare services have seen an increase in the complexity of need. As demonstrated by the increase in the number of hours of care funded and the average weekly hours per client in 2020, shown in Figures 10 and 11 below.

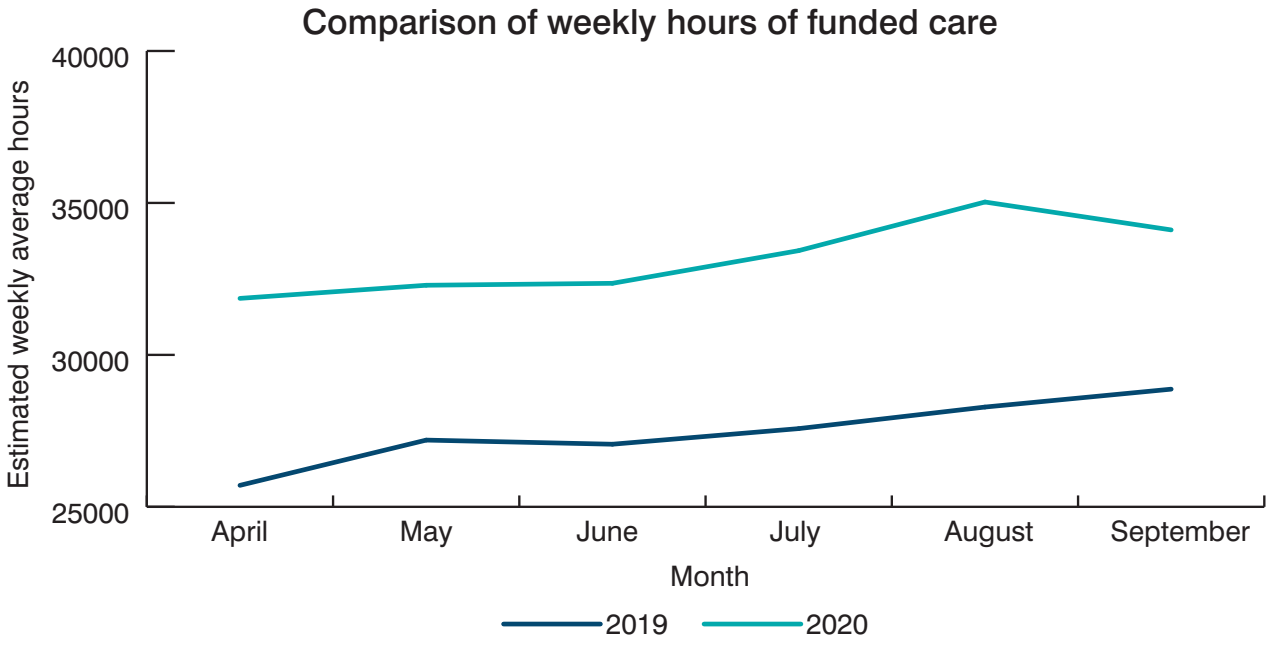


Figure 10: Comparison in the weekly hours of care funded by SCC and SCCCG between April and September in 2019 and 2020

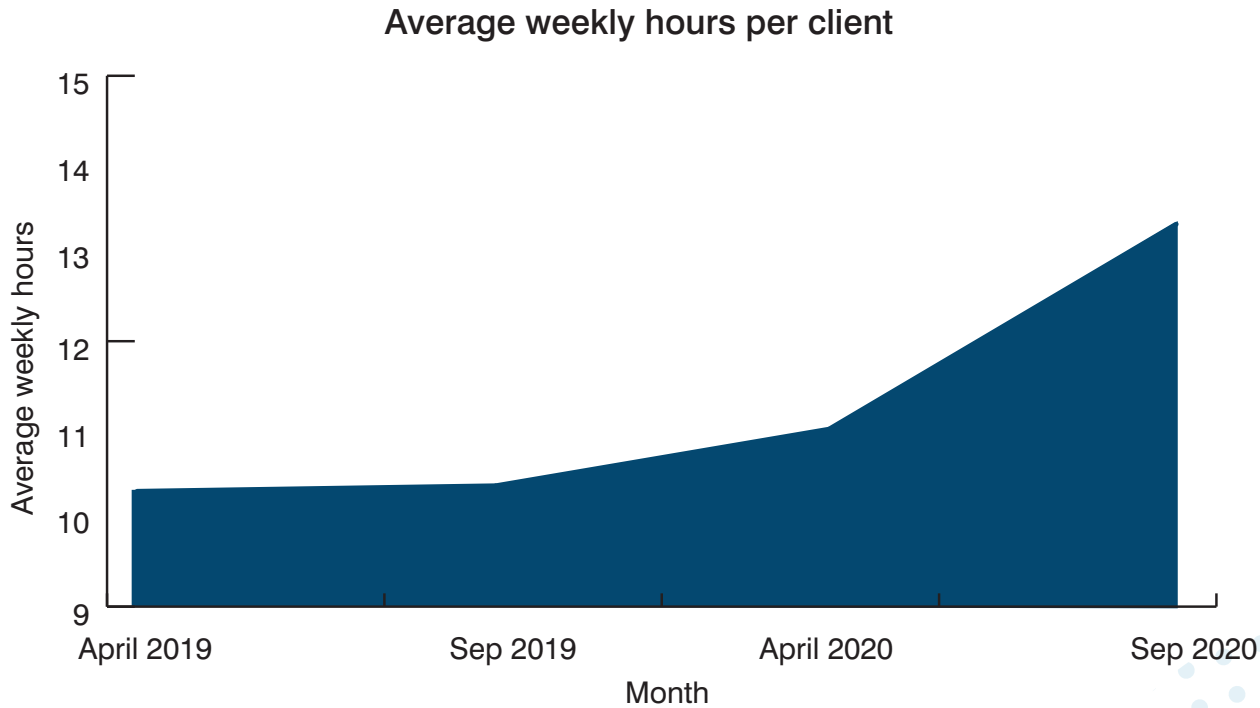


Figure 11: Increase in the average weekly hours per client from April 2019 to September 2020

COVID-19 EFFECTS ON SOUTHAMPTON'S HOMECARE MARKET

The COVID-19 pandemic has placed great pressure on the social care market. Many providers have faced COVID-19 outbreaks and have had to deal with the responsibility of both preventing outbreaks and managing those when they did occur. Additional pressures also arose from additional PPE costs, staff sickness and isolation levels; this impact was also felt in supported housing schemes.

Framework utilisation

There has been an increase in the number of packages of care with 'off framework' providers over the past 12 months, on average this equates to 28.75%. There is a notable spike in March 2020 to 39.86% which we believe is attributable to pressures associated with COVID-19. In addition, there was an increase in the number of care hours required from the bridging service which at the height of the first wave of COVID-19 was in excess of 880 hours a week.

The framework provides a structure which ensures packages of care are fairly and equally offered and apportioned within the homecare commissioned market. The use of 'off framework' providers can levy a risk and whilst this is mitigated by obtaining additional quality assurance, off framework provider use is not encouraged and in instances when it is required, close monitoring is undertaken by the senior commissioner. In addition, provider failure is always a risk, and the city has a clear Provider Failure Protocol which is implemented in such instances. SCC also had a significant number of approaches from new providers wanting to support the Local Authority during this period, an increase of around seven-fold from previous years.

Cost and operational pressures

Providers have informed us that they are experiencing increased costs in terms of additional PPE expenses and staff sickness. This is despite additional COVID-19 related funding, both through a 10% uplift for the period, and Infection Control Grant monies.

Despite the general upward trend, some providers reported a reluctance to take on new packages of care, particularly at the beginning of the COVID-19 period. This was due to uncertainty about the effect that this would have on their ability to provide these should their staff become unavailable due to illness or the need to self-isolate. This can be evidenced with data from the Lead Providers, who accepted 50% fewer packages of care eligible to them than pre-COVID-19. In addition, providers had reported clients and their families expressing concerns at having carers continuing visits during the pandemic. Providers talked through issues to ensure safe care could continue to be delivered.

Demand for homecare amongst hospital leavers

Demand for the bridging service can be subject to seasonal variation, however, Figure 12 shows an upwards trend in growth for demand of this service since quarter 1 2019/20, with 23% more bridging care required in Q1 20/21 than in Q1 2019/20; in response to this demand 392 hours of bridging core hours have been commissioned with the flex to increase should the system require. This is being closely monitored to ensure effective utilisation at all times.

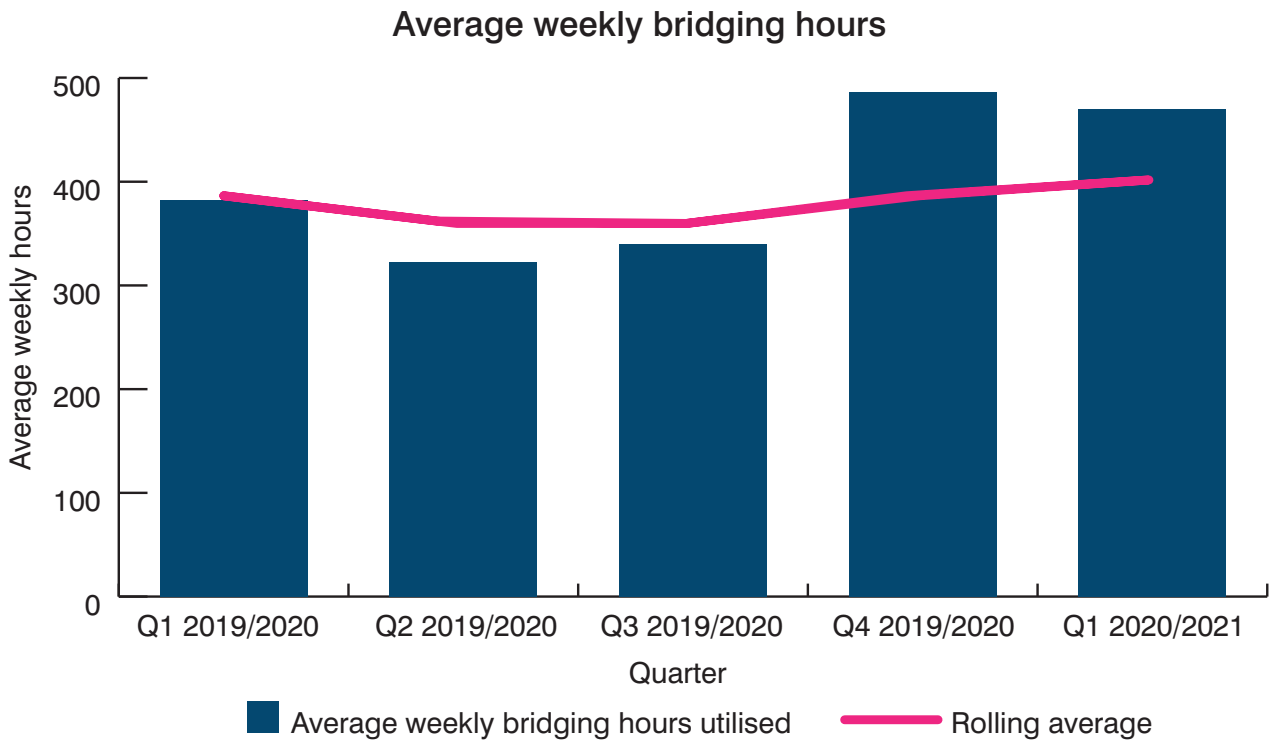


Figure 12: Average weekly bridging service hours per quarter

DIRECT PAYMENT UTILISATION

Direct payments enable people to choose the services they need themselves. In Southampton most people with direct payments make use of homecare and other services in the community. The number of direct payment clients was reducing prior to April 2020, and that reduction has continued during the pandemic period.

Multiple providers have reported that the anxiety of family members of having non-family members visiting caused several clients to cancel their packages of care in favour of support from family. This has caused some challenges for providers and clients who are in receipt of direct payments due to the personal relationship many direct payment clients have with their carers. Exact figures on this are unknown as this is an arrangement between the provider and the client. However, the needs and wellbeing of informal carers and the risk that such arrangements may not be sustainable will have to be considered more formally to ensure carers and clients can be properly supported and do not fall ill or require higher levels of interventions.

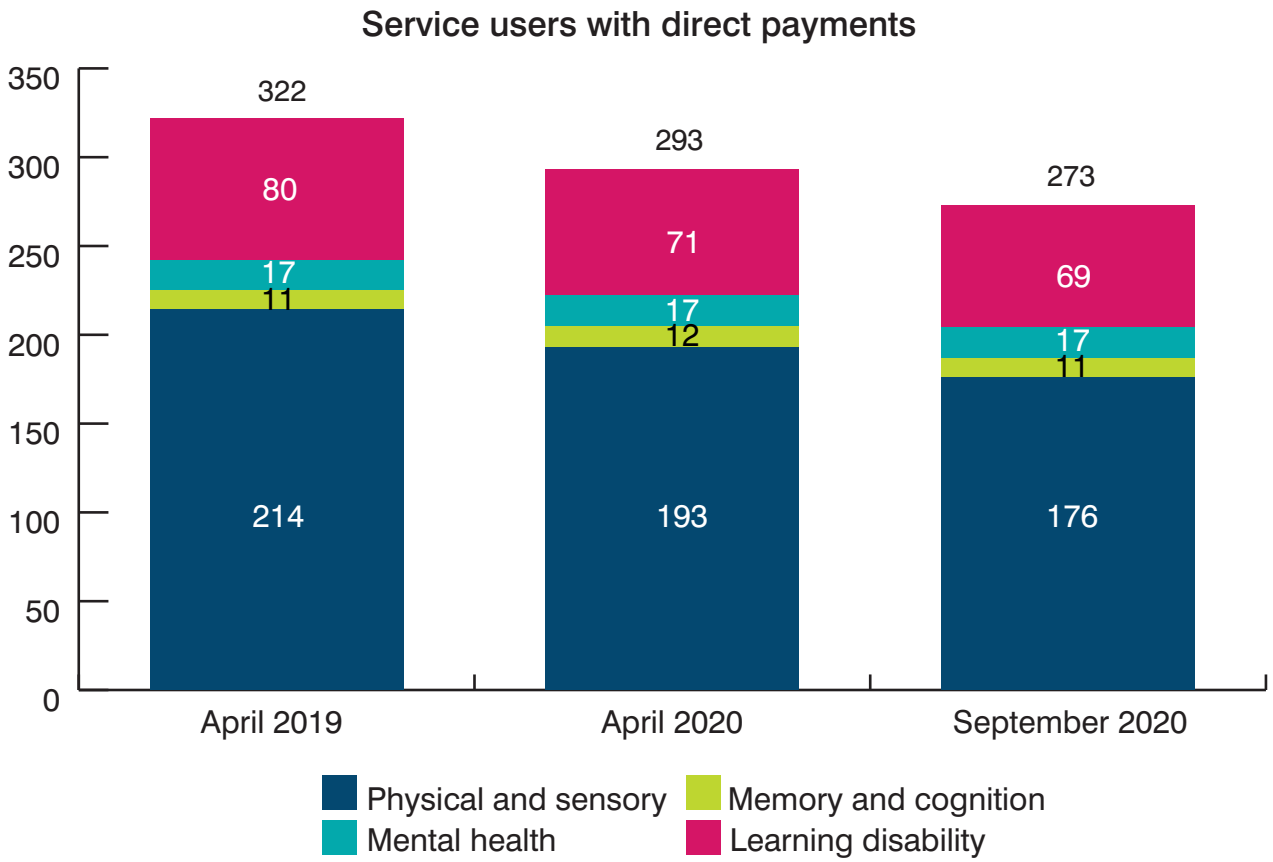


Figure 13: Number of service users with direct payments by care client group

SCC and SCCCG are working in parallel towards promoting the personalisation agenda which may result in a significant increase in the number of people who choose to take a direct payment. This will have an impact on the homecare market, with more directly employed Personal Assistants (P.A.s) and more people seeking a flexible approach to their care delivery. This will be a challenge for the homecare market in the coming months and years.

