Public Document Pack

Joint Commissioning Board

Thursday, 17th December, 2020 at 9.30 am

Virtual Meeting - Please Note:

A link to this meeting will be available on Southampton City Council's website at least 24hrs before the meeting

THIS MEETING IS OPEN TO THE PUBLIC

AGENDA

Please send apologies to: Emily Penfold, Business Manager, emily.penfold@nhs.net,

1 WELCOME AND APOLOGIES

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chair	Information	

2 DECLARATIONS OF INTEREST

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

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chair	Information	

3 MINUTES OF THE PREVIOUS MEETING/ ACTION TRACKER (Pages 1 - 6)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chair	Decision	Attached

4 QUALITY REPORT - PROVIDER FAILURE PROTOCOL (Pages 7 - 38)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Carol Alstrom	Discussion	Attached

5 PERFORMANCE REPORT (Pages 39 - 44)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Stephanie Ramsey	Discussion	Attached

6 BETTER CARE STEERING BOARD MINUTES (Pages 45 - 52)

Lead	**Item For:** **Discussion** **Decision** **Information**	**Attachment**
Chair	Information	Attached

Wednesday, 9 December 2020

Service Director Legal and Business Operations

Meeting Minutes

Joint Commissioning Board – Public

The meeting was held on Thursday 15th October 2020, 09:30 - 10:30
Microsoft Teams Meeting

	NAME	INITIAL	TITLE	ORG
Present:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	Councillor Lorna Fielker	Cllr Fielker	Cabinet Member – health and Adult Care	SCC
	Councillor Dave Shields	Cllr Shields	Cabinet Member – Stronger Communities	SCC
	Matt Stevens	MS	Lay Member – Patient and Public Involvement	SCCCG
	James Rimmer	JR	Managing Director	SCCCG
In attendance:	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG / SCC
	Donna Chapman	DC	Associate Director	SCCCG/ SCC
	Grainne Siggins	GS	Executive Director Wellbeing (Health & Adults)	SCC
	Sandy Hopkins	SH	Chief Executive Officer	SCC
	Moraig Forrest-Charde	MFC	Deputy Associate Director	SCCCG/SCC
	Keith Petty	KP	Co-ordinating Finance Business Partner	SCC
	Adrian Littlemore	AL	Senior Commissioning Manager	SCCCG
	Andrew Gittins(minutes)	AG	Senior Administrator	SCCCG
Apologies:	Councillor Chris Hammond	Cllr Hammond	Leader of the Council	SCC
	Maggie MacIsaac	MM	Chief Executive Officer	SCCCG
	Beccy Willis	BW	Head of Governance	SCCCG
	Claire Heather	CH	Senior Democratic Support Officer	SCC

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted	

2.	**Declarations of Interest**	
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship No declarations were made above those already on the Conflict of Interest register.	
3.	**Minutes of the Previous Meeting/Action Tracker**	
	The minutes from the previous meeting dated 18th June 2020 were agreed as an accurate reflection of the meeting. **Matters Arising** There were no matters arising. **Action Tracker**	
4.	**Better Care Highlight report - Quarter 1 and 2**	
	MFC joined the meeting and provided highlights from the report as follows: • We are expecting some national guidance this