4 Care homes - Older people, physical frailty and mental health

Section summary

Residential care homes and nursing homes both provide 24-hour care in an accommodation setting. Nursing homes also provide nursing staff, enabling them to provide a higher level of care to those individuals with the most complex needs. The key impacts identified in this section are increased complexity of client's needs and a lack of appropriate care home beds to meet that need, a reduction in the number of self-payers and increased costs incurred by care homes.

Pre-existing local care home market dynamics have been exacerbated by the city's experience of COVID-19, and the local supply of nursing care for those with complex needs is now under even greater pressure to cope within increasing levels of need and complexity. Additionally, the COVID-19 risk profile for older people and the role that care homes play in the wider health and social care system have both caused this service type to be substantially affected by the virus.

The self-payer market has notable reduced and it is unclear when this will recover, or if this marks a fundamental change in self-payer behaviour. If so, this could have a significant impact on the sustainability of the care home market, as self-payers are often charged higher rates, as a council is able to use its purchasing power commissioning position to negotiate lower costs.

The community alternatives to residential settings, including extra care services, provide an on-going opportunity to support clients. The development of Potters Court, which is due to open in 2021, will provide an appropriate alternative for clients to consider both when first leaving hospital and when being reviewed following a stay in a care home.

Prior to COVID-19

Under the Care Act 2014 a local authority has a duty to ensure sustainability of the care market and to ensure that there is diversity and quality in supply. Providers are autonomous businesses responsible for employing, training and setting pay and terms and conditions for their own workforces. SCC must set fees that cover the legitimate costs of delivering the service and make a fair return to support the business to be sustainable.

Prior to COVID-19, increasing the supply of nursing home capacity accessible to SCC and SCCCG was a priority. Work undertaken with the market suggests that the current nursing home market in the city is responding slowly to the future demands and requirements of SCC and SCCCG. Even where placements are being made, costs are rising. The reluctance to invest also reflects changes to the bank lending practices and the low returns this sector is providing.

Prior to the pandemic, Southampton's commissioning intentions for this segment of the market included:

- Testing cost models to ensure the price paid meets actual costs in the market.
- Assessing the appetite for joint commissioning across SCC, SCCCG and

West Hampshire CCG, and Hampshire County Council.

- Developing specifications to detail need levels and requirements.
- Developing new procurement approaches and assessing their likely impact, and any risks involved regarding both access and prices.
- Developing a Workforce Strategy to support the market in the longer term.
- Continuing to identify options for future nursing home developments in the city.

Infections and mortality in care homes in the city

53 individuals died from COVID-19 while a resident of a care home in Southampton between April and August 2020. There were an additional 29 deaths among care home residents who had been admitted to hospital. The mortality rate in Southampton's homes is comparable with near neighbouring authorities and England as a whole.

In Southampton, up to the 23rd July 2020, 27 of 63 care homes (43%) were reported as having a COVID-19 outbreak, which is very similar to the regional average. The national weekly publication of care home outbreak data ceased on July 23rd; however, local intelligence indicates a further 9 outbreaks occurred in Southampton care homes between this date and November 2020, but some of these have been second outbreaks in the same care home.

Shape of the local care home market

There are currently 58 care homes operating in the city - 49 residential care homes; 9 nursing homes (including one neuro-rehab unit). This is down from 61 that were open at the start of the pandemic. This reduction is due to:

- One home closing due to retirement of the owner following a planned reduction in care provided.
- One home closing due to long term voids (i.e. preceding the pandemic period)
- One home closing following a management decision to move all the business to the other home in the group.

Figures 14 and 15 show the number of care homes and registered beds in the city by client group. Older persons / general conditions are the biggest client group for both residential and

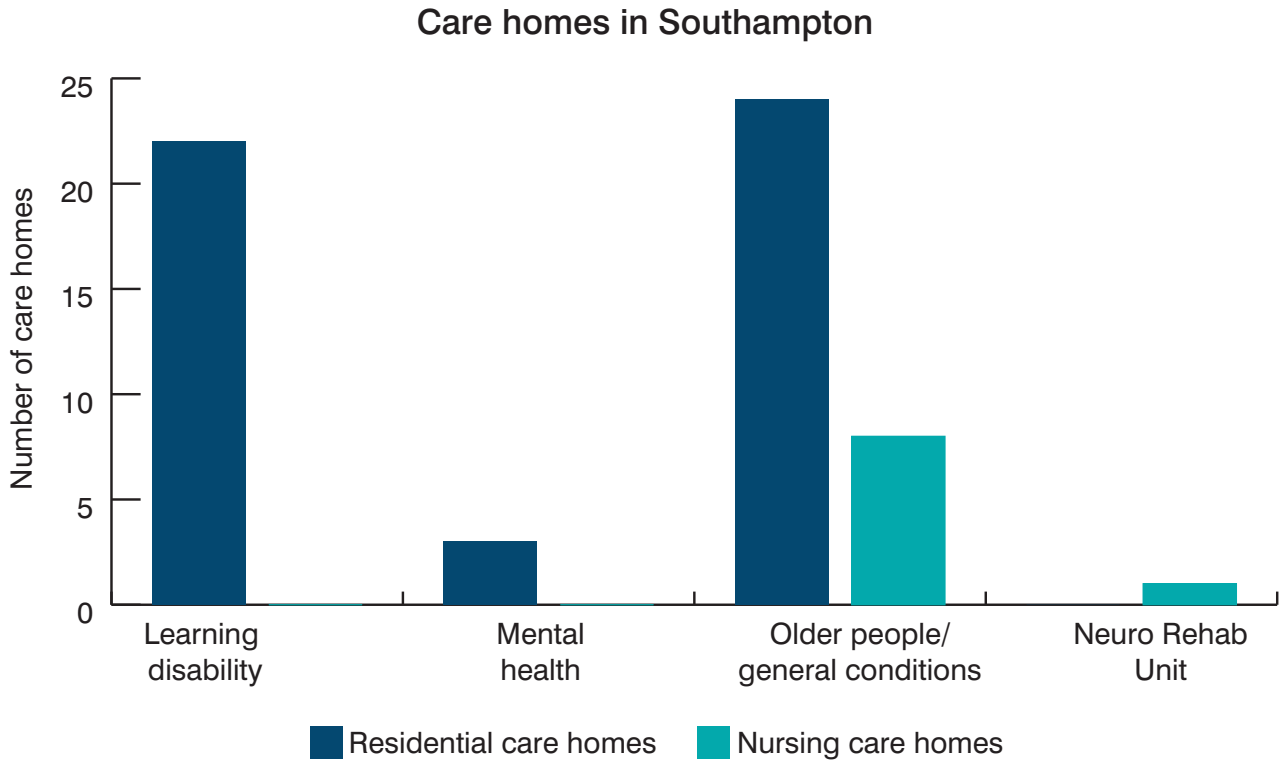


Figure 14: Number of residential and nursing care homes in Southampton by client group

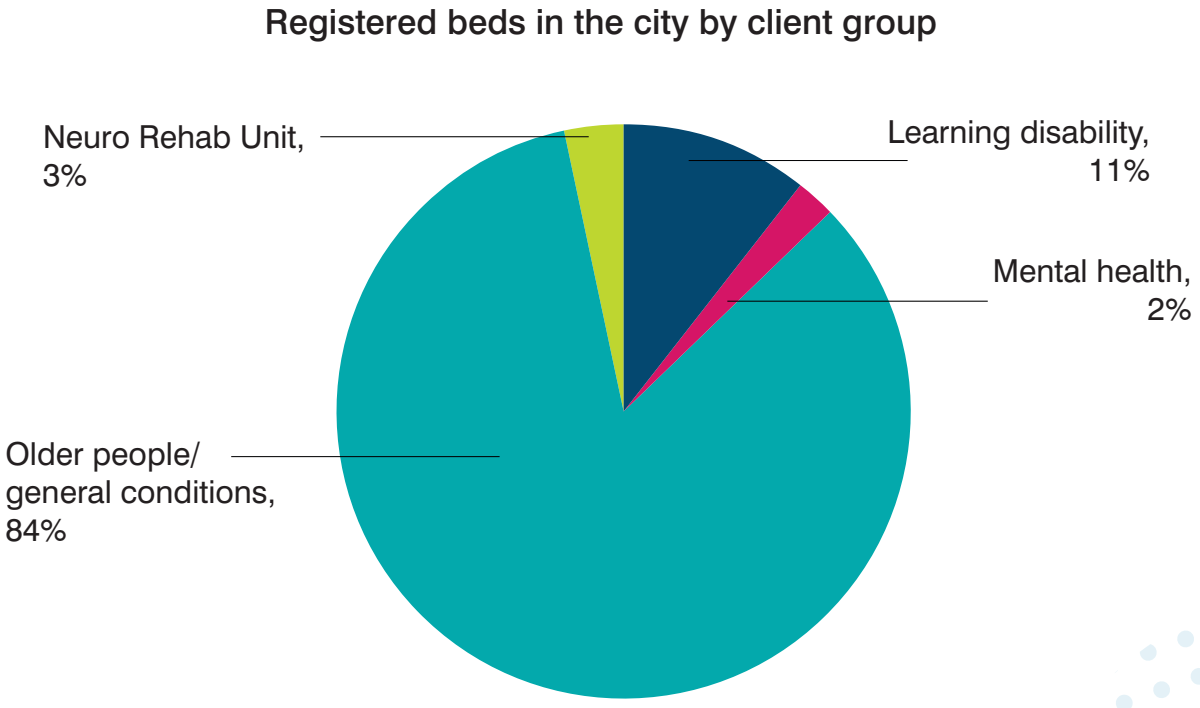


Figure 15: Registered beds in Southampton by client group

nursing care.

Figure 16 below shows the breakdown of national and local providers by client group. The residential care market is predominantly local providers whereas the nursing home market is predominantly national providers, with one provider supplying 241 beds. This exposes SCC to risk of shortfalls in provision should one of the national nursing home providers decide to change their provision locally.

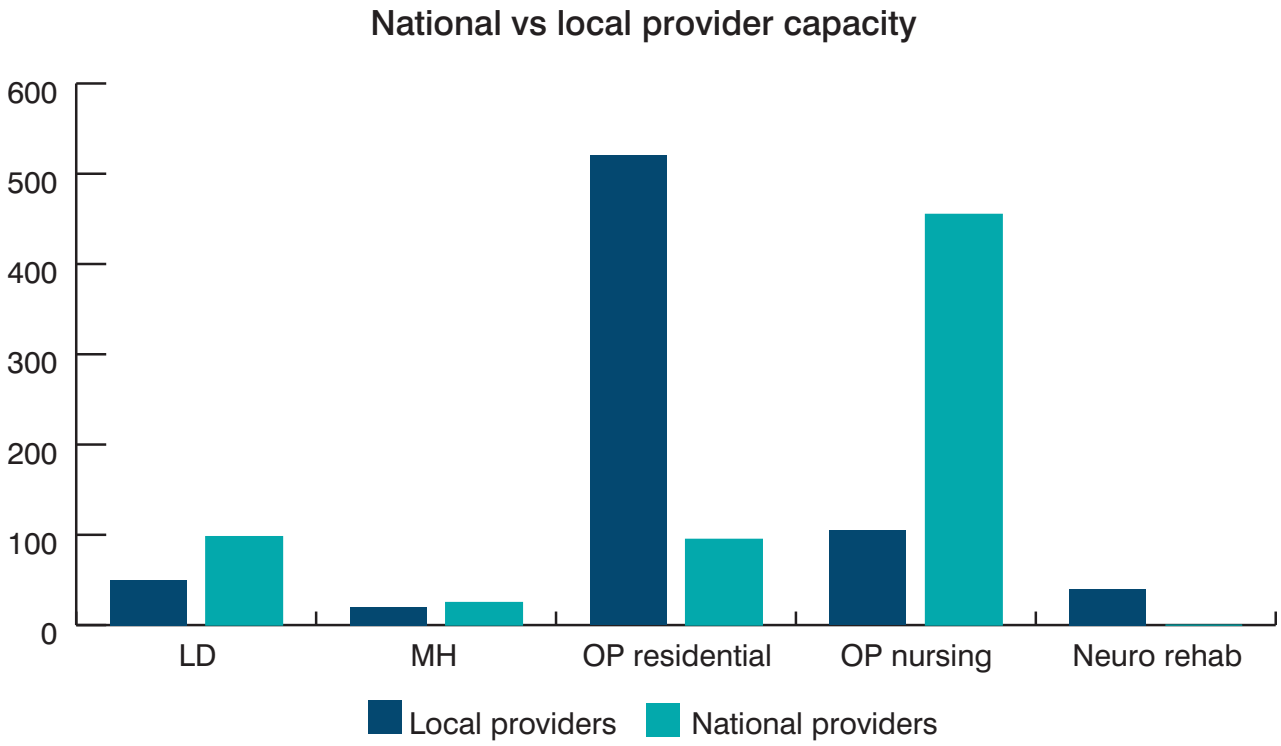


Figure 16: Local and national provider capacity by client group: number of beds and numbers of homes

Access for both SCC and the SCCCG to most care home beds is via a case-by-case arrangement with homes having signed SCC's terms and conditions (residential contract) and separate arrangements with the SCCCG. However, SCC has two long term contracts in place to access 102 bed spaces in two nursing homes. SCCCG has current contractual agreements with nursing home to provide 22 beds for D2A, with further arrangements to be in place shortly.

Although the number of SCC placements into nursing care have not changed significantly in recent years, the client need levels have increased significantly. Too much of the provision in the city remains targeted at clients with lower levels of need, leaving the city with an undersupply of care homes able to meet the more complex need requirements. Demand for nursing care that is suitable for those with cognitive impairments and complex needs are increasingly outstripping local supply. As a result, 40% of SCC and SCCCG nursing home placements for this group are made outside the city boundary, though the majority of these are made in homes within

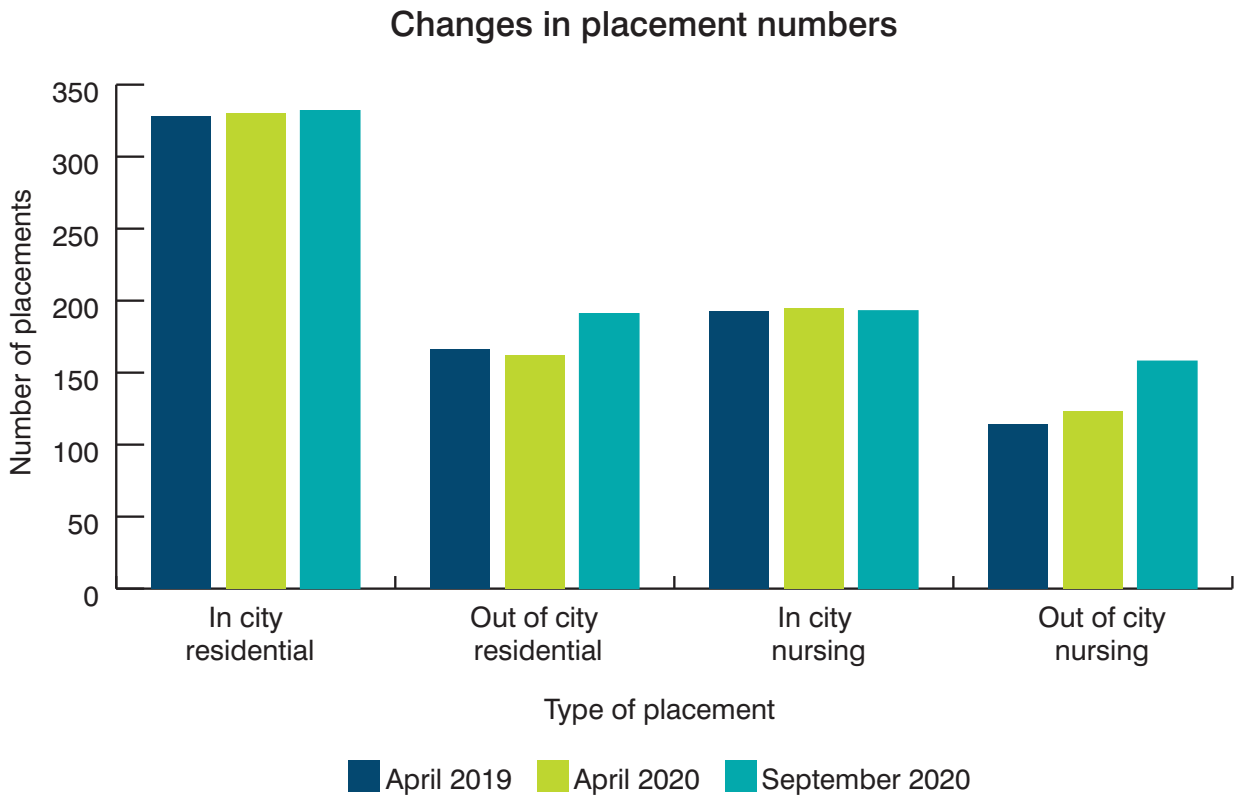


Figure 17: Changes in SCC placements between April 2019 and September 2020, by type of placement

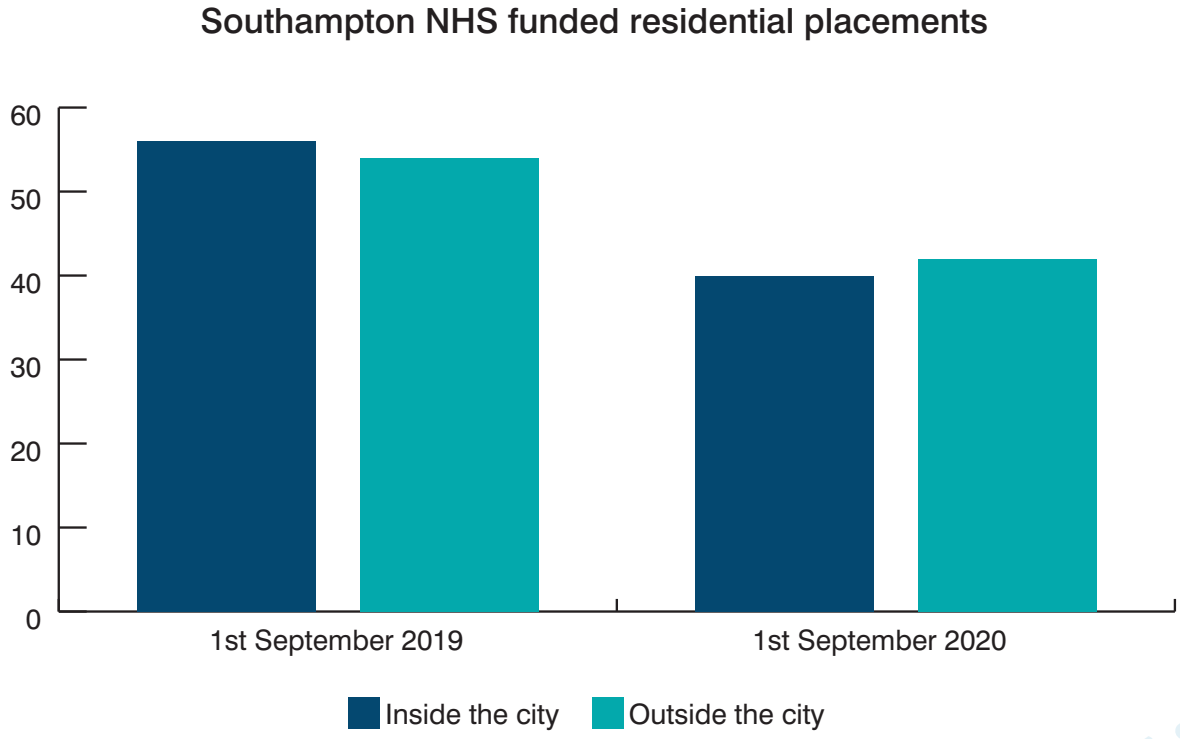


Figure 18: Changes in NHS funded Residential and Nursing placements between September 2019 and September 2020

five miles of the city boundary. The change in placement numbers is outlined in Figure 17 for SCC and Figure 18 for SCCCG.

Between April 2019 and April 2020, the number of publicly funded individuals in care homes had remained quite static overall. However, since April 2020 there has been an increase in out of city placements. This reflects both the COVID-19 response and hospital discharges, and the availability of appropriate local nursing home placements. It also reflects the willingness of providers to accept publicly funded clients, at a time when homes in the city were closed to referrals, either due to a COVID-19 lockdown or the policy of individual homes.

We are aware of high vacancy levels in some homes in south Hampshire which has helped to accentuate this shift. There will need to be a realignment of these placements and the costs paid as residents' needs are reviewed and any long-term placements are negotiated and agreed.

COVID-19 period placements in residential and nursing homes

As of 30th September 2020, there were 271 clients funded by under the COVID-19 arrangements in care homes, where a reclaim to the NHS against costs is expected due to the COVID-19 period. In addition to these clients, SCC has placed a further 66 clients in care homes, and SCCCG has placed a further 13 clients in nursing homes in this period. There are significant issues relating to this group. Firstly, the earlier discharge of clients from hospital has placed pressure on homes as these individuals can have more complex needs due to being discharged with often limited reablement support. There are then issues for the health and care system to determine: clients will have to be re-assessed to determine their long-term needs; whether the current placement in a care home is necessary for the longer term; and to determine who should pay for the care costs in the futures – SCC, SCCCG or if the client should fund their own care.

It is important to note that once a client is referred to a care home and has been there for more than a few weeks, unless a requirement to re-able the individual is agreed at the outset, it can be difficult to return the client to their own home or another setting. This is because many become used to the environment and moving to a less supported environment can be difficult to achieve. There is additional pressure on therapy support due to the number of clients discharged with needs from hospital, reducing the capacity of services to support homes as a critical time. The increase in care home use by the public sector may therefore become an issue for the medium term.

Self-payer market - Older people's care homes

Care homes are open to self-paying clients - although the self-payer market is almost exclusively within homes for older people and those with physical disabilities. Self-payers represent up to 60% of this care home market in the city. This can present a challenge to the public sector over access to vacancies at rates which are affordable within public sector funding rates, and it also means that both SCC and SCCCG are often required to find care home placements outside of the city.

As vacancies in care homes have increased since April 2020 whilst publicly funded placements have also increased, it is clear there has been a reduction in people moving in to care homes who pay for their own care. It is likely that two factors have influenced this trend:

- Some current care home occupants who are likely to become self-payers in the long term are currently 'hidden' within the cohort of patients placed in care homes since March and which remain funded by NHS England until they are reviewed (between September 2020 and March 2021). This may account for the slight increase in total publicly funded care but by no means all, and it will not account for the overall reduction in numbers.
- Fewer individuals, with the support of their families, are choosing to move into a care home at this time. Families and partners are providing more informal care currently. Informal carers may not provide a long-term alternative to care home provision, and these carers will also need their own support to sustain the help they are providing.

Vacancies caused by this reduction in numbers mean reduced income for care homes which can increase the cost of placements, as fixed costs are split between fewer residents. This could increase costs for public sector placements and the impact of this is discussed in more detail in Section 8.

Data on the local self-payer market has not previously been collected but approximate figures for 2020/21 have been calculated which show an 18% reduction in the number of self-paying residents in Southampton in the first six months.

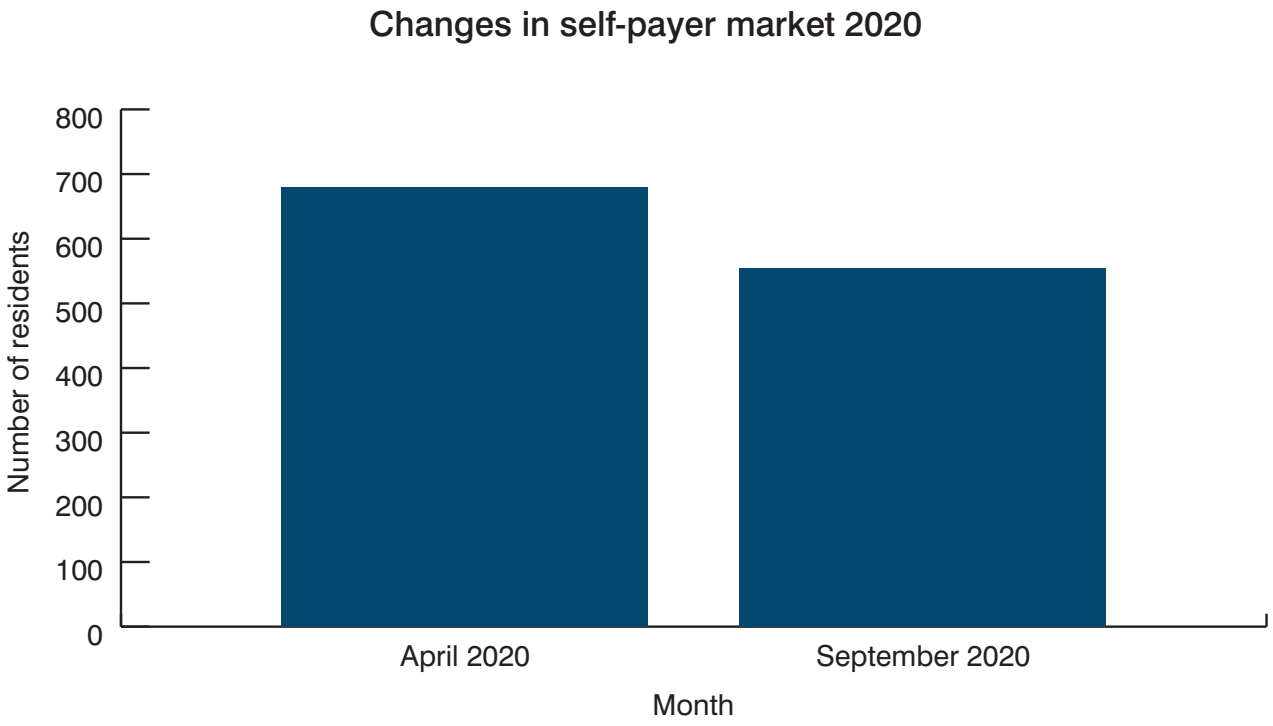


Figure 19: Changes in the self-payer market between April and September 2020

People who fund their own care often pay higher prices for that care than the public sector, which can often command lower prices due to its market share. The level of privately funded individuals goes some way to sustaining the market, as a core part of the income required by providers is through this route.

If private payer numbers reduce, the market either increasingly relies on the public sector to place more clients or higher vacancy levels are a consequence. This reduces the incomes for care homes, and increases the likelihood that providers become less viable as businesses. This puts the whole sector at risk and increases the pressure on the public sector to either intervene or see care homes exit the market, reducing the overall supply and market diversity. This, in turn could place more pressure on public funding as prices increase overall to cover the higher costs previously met through private payers.

This reduction in self-paying residents since April 2020 marks the largest shift in this market during the pandemic. This is a response to some care homes being closed during the pandemic, the fear from some members of the public that care homes have become an unsafe environment, a lack of visiting for families, and families being more able to care for their relatives at home because they are also currently working from home.

Vacancy levels

Some care homes are currently experiencing vacancy rates that are substantially higher than usual. Prior to the pandemic, nursing homes regularly had few vacancies, and rarely went above 5%. Across residential care homes, there were more vacancies, regularly being around 10% of the total market available.

Within this however, there are considerable differences between homes. Four nursing homes in the city have vacancy levels above 15% (and one is above 20%). Whilst residential care vacancy rates are normally higher than those for nursing homes in the city, four residential care homes have vacancy levels above 20%. If these higher than usual vacancy rates persist, this will likely have an adverse impact on the long-term sustainability of these care homes.

5 Older Person Day Care

Section summary

Older persons day care provides services to reduce social isolation and enable older people to stay independent for longer. The key impacts identified in this section are reduced capacity to provide services and a reduction in self-payers wanting to attend services.

There is a reduction in capacity of older person day care services together with a reduction in self-payers choosing to attend these services. This has directly affected the viability of many of these services, which are relied upon as a crucial part of the 'care ladder' in order to provide community support, preventing residential care placements where appropriate. Ensuring sustainability of the service so that it continues to provide the appropriate support to clients and to their carers will be a key activity for commissioners working with the provider.

Prior to COVID-19

In 2016/17 SCC and a range of partner agencies co-designed day services for older people in the city. This has begun to transform the day services that were provided at the time into a more flexible activity-based offer, open to all in the community, and available in a wider range of community settings. The aim has been to provide a greater focus on prevention and early intervention, as well as providing a care and support service for those who require these. Peer to peer support between users has been encouraged to delay the need for commissioned care and support services. If individuals need care to engage in their chosen activity, then people can be offered personalised tailored support.

Individuals who access the service for care are now undertaking a broader range of meaningful activities which are community focused. Reaching out to people outside of the care market has been challenging. Many users of the current service are frail or have dementia. The service not only supports individuals who live alone, but also individuals who live with carers, and so carers receive respite support as a result. Approximately 50% of the users and income received for the service came from the self-funding market.

Impact of COVID-19

Since the first national lockdown the service has been unable to deliver in person services at its community bases. SCC agreed to continue to fund the service on the same basis to provide assurance to the providers and ensure users received some continuity of service.

Each individual and their carer (if applicable) were risk assessed as to the impact of not attending. Clients received a range of interventions:

- Individual support to undertake activity out of the house (COVID-19 risk assessed)
- Regular home visits (observing social distancing)
- Regular phone calls to check on their wellbeing and welfare

The provider has given SCC detailed information as to what interventions have been provided to which customers. Analysis of this is taking place to determine what, if any, client contribution should be made to the service costs. The service has supported other vulnerable people in the city, working in partnership with other agencies, including

providing additional capacity for meals on wheels. There has been no resource provided to meet additional costs for PPE or to undertake work to make these community hubs COVID-19 secure.

The provider has completed environmental risk assessments resulting in a provisional capacity of between 40% and 50% fewer attendees than before the pandemic. Social care staff have commenced individual risk assessments to determine how and if clients can return to the service. No date has yet been set by SCC or the provider to recommence the service to the commissioned model.

While the provider has assured commissioners that they intend to honour the SCC contract capacity levels, there is currently little interest from self-funders to return to the service. It will take considerable effort to re-generate this market to reach pre-COVID-19 levels.

6 Learning disability

Section summary

Learning disability (LD) services are primarily respite and day services, which provide clients with activities and independence and provide carers with a break from care responsibilities. The key impacts identified in this section are a reduction in the capacity of services and increased health needs.

The respite and day services have been highly affected by COVID-19 due to lack of capacity and closures, however, it is expected that these services will seek to resume as normal shortly. This client cohort has seen an increase in health needs during the pandemic, and from November 2020 individuals with Down's Syndrome have been included in the Clinically Extremely Vulnerable group. Overall, LD services have seen an increase in complexity of need and a decrease in capacity. Commissioners are working with providers to consider appropriate reopening of services, where these can be managed safely and are sustainable.

Prior to COVID-19

The table below shows the main types of service commissioned for people with Learning Disabilities by SCC or SCCCG, it also shows the broad pre-COVID-19 commissioning intentions for each service type.

Service Type	Commissioning Intentions
Residential Care	Reduce the number of individuals with learning disabilities living in residential care and support a move towards tenancy-based options like supported living. Support homes to de-register where appropriate.
Supported Living & Home Care	Increase the amount and quality of supported living options so that more people have their own tenancy and personalised support that suits their needs.
Respite	Develop a range of respite options to include bed-based provision as well as Shared Lives and creative use of direct payments. Using respite as a stepping-stone to supported living where this is agreed with the individual and their family.
Day Services	Work with the market, service users and carers to support a redesign which promotes independence and community inclusion. Promoting the development of daytime provision to support people with behaviour that challenges or with profound and multiple learning disabilities.
Life Skills Employment Service	Increase profile of service as well as mainstreaming the approach so that other providers can support people to find and maintain employment.
Specialist LD Community Health Team	New service specification being agreed alongside Southern Health NHD Foundation Trust and West Hampshire CCG.

For more information about any of these areas please refer to the Learning Disability Market Position Statement.[9] COVID-19 has not changed any of these broad intentions but inevitably has delayed some of the work to achieve them.

The learning disability client group in Southampton has been affected by COVID-19. National and local evidence shows that people with learning disabilities tend to have more complex health conditions and that they occur earlier in life compared to the general population. Some of these conditions are linked with being clinically extremely vulnerable and sadly there have been some deaths of people with learning disabilities in the city from COVID-19.

The impact on services accessed by this client group has in many ways been significant, with day care services particularly affected. These will take time to recover and change to meet new demands, and this will still be subject to any further waves of infection.

Day services

SCC commissions day services from around 15 external providers as well as providing a service itself through Southampton Day Services. The internal provision represents around 20% of the market.

Although COVID-19 has impacted on all provision to some extent, by far the greatest impact has been on day services. For most services to this group, there were no significant changes in the number of clients registered with each service between pre-COVID-19 and currently, as often placements in services are long term and relatively stable. So, while other services have generally been able to adapt provision to fit new requirements and keep their clients safe, day services have altered more radically.

Learning Disability day services are currently purchased individually on a case-by-case basis. Prior to COVID-19 there was consideration of a move towards specifically commissioning services so there would be a greater emphasis on providing life skills support. It would also enable a greater focus on improving service quality and outcomes.

There was some oversupply in the day care market, with most day service providers operating at some level below capacity, with the majority currently operating at around 75-80% capacity. In one case the service was only operating at around 50% capacity.

Day services were significantly disrupted and had to close during lockdown. Only a limited amount of 1:1 provision continued at services or within the community in the initial stages of lockdown, mainly where individuals with priority needs were identified, and/or where the provider had the environment to support this safely (e.g. lots of outdoor space). Day services that closed only started to reopen in October 2020 so there is limited information about what the long-term effect may be on providers and the service they deliver.

Other demand has been met through remote service provision – online sessions, social media, activity packs, and phone calls.

The changes have been well received. Online support is, however, not suitable for everyone due to internet access and digital skills/capabilities. This is therefore not a long-term replacement for face-to-face support. There may, however, continue to be some opportunities for individuals to have their support supplemented with remote offers of support.

[9] http://www.southampton.gov.uk/images/ld-market-position-statement_tcm63-405646.pdf

At the start of the pandemic, Sembal House, a day service on the west of the city operated directly by SCC, was identified as a location for the COVID-19 response hub. The site is, however, has since reopened as a day service, and day service capacity will increase, although it is important to acknowledge that due to social distancing guidelines the service will be operating at only 50% of its previous capacity.

Respite

Respite services provide a break for those providing regular care for people with learning disabilities. There are three main buildings-based respite services for adults with learning disabilities, two are commissioned externally and one is provided by SCC at Kentish Road.

In the past two years there has been an increase in the number of people using overnight respite, from 80 people in 2018 to around 90 in 2020. The number of nights allocated has also increased in that period from around 2,300 to 2,800 per year. This is partly due to new respite referrals and partly to an increase in the number of emergency respite stays, which have increased from an estimated 200 nights per year in 2018 to 258 nights just between April and September 2020. The increase in emergency stays is partly due to COVID-19.

The two externally commissioned learning disability respite services (Weston Court & Rose Road) remained open throughout lockdown, following risk assessments to ensure the services remained safe. They both experienced an initial reduction in the number of clients accessing their regularly scheduled respite (20% & 10% respectively), however, this only lasted around 2-3 months before returning to pre-COVID-19 levels.

During the same period, all respite within SCC's directly provided respite service, Kentish Road, was stopped in order to use staff in other settings during this period. However, this has now been reopened in a COVID-secure manner by ensuring that a robust risk assessment process is completed at the beginning and the end of each client's stay. Decisions on the service's near future will need to reflect any further waves of infection.

Carers

The changes in day service provision and to respite care times have often been user and carer led. We are aware of the potential added pressure on carers at this time and are ensuring their needs are met through carer support networks, and ensuring the alternative services offered take account of carer needs. SCC has also recently begun a Scrutiny Inquiry on the subject of 'Carer Friendly Southampton', which aims to identify improvements for carer support.[10]

Life skills and employment

Since April 2018, SCC has funded the Life Skills Employment Service, a project undertaken by the SCC's Employment and Skills Team. The team's main role is to support people with learning disabilities into volunteering or employment as an alternative to using day services. This service has been affected by the economic impact of COVID-19, with some clients having difficulty attending their workplaces due to health risks and shielding, some losing their jobs and no new paid employment found between April and August 2020.

One of the national ASCOF measures reports the number of adults with learning disabilities aged 18-64 in employment who also have a funded package of care. The latest figure is 2.9% (15 people out of 510). This is lower than comparator areas and will be a focus on coming years to increase employment opportunities.

[10] http://www.southampton.gov.uk/modernGov/ieListMeetings.aspx?CId=750&Year=0

Shared Lives

The Southampton Shared Lives scheme supports adult residents with learning disabilities, mental health and other social care needs. The scheme matches an individual who needs care with an approved carer. The carer shares their family and community life and gives care and support to the person with care needs. Some people move in with their shared lives carer, while others are regular daytime visitors. Some combine daytime and overnight visits.

During the pandemic, all non-urgent respite care was stopped. This has recently been reintroduced ensuring that a robust risk assessment process is completed at the beginning and the end of the stay. Ordinarily respite within the scheme is utilised to provide a break for the carers. In addition, users of the service who would ordinarily attend day services have been unable to. Shared Lives carers have had to provide increased care and support to compensate for the reduced access to day services and respite for this client group during this period.

Other COVID-19 related considerations

Due to national policy, staff working in supported living and day services are not included in scope for regular COVID-19 testing even though the risks associated with transmission are the same or similar to care homes and those accessing services have similar vulnerabilities. This presents a higher risk to these sectors of an outbreak happening.

Commissioners have been working with public health colleagues to develop action cards for day service settings which contain a specific set of instructions for day services in the event of a COVID-19 outbreak at their setting.

Commissioners have also produced an escalation framework for day service settings to provide guidance on actions that will need to be taken or considered if COVID-19 alert levels change locally. This has recently been reviewed to more closely align with the alert levels set out in the Southampton City Council COVID-19 Outbreak Control Plan Escalation Framework.

Infection prevention and control procedures are to remain in place within the market whilst the risk of further outbreaks remains. For day service providers, these include measures to support social distancing such as floor markings and one-way signs, regular and robust cleaning regimes, staggering arrival and departure times, use of PPE, and robust arrangements for what happens if someone starts to display COVID-19 symptoms.

As a result, consideration must be given to the extra costs involved and ensuring robust risk assessments are carried out on services to maximise safety for staff and residents. These costs are currently being sought and discussed with providers to ensure they are robust and can be supported as fully required, and that they meet the risk requirements identified in full.

There is an anticipated increase in health needs for people with learning disabilities and their carers, as their focus is on supporting the cared for individual. Additionally, there may be increased mental health needs impacted by a lack of stimulation for some people due to reduced social contact and an increase in mobility issues. The addition of people with Downs Syndrome to the vulnerable list in November 2020 will potentially impact on those who attend day services going forward.

7 Mental health

Section summary

Mental health services provide residential and community support for people. The key impacts identified in this section are an initial reduction in demand followed by an increase and an increase in demand for older persons mental health services. The information we have been able to provide for this Mental Health section is ICU and SCCCG only and not wider social care; it is important to bear this in mind throughout this section.

Most mental health services saw a drop in referrals in April and May 2020, followed by an increase, with most services back to similar levels as 2019 by the end of the summer. The reduction in referrals for primary care mental health therapy treatments was reflected nationally and thought to be as a result of people adapting to the sudden changes in work and home situations. In secondary care services there has been anecdotal evidence of presenting or re-presenting more acutely. The long-term impact of the pandemic on mental health continues to be researched nationally

There are no reported significant changes to operating costs for mental health services at the present time and there are no concerns relating to provider viability in relation to COVID-19 and mental health services.

Prior to COVID-19

Prior to the pandemic, commissioning intentions for Mental Health were aligned with the local Mental Health Matters consultation, the ICU Commissioning Plan, final requirements of the NHS Five Year Forward View and the NHS Long Term Plan.

Mental Health commissioned activity for adults in the city is provided by a core number of providers across the health and social care landscape.

- Primary Care Mental Health services in Southampton are delivered by means of a block contract by Dorset Healthcare University Foundation Trust via the Steps to Wellbeing (Improving Access to Psychological Therapies - IAPT) Service. This service provides stepped approach talking therapies and counselling.
- Secondary Mental Health Care is commissioned through the NHS block contract that the SCCCG has with Southern Health NHS Foundation Trust (SHFT). This contract covers a range of acute, specialised and community mental health services for adults aged 18+. Services are directly commissioned from SHFT, which are part of an Integrated Commissioning System across Hampshire, Southampton and the Isle of Wight.

In addition to these health-based services, the ICU also commissions:

- Residential Rehabilitation and Recovery for people with severe and enduring mental health problems. This 10-bed service offers 12-month placements of intensive recovery and life skills to people discharged from inpatient mental health services.
- Mental Health Peer Support and Community Navigation.
- Individual Placement (employment) Support to people engaged with local Community Mental Health Teams.

- Mental Health and Service User Network, and Dementia Friendly Communities Co-ordination across the city.

The significant focus for pre-COVID-19 commissioning in adult mental health services was around housing, rehabilitation and reablement.

- A Mental Health Housing Needs Assessment has commenced and is due to report in December 2020 and the Market Position Statement will follow soon after. The needs assessment and subsequent market position statement will assist the Integrated Commissioning Unit to gain a greater insight into the housing and housing support needs of those experiencing mental health problems and will also assist with flow from secondary care services into community-based support.
- The Hampshire and Isle of Wight Sustainability Partnership have been leading on a review of rehabilitation and reablement for Mental Health across their geographical footprint. This review was in response to the numbers of out of area placements and rehabilitation placements and limited options for people to receive care in their community. Currently a project group is being formed which will consider any recommendations within the review.

The ICU commissions a significant number of personalised s117 (Mental Health Act, an enforceable duty on both Health (SCCCG) and Social Care (SCC)) placements across a range of providers and these packages can be funded by both SCC and SCCCG.

Over £30m is spent annually on Mental Health Services in Southampton, with the majority invested in secondary Mental Health. Investment in Mental Health services has increased in line with national expectations.

Our block contract for secondary care services with SHFT may at times result in out of areas placements being used to support acute in-patient activity when increased demand outstrips the available capacity within local provision. Sourcing any acute in-patient out of area placement is the responsibility of SHFT and is set within a national drive to reduce the use of inappropriate out of area placements.

Where people are subject to s117 of the Mental Health Act 1983 there is a range of providers both within and outside the city who provide support services. Evidence points to a gap in local provision for people with the following conditions:

- complex co-occurring conditions (mental health and substance use disorder)
- Personality disorder (providing very specialist rehabilitation)
- long stay chronic illnesses such as Schizophrenia where long term management in a safe and secure setting that is not a hospital is required, which may include supported living options.

There is also an increasing need for older people's mental health provision where they require locked rehabilitation due to challenging behaviours that are not manageable within residential or nursing care homes.

S117 funding can be provided by either SCC or the SCCCG or both. As of October 2020, the funding split leaned to a greater number of joint funded placements meeting both health and social care needs, which reflects the health and social care needs of people with mental health problems.

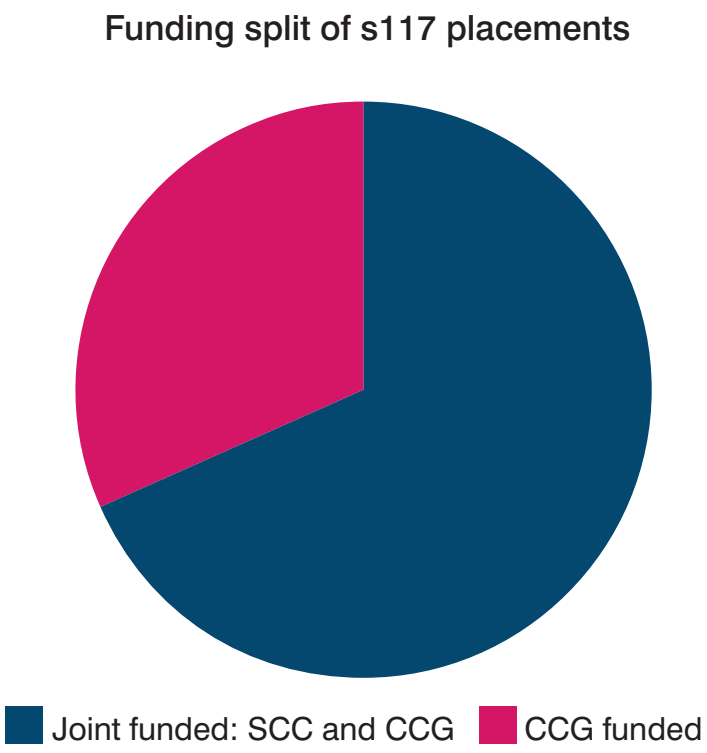


Figure 20: Funding split of s117 placements between SCC and SCCCG

At October 2020, there were 76 s117 placements, which ranged in cost, as detailed in Figure 21 below:

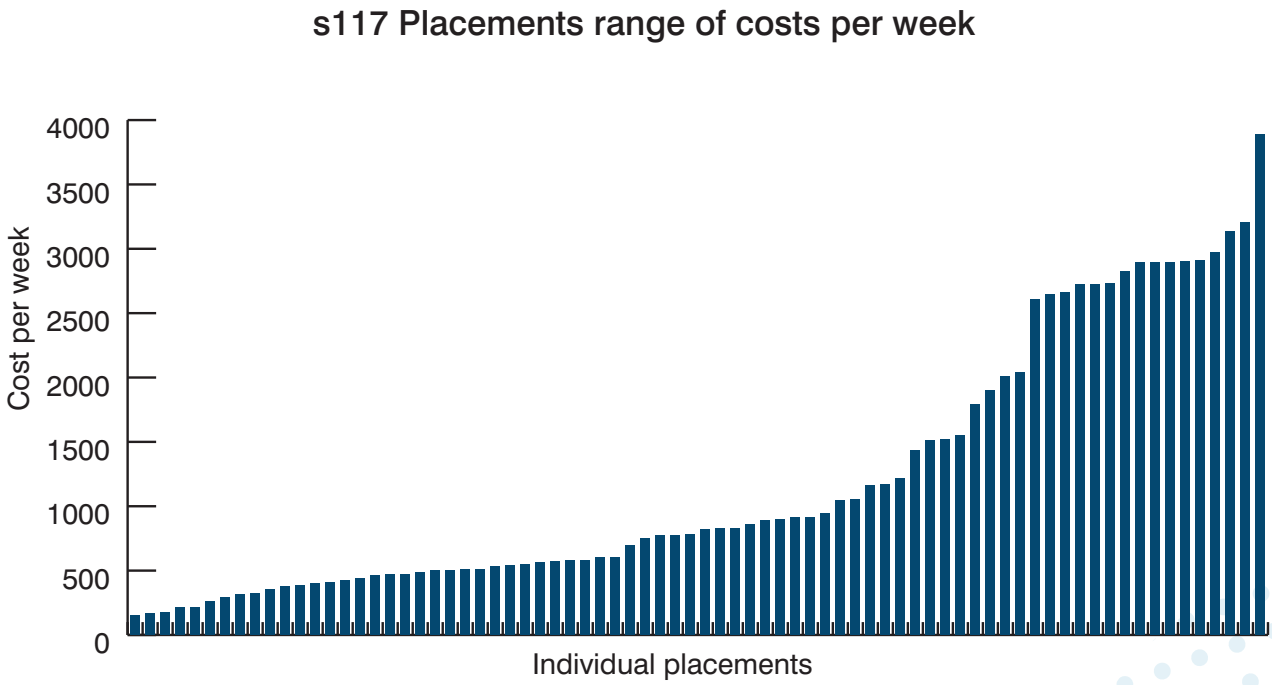


Figure 21: Range of costs of s117 placements per week

There are a range of both in and out of city s117 providers, with 38 providers currently providing the city's s117 placements, the top five of whom are detailed in Figure 22 below. The largest number of placements with one provider is with the Priory Group across a number of their sites, with the other 'top five' providers also providing care across a number of sites. The range and diversity of providers means s117 eligible clients are spread across a large number of providers which minimises risk associated with provider failure for this client cohort, though does not remove it entirely. Should a provider fail alternative placements would need to be found for these complex individuals.

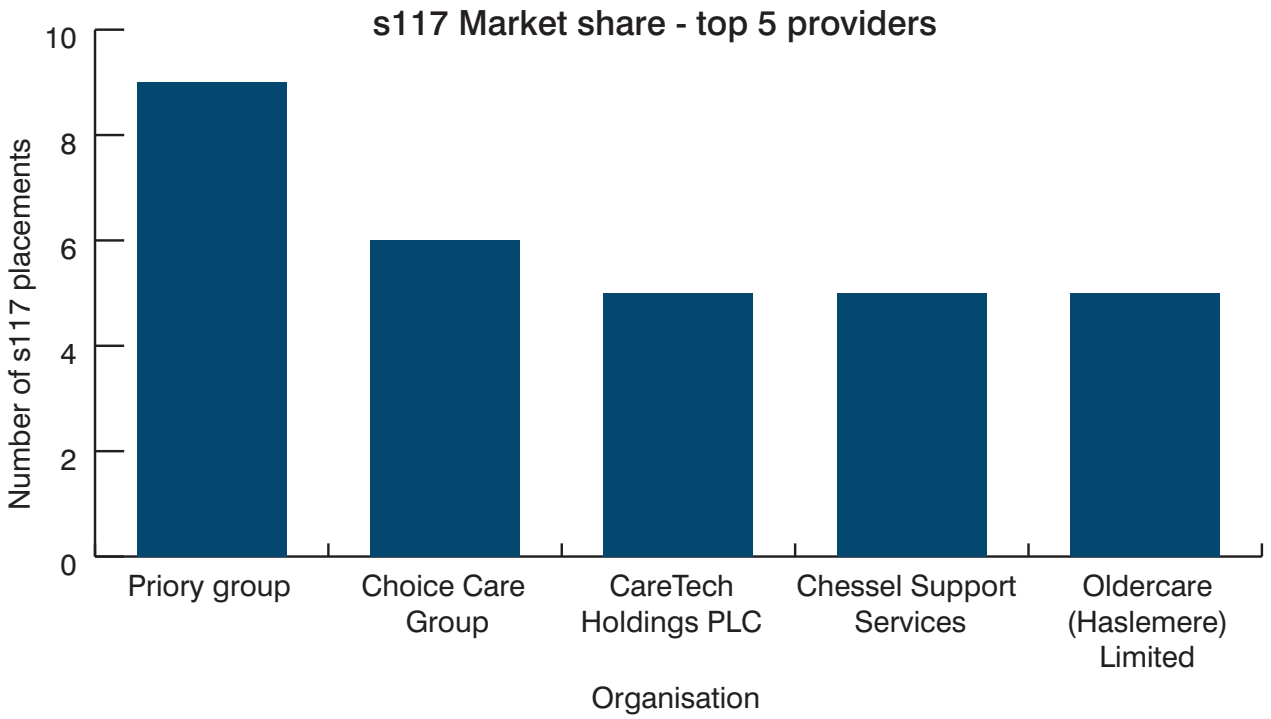


Figure 22: Market share of top five providers of s117 placements

Impact of COVID-19

It is too early to say whether mental health services will see a significant long-term change in service demand as a result of the pandemic, and while there was a reduction in people seeking support through Steps to Wellbeing talking therapies in the first quarter of financial year 2020/21, this has now recovered and surpassed pre-COVID-19 activity levels.

Early national modelling indicates a varying range of %'s in potential surge in demand for all mental health services across the broad spectrum of need ranging from common mental illness (depression, anxiety and stress related disorders) through to severe and enduring mental illnesses (schizophrenia, bipolar or other affective disorders) due to the impact of COVID-19. The Integrated Care System, through the Mental Health and Emotional Wellbeing Recovery Group are co-ordinating a number of pieces of work that include (but not limited to); academic review, modelling of potential surge, service availability and capacity, supporting staff and mapping the service offer to meet the needs of those experiencing bereavement and complex grief.

We are working with all partners across the health and care system to ensure that they are supported to adapt in order to meet the changing demand profile now and in the future, whilst following current general population national guidelines, as well as specific guidelines that may be applicable to this market sector.

Primary Care Services

COVID-19 has had a significant impact on referrals to primary care mental health therapy treatments and the data shows a 55% reduction in referrals in April 2020 compared with April 2019 and a 42% reduction in referrals between May 2020 and May 2019. These are due to few individuals being seen by the health system during this early period of lockdown. However, by June 2020 referrals had recovered significantly and were only 3.19% below June 2019 levels. Referrals to this service are mostly self-referral.

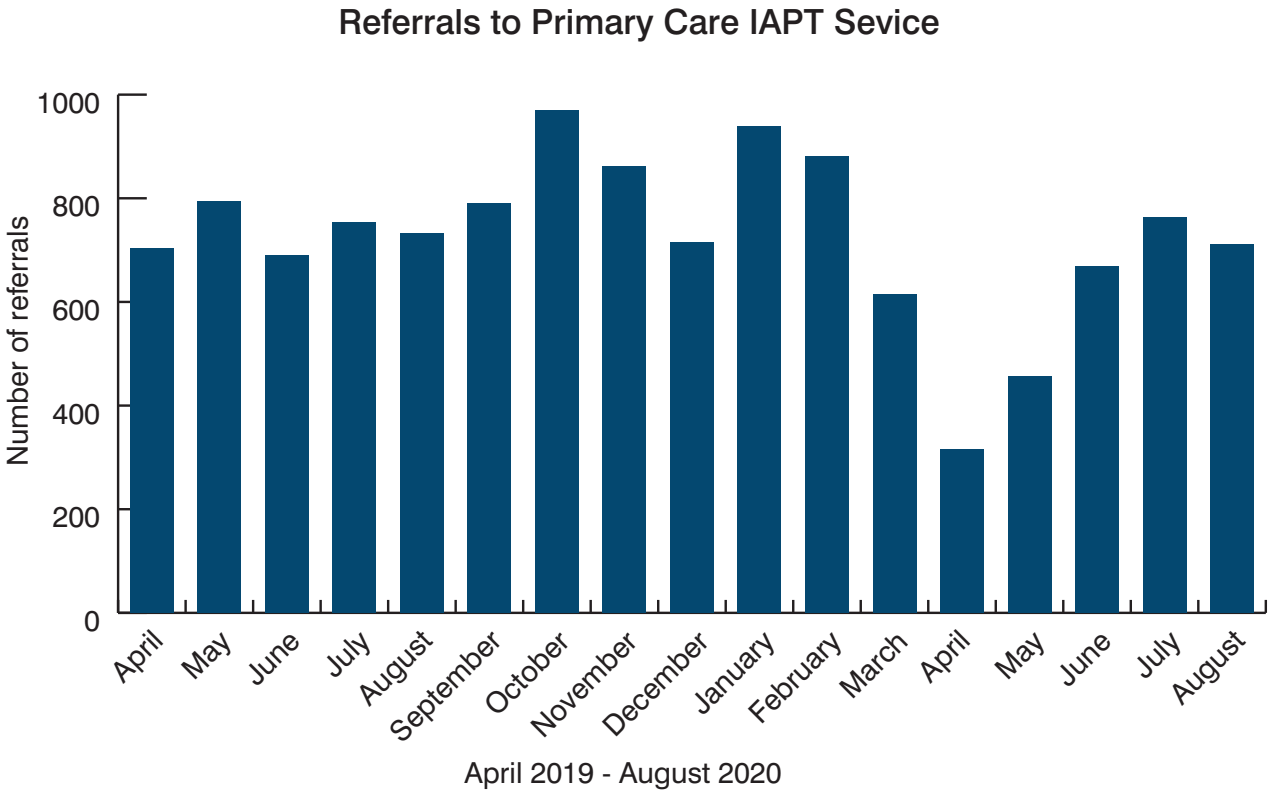


Figure 23: **Referrals to the primary care IAPT service between April 2019 and August 2020**

The requirements of 'lockdown' and COVID-19 safety precautions meant that all treatment for primary care mental health services moved online. While the service has always offered online options, these had to increase exponentially. Furthermore, the existing services have tailored their treatment pathways to meet emerging needs, such as health anxiety, bereavement and Post Traumatic Stress Disorder. During the easing of lockdown, services have been working to restore face to face service provision, however COVID-19 safety requirements are likely to have an impact on service delivery methods going forward.

Secondary Care Services

For secondary care services, there was also a reduction in activity in April 2020. Demand for the service fluctuates, but as shown in Figure 24, occupied bed days for inpatients services in Southampton dropped significantly during April 2020 and began to increase from May onwards.

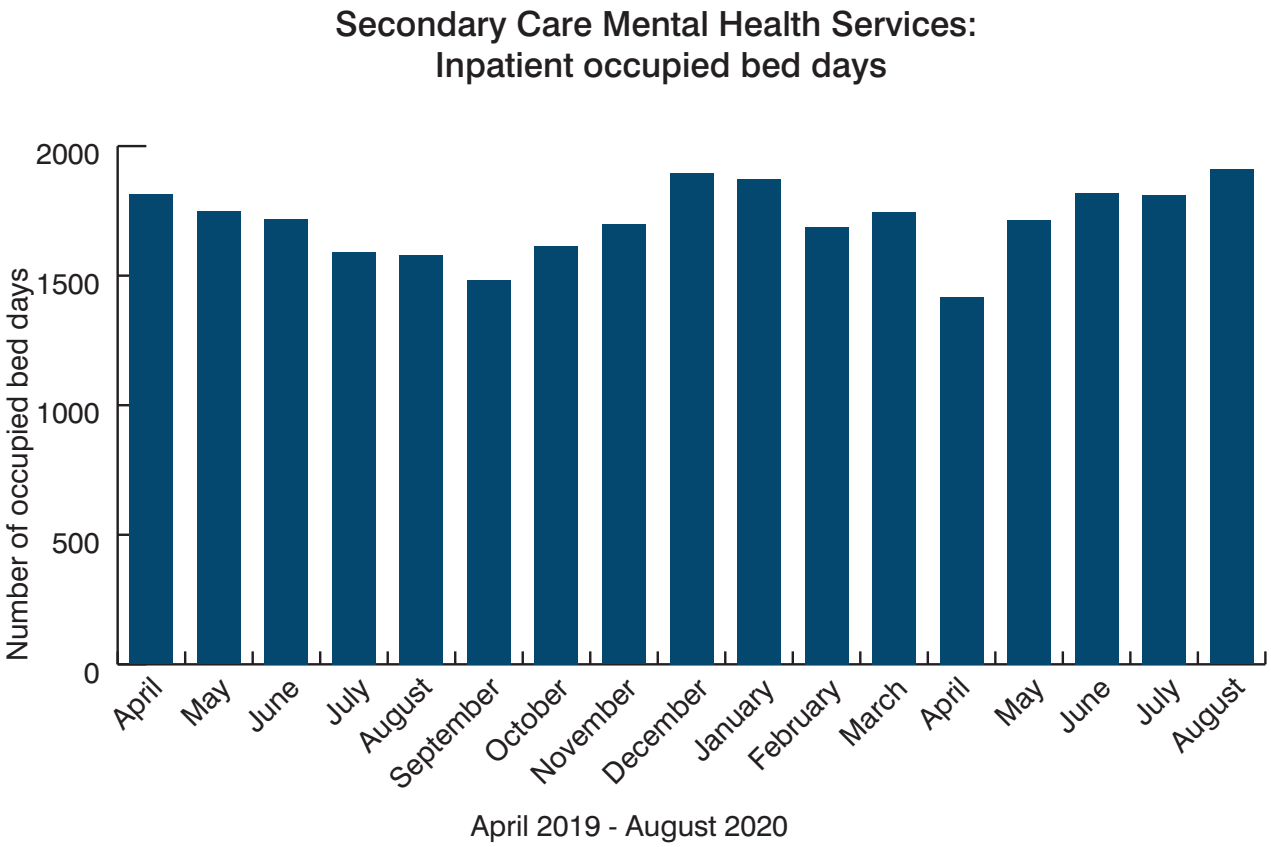
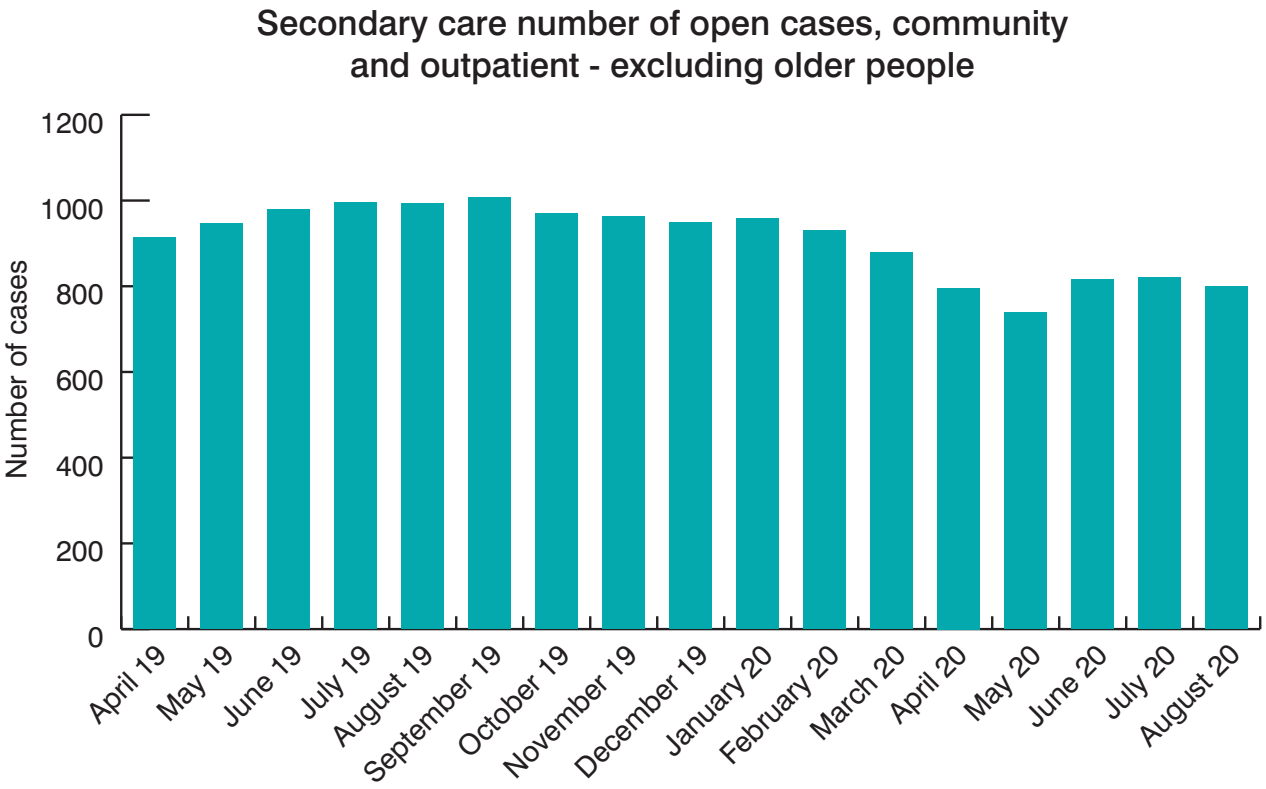
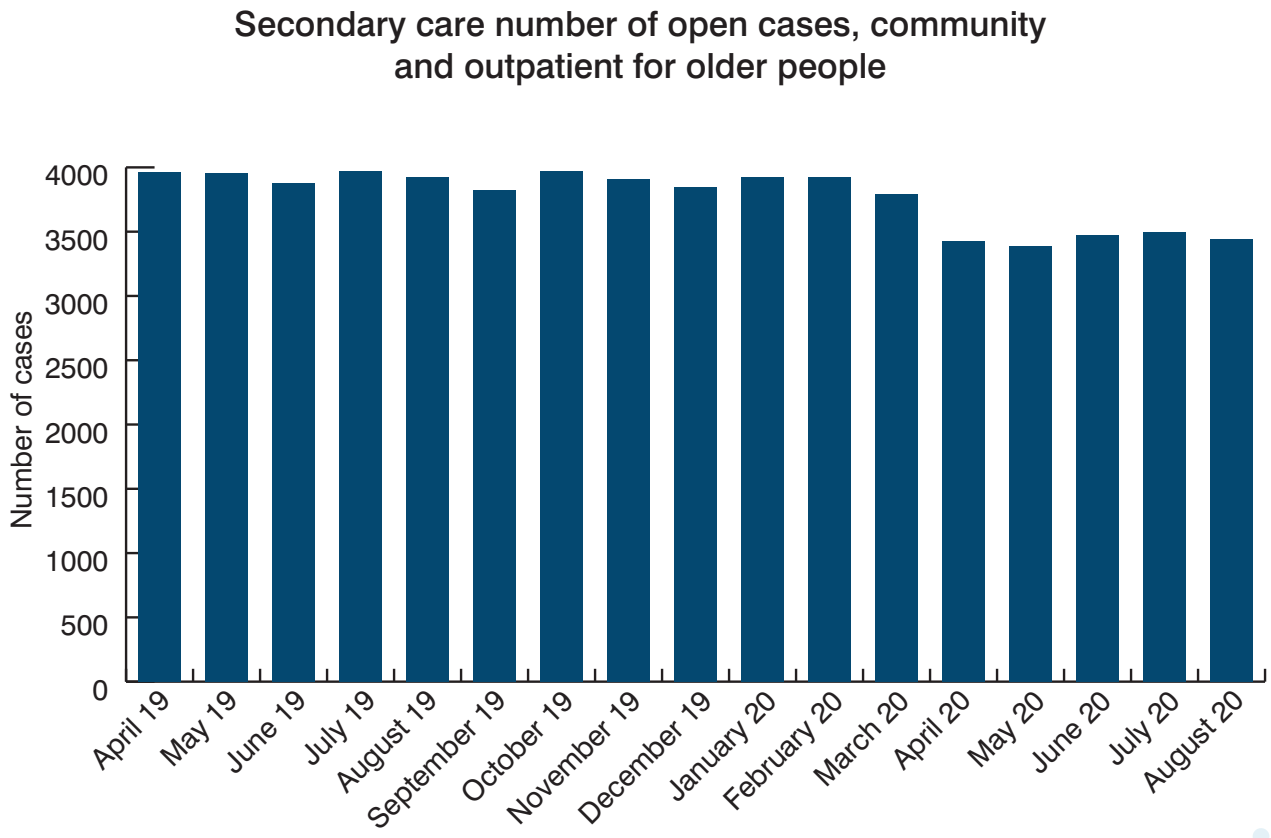


Figure 24: Secondary care mental health services, inpatient occupied beds April 2019 to August 2020

The numbers of open cases for community and outpatient care for Adult Mental Health (AMH) and Older Persons Mental Health (OPMH) for the periods April 2019 to August 2020 are shown in Figures 25 and 26 below. At the start of the pandemic cases dropped off for the months of April and May 2020 and have been stable at that level since. Anecdotally it has been reported that while fewer people may have been referred to services, those that were presented more acutely or re-presented in a more acute state following a significant period of not requiring secondary mental health care.





Figures 25 and 26: Secondary care, number of open cases, community and outpatient for adults excluding older people and for older people

Community support

Unlike primary and secondary care, community support such as peer support and community navigation has seen an increase in referrals/client engagement. This information should be interpreted with some caution, however, as a recent commissioning exercise to combine young people and adult peer support may skew the data and a new community navigation service commenced in October 2019 which may also impact on the activity levels reported. Furthermore, in order to respond to COVID-19 pressures placed upon the market, monitoring was suspended for quarters 1 and 2 of financial year 2020/21 and data for this period is not currently available.

Community and voluntary based services responded innovatively and knowledgably to the pandemic, with the value of the voluntary and community sector within Mental Health provision being emphasised once again. Local services went above and beyond to provide support to people known to their services and extend support to those who felt they needed support. Services moved online, to text or phone call and online forums with safeguarding at the heart of support provision.

8 Impact of COVID-19 on the cost of operating local adult care services

Section summary

The biggest challenge identified by this impact statement is the impact of COVID-19 on the cost of operating local adult care services. The key points identified in this section are an increased complexity of need, the impact on care staff, increased Infection Prevention and Control measures and a reduction in self-payers.

This section highlights just part of the picture that is emerging showing, both the cost impact on providers and the likely on-going cost pressures that will be faced by the health and care system as a direct result of the pandemic. The impacts of Long Covid are only now beginning to be identified and may be an additional cost pressure.

While a direct comparison of costs within the system and the impact on budgets to the end of 2020/21 and 2021/22 is not possible at this stage, it is anticipated there will be a significant impact on both SCC and SCCCG. As more reviews of clients discharged from hospital are undertaken so the picture of costs and impacts for this group will become clearer. Community-based options, including extra care will provide some alternatives to higher cost settings, and these opportunities will be maximised by commissioners.

Costs of inflation and changes to wage levels, mainly through the National Minimum Wage changes, are part of standard changes made to costs for providers. However, the longer-term impact of COVID-19 is not yet known. This means financial planning for 2021/22 is taking place in an uncertain environment. This makes it difficult to assess the financial packages and budgets required to meet needs. For both providers and the public sector, this is creating anxiety as to the medium and long-term viability of services and requirements. Commissioners, finance specialists and the market are working together to identify these potential costs to ensure a level of certainty can be provided to the sector as a whole.

Prior to COVID-19

Prior to the pandemic costs across the care sector were increasing. The largest changes in costs were related to annual increases for the National Minimum Wage and inflationary pressures. In addition, providers would change the cost base required for individual placements due to complexity levels of new or existing clients. These changes are agreed through negotiation with SCC and SCCCG. As part of business-as-usual practice, in April 2020 SCC uprated its published rate levels – the base level paid for a placement in care homes. This increased levels by 5% for residential care settings, and 6% for nursing care settings.

Other changes were made to services in line with contractual obligations. The reopening of the homecare framework also enabled providers to submit changed rates, if required – but also led to a reassessment of their place in that framework (see Section 3). SCCCG did not automatically change the costs paid but have allowed providers to approach them on a case-by-case basis. SCC and SCCCG work closely together to ensure that increases outside of the above changes are managed in a coordinated manner and can be evidenced.

Cost impacts for providers

Since COVID-19 the cost base of delivering care services has changed considerably due to factors including:

- **Workforce requirements** – The largest single impact has been on the cost of staff. This has been the result of:
  - Increased complexity of need, which not only results in larger packages of care but also in an increase in the skill sets required by care staff, leading to higher pay for these in-demand staff due to the scarcity of staff and the additional training requirements to achieve this level.
  - More cover needed for staff sickness, those isolating following possible COVID-19 infection
  - Ensuring greater protection for Black and Minority Ethnic staff who are more at risk of significant impact should they become infected.
  - Supporting staff who are vulnerable or in the Clinically Extremely Vulnerable group to isolate, and the cost of replacement staff
  - Changes to the use of temporary staff to ensure they only work with one care home or care agency to reduce infection risk and spread. This has often required payment of retainers or higher wages to cover for any loss of earnings from these restrictions
- **Infection prevention and control** – including PPE costs, ensuring residents of care homes can be isolated where required, new visiting requirements to keep people safe, ensuring staff work in only one care home, or with a regular group of clients only. While these are covered, at least in part by the government's commitment to 31st March 2021 to cover PPE costs for most care providers, and through the provision of the Infection Control Fund (ICF), these measures do not cover all providers (e.g. day services do not receive the additional PPE support). The ICF is less generous for the winter period than for the first round. In addition, the additional PPE and other infection control measures required of providers are expected to remain after this support is due to cease.
- **Insurance costs** – Providers are identifying increased costs from insurance policies when these are renewed. Not all have faced this issue from their insurance companies, but many have. In addition, insurance companies are excluding pandemics from their cover, which may leave providers at risk from costs that would put them in severed financial difficulties should a case of infection be brought against them. These issues are being shared with government as a national priority.
- **Vacancy levels** - The impact of vacancy levels (also known as voids) on care homes will see their income reduce and their costs per client rise, and this may feed into costs for publicly funded clients. For care homes, the costs of maintaining fixed assets such as the buildings as well as minimum staffing requirements mean that costs do not reduce proportionate to client numbers.
- **Reduction of self-payers** - For care homes, the impacts of the reduction in self-payers that traditionally make up approximately 60% of the total market locally, may lead to financial instability. This may have a potential corresponding impact on the public sector in how we respond and support the market.

Hampshire Care Association (HCA)

HCA is the local umbrella membership body for the care home and homecare sector. It estimates that provider costs have risen by 22%, with the greatest increase due to rising staff costs.[11] These additional costs are significantly higher for some providers, particularly those that have faced COVID-19 outbreaks.

For most providers, the need to ensure adequate cover for staff who are sick or who must isolate due to a COVID-19 diagnosis or due to potential contact with another individual diagnosed with COVID-19 can be significant. Although the ICF will help with this, it is a fund that is to be used in several different ways. Many providers are reporting that additional funds made available are not sufficient to meet all their increased costs.

- One care home of 44 beds in the city has reported additional costs of £55,000 during the period March to June 2020. These related to staffing – mainly the need to replace nursing and ancillary staff who were unable to work for periods. Another 14-bed home has reported additional costs of £25,000 over a similar period. Both are net of the additional financial support provided by SCC, including the Infection Control Fund grant.
- SCC's own care home has reported similar increased costs. Between the months of April and July 2020 Holcroft house has spent an additional £77,060 on staffing. Due to the service specialising in dementia additional staff were required to support residents to social distance.

The HCA survey further confirms increases in vacancy levels as a result of the COVID-19 period. It also confirms the impact has been greatest on providers with the greatest number of self-payers in their services. Of the survey respondents, 94% of care providers have concerns as to their service's financial stability.

Care homes

The costs of the average placement in homes for SCCCG are high because clients have very complex care needs often due to behaviours and medical requirements that mean only specific types of accommodation and care provision are suitable. This sets a high starting point in the cost base for placements. It is also accentuated by the more limited market available to meet needs – this is true of both care home requirements and homecare provision in the community. Figure 27 below shows the costs of placing an individual in a care home for SCCCG before and since COVID-19.

[11] https://hampshirecare.org/financial-impact-and-market-stability-covid-19-impact-on-care-providers-in-hampshire-a-follow-up-survey/

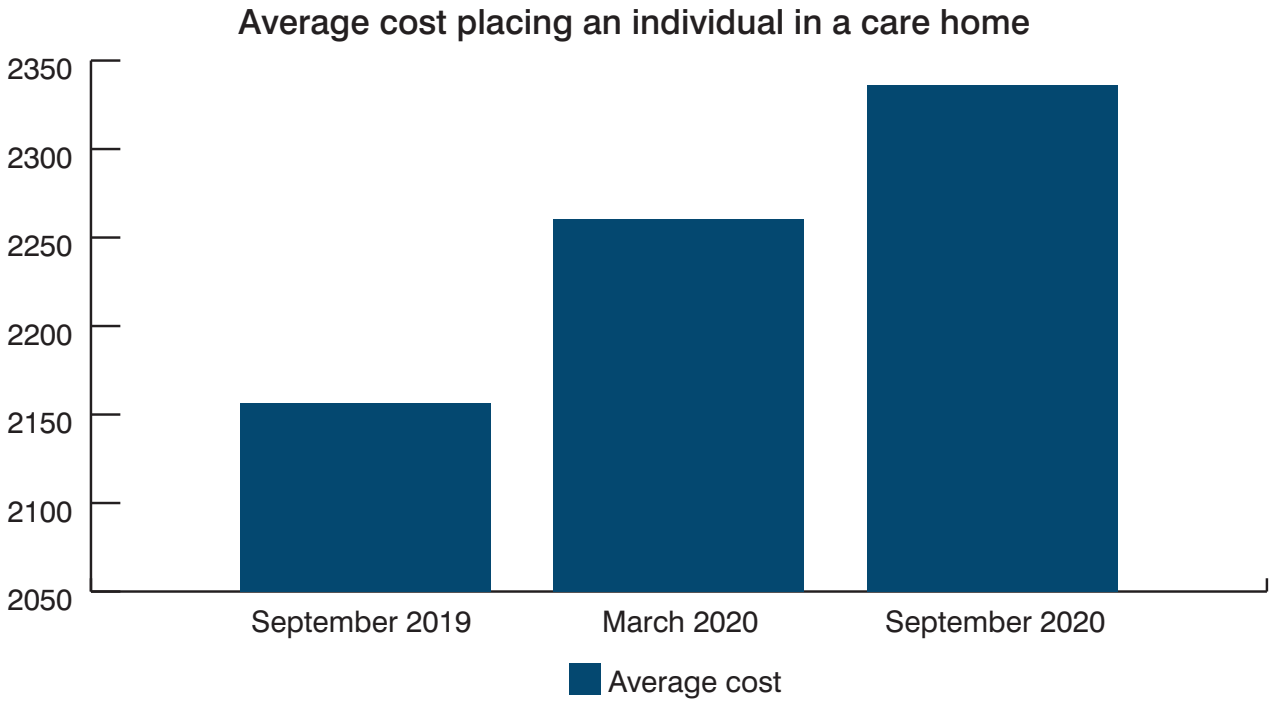


Figure 27: Average cost of placing an individual in a care home for SCCCG funded clients

SCC's cost base for care homes is lower but shows a discernible difference in costs met by SCC for care homes inside and outside of the city – something less accentuated within the SCCCG costs. These cost differences reflect the availability of rooms in care homes in the city, and generally the higher care needs that some homes outside of the city are prepared

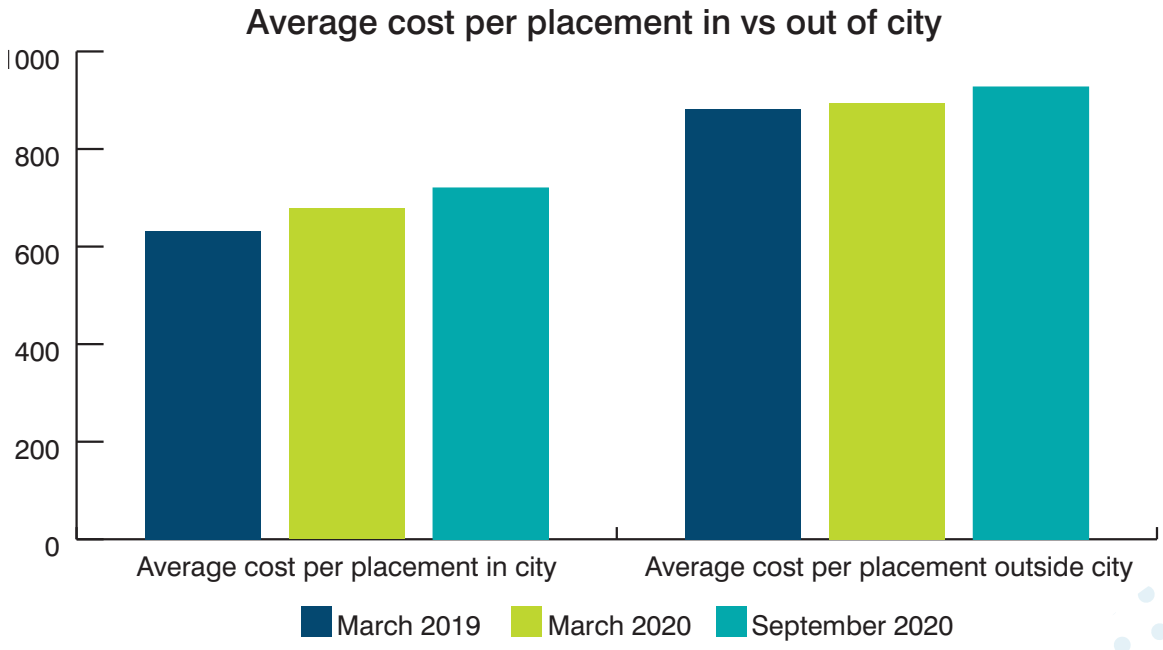


Figure 28: Average cost of SCC placements in care homes (not including placements direct from hospitals from April to September 2020)

to meet. The average cost of all placements made by SCC prior to COVID-19 was £768 per client per week. Figure 28 below shows the in and out of city cost split between SCC clients in care home settings and the increase in costs from March 2019 to September 2020.

Increasing the access to care homes in the city is important for a number of reasons, including:

- Ensuring available local capacity is maximized
- Sustaining the local market
- Increasing the complexity and need levels supported locally will enable the market to future-proof itself as SCC and SCCCG increasingly focus on accessing care homes for only the highest need clients
- Ensuring the best access for families locally.
- Ensuring consistency in quality, safeguarding, Infection Prevention and Control training and support for more Southampton clients.

Homecare services

For homecare services, increased costs reflect both the increasing levels of support required by clients as well as the number of clients supported. Both organisations work with a significant number of clients with homecare needs, including those who are jointly funded.

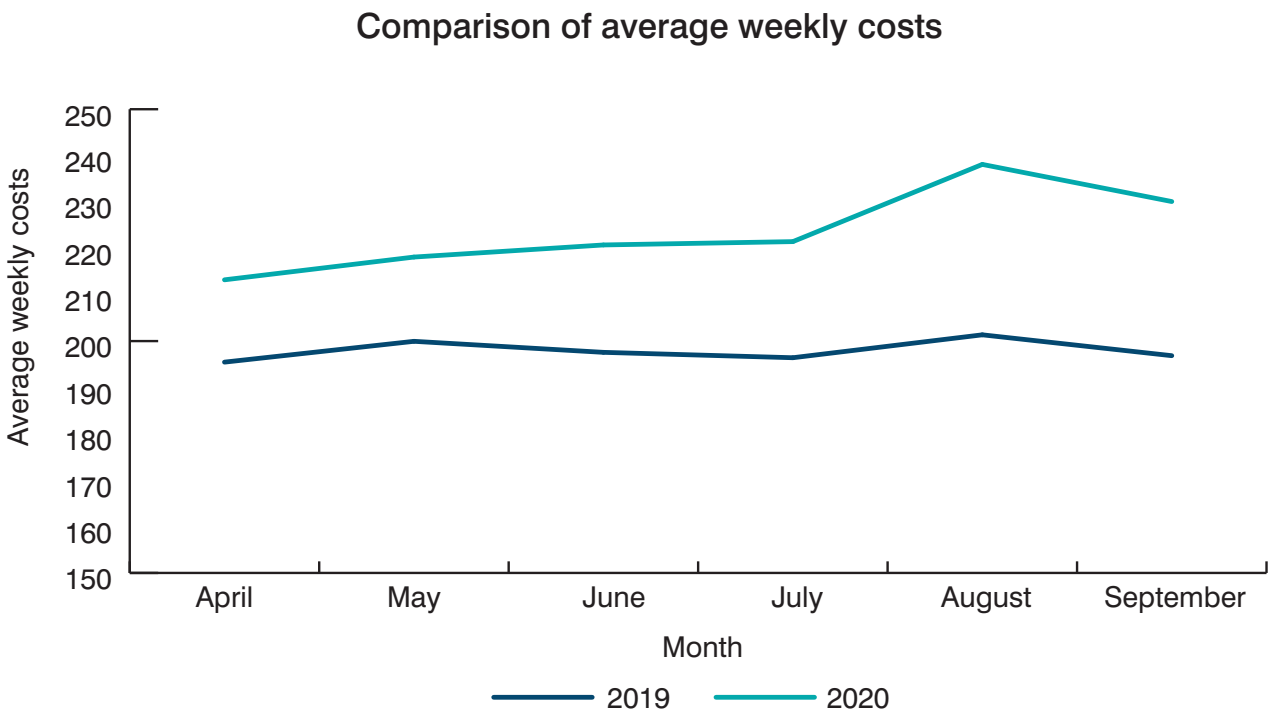


Figure 29: Comparison of the average weekly costs between April and September in 2019 and 2020

Over 1500 clients are supported by both organisations at any one time.

Costs are considerably higher than 2019. The figures below relate to SCC costs:

There is a 15% cost difference in the average cost of SCC weekly care packages between September 2019 and September 2020. Only 2.3% of that additional cost is related to increased charges by providers. The remainder is due to the more complex requirements of clients receiving homecare over this time. Section 3 highlighted the issues regarding complexity of care packages. The volume and complexity of care required by the public sector will place pressure on budgets for community-based services, as well as requiring staff trained in a wider variety of care requirements.

Care costs of individuals discharged from hospital

During the period from March to end of August 2020, costs of clients from hospital were met by NHS England. The costs of those placements have increased significantly from the usual average for

	Residential care – Average weekly cost of new COVID-19 placement	Nursing homes – Average weekly cost of new COVID-19 placements	Average weekly cost or new placement post COVID-19
In city	£714	£1,338	£1,050
Out of city	£968	£1,630	£1,351
Totals			
Average weekly cost	**£815**	**£1,465**	**£1,176**

Figure 30: Cost of new placements into care homes under COVID-19 regulations – April to September 2020

SCC. While these costs are high, they reflect the added complexity of care needs of many individuals, partly due to the policy of discharging patients when MOFD (see Section 2) and the potential effects of Long Covid.

For SCC, this represents a 53% rise in placement costs for new care home packages over the £768 pre-COVID-19 costs. It represents a significantly lower cost than existing SCCCG placements. As reviews of needs progress, it will become clearer who SCC has responsibility to fund under the Care Act requirements, who may be the responsibility of SCCCG and who may be required to self-fund their care. It is likely however, that the result will be a further increase in client numbers for both SCC and SCCCG, with additional associated costs. Estimates are regularly made and updated and shared with Finance colleagues to ensure the correct financial packages are in place for the current financial year and to meet needs in 2021/22.

9 Support for the local care market

Section summary

During the pandemic SCC and SCCCG have provided additional support to the local adult care market. The key areas of support identified in this section are infection prevention and control, training, digital access and finance (both directly and administering funding from central government). Much of this support continues and is being developed further.

Considerable support has been provided to the care sector during the COVID-19 period. Much of this is continuing into the winter period, including the Infection Control Fund contribution to care providers. SCC can exercise discretion regarding investment of the final 20% of the fund, but there are many calls on the resource, particularly in areas not supported with free PPE (day services, housing support), and a potential need to ensure adequate financial safeguards to meet substantial financial pressures on providers over the winter period if outbreaks should occur. As was seen in the previous section, the long-term costs of COVID are still being assessed, and the appropriate level of support required for the future is therefore still uncertain.

ICU support

A commissioning support centre was set up in March 2020 to provide support seven days a week to respond to urgent queries. This ensures providers can request support or guidance where they are experiencing difficulties, national guidance is distributed as it is published, regular updates are provided about support available for social care providers and it acts as an access point for emergency Personal Protective Equipment stocks. The Commissioning support centre, led by the ICU, is resourced according to the demand from providers in the system.[12]

There is a regular overview of the local care market from a quality and market resilience perspective by the ICU team. Intelligence gathered through regular contact with providers, including via our Placement Service, is used to supplement information on the COVID-19 Adult Social Care Tracker.[13] If there is an indication of issues developing, then appropriate action can be taken. For example, the actions taken to increase access to PPE, support required to manage workforce challenges or safeguarding actions if required.

Digital access

The Digital Care team have been supporting providers to use NHS digital systems. The team, part of the ICU, is monitoring adoption and usage of systems to ensure providers can access their accounts. Over 80% of eligible providers have signed up to NHS Mail. The remainder have so far refused to take this on, though are still being encouraged to. The team can track usage of the local pages on Teams.

Data Security & Protection Toolkit (DSPT) - by 30 September 2020, 90% of providers that use NHS systems had registered on the DSPT, and the Digital Care Team is continuing to encourage the remaining providers to sign up.

[12]The support centre can be contacted on soccg.ASCandCHCCOVID19@nhs.net
[13]https://carehomes.necsu.nhs.uk/

iPad cart distribution – £60,000 was spent to deploy iPad carts into care homes in Southampton at no costs to the homes. The iPads support care homes to conduct remote consultations with health and social care partners, reducing the need for on-site visits. Residents are also able to use the devices to stay connected with families. Over 80% of homes accepted the offer of the iPads.

Training

Current training and support available to the sector, including:

- Training sessions, support and advice from the ICU's Quality and Safeguarding Team, the Enhanced Care Home Quality Team, and the Infection Prevention and Control lead:
  - Disseminating guidance and updates, improving medicines management, weekly PPE and infection control training, ensuring clinical support is in place to all care homes
  - Educational updates on clinical care
  - Competency based PPE training based on the nationally mandated programme via the NHS
  - Roll out of RESTORE2 – an early warning system to help identify deterioration in care home residents
- Partnership Working via the Quality in Care Forum, the Southampton Registered Managers Network and the Hampshire Care Association
- A local wellbeing and resilience resources pack[14]
- A training and information booklet *Stop Look Care*[15]
- Free training via Grey Matters Learning, (a Skills for Care Centre of Excellence endorsed provider)[16]
- Free training sourced via the European Social Fund to develop Health and Social Care sector staff, provided by CSW Group
- Solent NHS Trust health training for unregistered staff
- Supporting homecare providers to share spaces on training programmes and to share costs.

The Infection Prevention and Control and Quality teams within the ICU have provided regular updates in the form of weekly multi-agency forums, emails and comprehensive support via IT connections with up-to-date information. This is now focused on a combination of updates and training on subjects such as managing outbreaks, protecting staff with PPE and identifying innovate ways of managing risks. The forum is used by the market to support one another and to direct scenario-based questions to infection control specialists.

Recruitment and Retention

Prior to the pandemic, statistics from Skills for Care showed that within Southampton's adult social care workforce of 5,400 staff there was a high vacancy rate (6%) and high staff turnover rates (24%). In addition, there is significant churn, with staff often recruited from within the sector instead of achieving net growth in the local care workforce.
To effect change, the ICU is supporting providers by:

[14]https://www.southampton.gov.uk/health-social-care/adults/impairments-and-disabilities/care-profesionals-training/
[15]https://www.southampton.gov.uk/images/stoplookcare_110520_tcm63-427072.pdf
[16]https://greymatterlearning.co.uk/social-care-courses/online-learning/stress-resilience-course/

- Providing information on recruitment initiatives set up across the Hampshire and Isle of Wight area, and nationally to attract and recruit staff to the sector, including:
  - SCC's recruitment team passing on potential applicants to local providers
  - Aircraft cabin crew and airline staff are being actively recruited
- The SCC's temporary staffing agency supporting the sector, where required
- Utilising Solent NHS Trust's Nurse Bank
- Induction training is provided to support staff who have not previously worked in the sector

As part of the national and regional NHS IAPT Team, providers are being supported with joint/centralised recruitment approaches, therapist training, availability of training places and Health Education England incentives for increased trainees.

Financial support

In recognition of the significant additional costs faced by the market during the pandemic, both SCC and SCCCG have provided substantial additional financial support to local adult care providers. Some of this has been from SCC and SCCCG budgets and some as been passed through from central government.

Up to 30th September 2020, SCC had made contributions of £4.18 million to the sector. This largely consisted of a 10% uplift to existing costs of placements with care agencies and for some block contracts. In addition to this support, SCCCG has provided an additional £640,000 of funding to the care sector between 1st April and 30th September, through a 10% uplift to payments. SCC has also distributed a further £2million to the care sector through the first round of the Infection Control Fund, which ran from 19th May to 23rd September 2020.

Figure 31 below shows the breakdown of the funding between SCC, SCCCG and the Infection Control Fund from central government up to 30th September 2020.

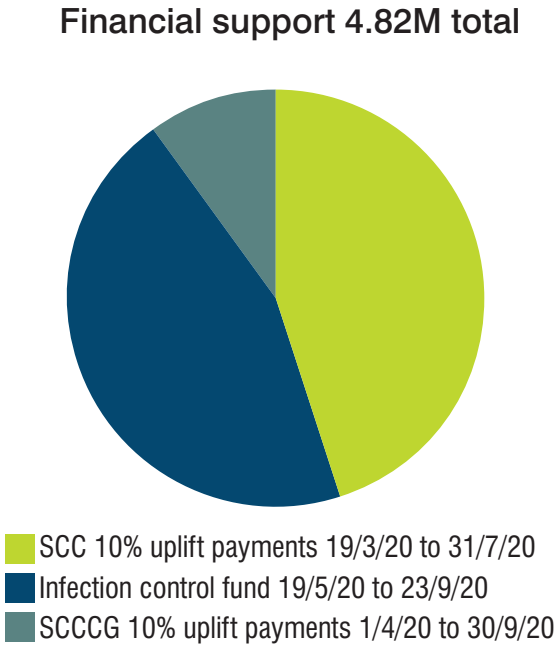


Figure 31: Financial support to the local care market from or administered by SCC and SCCCG

SCC is now in the process of distributing the second round of the Infection Control Fund. This will run from 1st October 2020 to 31st March 2021. The £2.189 million fund is currently being distributed largely to care homes and community providers (mainly homecare agencies with registered offices in the city). Commissioners are engaging with all relevant stakeholders to develop an investment plan for the final £400,000 of the fund.

	£ 000's
Care Homes	1,060
Home Care and Community	691
To be distributed	437
Total	**2,189**

Figure 32: Distribution of the second round of Infection Control Funding money 01/10/20 to 31/03/21

Provider Failure Protocol

The financial context risks provider failure and systemic market failure which would have far reaching consequences for the city. There is a duty under the Care Act 2014 to ensure a sustainable and diverse local market of care and support service. In the case of provider failure, it also requires the relocation and finding appropriate care for all clients within that setting, regardless of whether they are publicly funded or self-funding clients.

Southampton's jointly agreed Provider Failure Protocol contains mitigations including accepting requests for additional emergency funding from providers if they are eligible and working with providers to decrease the risk of failure through other means. Where there is no alternative to provider closure, then we will work with the provider to ensure a safe and managed exit from the market.

10 Engagement, partnership working and co-production

Section summary

Engagement, partnership working, and co-production are essential components of sustainable local adult care services. The key points identified in this section are the ways SCC and SCCCG are and will continue to engage with the market and work with it to develop the services needed at this time.

This report is not intended to be a summation, but instead a continuation of the ongoing conversation between commissioners and providers about how we can work together to ensure we maintain a sustainable, diverse and effective supply of high-quality adult care services despite the challenges of COVID-19. The necessary changes required to adapt for COVID-19 will be built upon to strengthen the market, including utilisation of technology and improved networks for recruitment, engagement, interaction and collaboration.

Engagement, partnership working and co-production

The ICU works with stakeholders, including clients and potential providers, to inform the design of services to ensure they meet the needs of clients and provide value for money and good social value. Voluntary, community and social enterprise (VCSE) sector schemes can support and influence the demand on homecare and the discharge process. Schemes prevent or delay the need for homecare for many individuals; engagement with this sector in the co-design of future services will influence future commissioning intentions.

Examples of current services are:

- Communicare in Southampton; Welcome Home Service builds upon good neighbourhood approach to provide light domestic duties, including shopping for 6 weeks post-discharge
- Community Transport; settles people in their own homes following discharge, links with Communicare
- Older People Day Services: activities and social contact, keeps people active for longer, delaying the need for care
- Carers; developing contingency plans in the event of an emergency, e.g. carers becoming unwell
- Meals on Wheels – Eat Well: nutrition and hydration, welfare checks
- Advice in Southampton; right income levels, helps prevent fuel poverty, maintaining independence
- Falls Prevention Programme; prevents deterioration, maintains independence in own homes

Market engagement is needed to agree the learning disability service offer in the medium term and an associated re-costing exercise to understand the financial impacts of COVID-19 and the current position re COVID-19 related service costs. Partnership working will be undertaken with providers and the community to support service change, including promoting an employment and volunteer focus and achieving real community inclusion. We will consider whether external expertise would be beneficial in working with key stakeholders to shape and achieve this.

While the main area of learning disability service redesign planned for the next 1-2 years is around day services, we will continue to engage with the groups listed below to ensure all learning disability services continue to deliver good levels of service.

- There are 4 key groups operating within the city that support coproduction:
  - The Learning Disabilities Partnership Board (LDPB)
  - Southampton Mencap carers sub-group
  - Carers coproduction group
  - Busy People self-advocacy group
- We will achieve co-production through the Learning Disability Partnership Board and consider opportunities to set up other co-production formats. We will look to involve our new advocacy provider, Voiceability, in this work to ensure that self-advocates are well supported.
- We will work with people who use services to ensure their voice is heard in any redesign/development.

Our NHS commissioned mental health services are focussed on meeting the requirements of the NHS Long Term Plan, which includes partnership working on:

- Keeping staff safe, healthy and well - both physically and psychologically
- Addressing systemic inequality that is experienced by some of staff, including BAME staff
- New ways of working and delivering care, making full and flexible use of our people's skills and experience
- Workforce planning and transformation and growing our workforce
- Delivering a very significantly expanded seasonal flu vaccination programme - determined by priority group, including providing easy access for all NHS staff promoting universal take up
- Working collaboratively with local communities and partners to take urgent action to increase the scale and pace of reducing health inequalities and regularly access this progress
- Protecting the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions, and better engage with those communities who need most support
- Restoring NHS services inclusively, so they are used by those in greatest need.
- Winter Preparations alongside COVID-19 including meeting the needs of the COVID-19 vaccination programme once this is launched

The ICU is working in partnership with colleagues across health and social care and the VCSE sector on peer support in Mental Health. Peer Support features heavily within NHS Long Term Plan ambitions and we are working to develop a framework for peer support workers to facilitate structure and support for their profession.

The ICU is supporting a Mental Health Network and Service User Network to start at the beginning of the next financial year. This will be key to engagement, partnership, and challenge with those working in the city developing mental health services across statutory, health, community, and voluntary sectors.

In October 2020 SCC began a Scrutiny Inquiry for 'Carer Friendly Southampton', with the purpose of identifying opportunities to improve support for carers in Southampton. This will involve carers and stakeholders and is due to consider topics such as health, wellbeing and safety, identification rights, recognition and support, information, advice and guidance, support for carers and for education and work.[17] The committee is due to produce its final report in April 2021.

Following this, the SCC carer's strategy will be updated. SCC understand the importance of giving full recognition to the role of informal carers. The ICU will input to this process and already provide support for carers through commissioned services.

[17] http://www.southampton.gov.uk/modernGov/ieListMeetings.aspx?CId=750&Year=0

11 Indicative 2021/22 Commissioning Intentions

Section summary

This impact statement has raised many issues that will need to be addressed to ensure market sustainability. Work on some is already in progress, while others have yet to begin. Each issue will need all parties to work together to ensure sustainable solutions are found in the short, medium and long term.

Intermediate care

The criteria for discharging patients into the community following medical treatment in hospital changed during the pandemic. The new policy of MOFD had consequences for community services and homes to adapt to. There is more work to be undertaken on this to enable a new commissioning response to be delivered for the longer term. This includes developing a greater understanding of the issues and long-term impacts of placing clients who are considered medically optimised for discharge in care homes and home care settings. This will enable the development of a comprehensive approach to ensure long term needs can be met. This can be linked to the programmes for home care and care home commissioning intentions.

- Ensuring community-based services have adequate capacity and the necessary skills base to support the levels of complexity of need and speed of discharge from hospital
- Ensuring services can meet the increased complexity of need. Capacity to enable discharge to assess and designations of accommodation are being put in place, but there is also a need to ensure other community services are able to support people with complex needs to a greater extent than is possible at present.
- Further research is needed to understand returns to hospital following the usual 28-day reporting period after the discharges. We can map impacts on complexity as clients are readmitted but understanding if these can be managed more appropriately will be key.

Homecare

Homecare has seen an increase in complexity, increase in demand, issues with recruitment, increase in anxiety around accepting homecare and challenges for families in making the decision to withdraw homecare from a loved one. To address these a number of actions are needed:

- The increase in off-framework provider use, together with new off-framework providers approaching to offer packages of care, has highlighted the need for a closer look at the use of off-framework providers. The annual framework re-opening will provide an opportunity for this to be reset and for these providers to register for the framework. This will promote market diversity and sustainability. The appointment of new lead providers for the parts of the city that do not currently have one will also help to build this.
- Increased complexity of client care needs is leading to the need for more capacity. This is a crucial part of planning together with providers.
- A new 83-bed extra care scheme, Potters Court, is due to open in 2021. This will provide additional capacity for a supported environment in the community and will be monitored to see the impact it has on SCC's ability to meet demand in the post-COVID-19 environment.

- Commissioners will proactively work with providers to enhance relationships between homecare and health providers in the city, to raise the profile of the significant role homecare plays within the health and social care system. COVID-19 has heightened the importance and relevance of this sector and provided an opportunity to raise its profile.

Care homes

Commissioners are engaging with providers, considering options for addressing each of these challenges, and work is commencing with the market to ascertain needs, costs and options for new commissioning arrangements and routes to market for the future. This will include:

- Continuing to monitor self-payer access to care homes. This includes understanding the impact on informal carers as well as assessing the longer-term impact on the market.
- Enabling clients to live in the community in a supported housing environment if required.
- A new 83-bed extra care scheme, Potters Court, is due to open in early 2021. This will provide a high level of care and will be staffed by carers from a lead homecare provider agency with experience of managing extra care services. This will provide additional capacity to work with clients with higher needs in the community, reducing the need to move to care home settings. This will also help with the long-term accommodation and care needs of individuals who were found care home places when being discharged from hospital.
- A new commissioning and procurement programme to secure more beds for individuals with the highest care needs and involving collaboration amongst commissioners across the south Hampshire sub-region.
- Assessing the commissioning and procurement approaches to long-term care with the care home market and assessing their likely impact, and any risks involved regarding access, prices, and the longer-term sustainability of the market.
- Developing specifications to detail new need levels and requirements.
- Developing a Workforce Strategy to support the market in the longer term.
- Continuing to identify options for future nursing home developments in the city.

Older Persons's day services

Discussions have begun about how the service might be adapted for post-COVID-19 needs and demand. Consideration is being given to splitting the existing service into two distinctive elements. One would be focused on prevention and early intervention and based on activity for all. The second element would provide buildings-based care and support to vulnerable clients, which would be substantially funded by the self-funding market. Significant remodelling and financial planning would be needed to achieve this. In addition, work continues to financially map the impact of the change in provision as a result of COVID-19.

Learning Disability

Commissioners are working with the day services market to ensure operating models are COVID-secure and the safety of clients can be assured. This includes:

- Market engagement to agree the service offer in the medium term and commissioners are gathering detailed intelligence of operating costs via a re-costing exercise. This will enable an understanding of the financial impacts of COVID-19 and the impact on future service costs.
- Partnership working with providers and the community to support service change towards outcomes led provision, including with an employment/volunteer focus and achieving real community inclusion.
- Continued engagement with providers, via contract monitoring, to monitor the impact of subsequent waves or individual outbreaks on service provision and costs, both for individual services and across the market.
- The impact of COVID-19 on recruitment, retention and training will be monitored and will feed into the broader workforce strategy.
- A Learning Disability provider forum is also being held every two months at which providers can discuss different aspects of their response to COVID-19, including sharing resources and good practice.

Mental Health

Primary Care IAPT Services were due to be re-procured for a service start date of 1st April 2021. However, due to COVID-19, a single tender waiver was granted and the intention is that the service will now be re-procured for April 2022. This service will continue to expand access to those with common mental health illness, include specific pathways for long term health conditions. An invitation to tender will be issued via the NHS South of England Procurement Service in early 2021. Meanwhile the existing service will continue to develop therapy pathways which meet the requirements of COVID-19 policy and guidelines.

Secondary care mental health services continue to be provided by the local Mental Health Foundation Trust. There is no change to this as a result of COVID-19, though other changes are anticipated as the NHS Long Term Plan expects the following transformation across secondary Mental Health Care to 2023/24:

- Specialist community perinatal mental health care
- Increase in Serious Mental Illness (SMI) community care, including physical health checks, access to Individual Placement Support and NICE approved care for those experiencing a first episode of psychosis
- Suicide reduction and bereavement support
- Overarching transformation of community mental health.

A mental health housing needs assessment is in progress and the outcome of this work will quantify the future requirements for housing for people with mental health problems.

Finance

To limit the impacts on budgets, while supporting providers appropriately, commissioners will work with finance specialists in both SCC and SCCCG to ensure the new market cost pressures affecting the

public sector budgets in both the current financial year and future years can be understood. This includes:

- Commissioners are undertaking a re-costing exercise with Learning Disability day services market, to inform future operating costs.
- In Mental Health there are several modelling exercises currently underway to gauge the impact of COVID-19 on service demand and potential costs. Current modelling for both secondary and primary mental health care services indicate a 10% increase in demand for services as a result of COVID-19.
- As assessments of clients placed with care services during the COVID-19 period are undertaken and the decisions on long-term funding are made, it's anticipated the majority of these will fall on SCC and SCCCG. Commissioners need to develop plans to manage these changes of financial responsibility in order to limit their impact. This may require new approaches to the market to secure care, as well as options for moving clients where negotiations fail to achieve the objective of setting reasonable prices for the complexity of need. This needs to be balanced ethically with choice, equality and human rights.
- The need to consider appropriate support to the market in the short term to maintain a sustainable market. This will require a commissioning approach to the market to determine the most appropriate use of resources, where required. There is a need to ensure decisions on support are based on our understanding of the long-term needs and demands within the market, and to return as quickly as possible to the goal of providing community-based support and using care homes as only the last option for meeting client needs.
- To date, additional support has been funded both via additional central government support to councils and at source by Central Government. There is no guarantee that this will continue after this financial year. This will present a challenge to both bodies and the care market in 2021/22. This will need the development of a strategy whereby a sustainable market is aimed to be reached as soon as possible. However, with the long-term impacts of COVID-19 still uncertain, there remains a need to review long-term costs regularly to ascertain potential impacts and for SCC and SCCCG to refine their responses.

Training

Following engagement with, and agreement from providers, the ICU will be conducting a series of additional surveys and seminars which will cover:

- Undertaking a Training Needs Survey (TNS) to establish gaps/issues
- Mapping the current training available
- Creating a Training Resource Directory from the results and analysis
- Discussing the results of the TNS with SCC's Learning and Development team to ensure the training offer to the sector is providing the identified requirements.
- Sharing the results of the TNS with further education establishments to ensure that they are aware of the future training required for the sector

Conclusion

The adult care sector is facing an unprecedented period of uncertainty. COVID-19 has changed the landscape of care delivery and will have a long-term effect. This will have significant implications for providers and for the public sector. The full impacts are still not yet fully understood, but it is likely that they will change both the shape and size of the market. On the horizon are other potential challenges: the full impact of Brexit is not yet known; the delayed publication of the Social Care Green Paper and long-term funding arrangements; and challenges for the way the sector is viewed by individuals paying for their own care. SCC and SCCCG will be seeking to support the market to respond effectively to these challenges through partnership working, planning and risk sharing, whenever appropriate.

We are currently undertaking further research designed to better understand the actual costs of care, issues affecting sustainability of the local care market and potential future pressures including inflation and National Minimum Wage. We will be engaging with providers and their representative and membership bodies to ensure their views are reflected within this.

We will need to understand the future of the local self-payer market, and if recent changes in decisions made by individuals will have only a temporary or longer-term impact on the market, and ultimately the impact this will have on the local supply of publicly funded care.

This is a challenging period for the market and the public sector. By working together, we can develop an agreed picture of how we ensure market and financial sustainability while managing the long-term impact of changes in care delivery.

We hope that this report has provided an understanding of the pressures faced locally and on the strategic direction of SCC and SCCCG. We are always keen to hear from people and organisations who wish to work with us or find out more about the City. We welcome the input of the market in shaping the future work programme and outcomes.

If you would like to speak to us about this document or discuss joint working opportunities, please contact us at **market.development@southampton.gov.uk.**

We look forward to hearing from you.

Glossary

Bridging service
Provides temporary care packages to enable clients to leave hospital prior to long term care packages starting

Care home
Provides 24 hr care on site for residents.

Care package
A homecare services specific to a client to meet their individual needs. Also known as package of care

Care Quality Commission (CQC)
The independent regulator of health and adult social care in England.

Chronic Obstructive Pulmonary Disease (COPD)
The name for a group of lung conditions that cause breathing difficulties, including emphysema and chronic bronchitis.

Client/ patient
These terms have been used interchangeably throughout the report and refers to a person in receipt of support from SCC or SCCCG. They may also be referred to as service users or customers.

Continuing Health Care (CHC)
Care and support which is arranged and paid for by the NHS. It is for people who have ongoing health care needs

Elective admissions
Planned admissions to hospital for treatment or surgery

Homecare
Providing care services to clients in their own homes, enabling them to stay independent for longer. Previously known as domiciliary care.

Integrated Care System
Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations

LSOAs
Lower-layer Super Output Areas, linked to Indices of Multiple Deprivation - Lower-Layer Super Output Areas (LSOAs) are small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 Lower-layer LSOAs in England. LSOAs are a standard statistical geography produced by the Office for National Statistics for the reporting of small area statistics. LSOAs are also referred to as neighbourhoods throughout this release. Reference https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835115/IoD2019_Statistical_Release.pdf

Medically fit for discharge
Patients are discharged from hospital when they have received clinical support and have had a recovery period

Medically optimised for discharge
Patients are discharged from hospital when they have received clinical support from the hospital but excluding any recovery period

NHSE/I
NHS England / Improvement

PPE
Personal Protective Equipment is items such as face masks, gloves and aprons, that provide protection from viruses and bacteria.

Providers or service providers
Organisations that provide services under a contract to SCC or SCCCG. These may be private sector businesses, sole traders or voluntary and community sector organisations

Regulated activity
A care activity that is regulated by the Care Quality Commission

s117
A Section 117 applies to those who have been subject to Section 3, 47, 48, 37 or 45a of the Mental Health Act and entitles them to aftercare provision. This can be via health and social care provision such as a specialist placement and other rehabilitation and recovery activities.

s75
A Section 75 agreement enables local authorities and health bodies to create a pooled budget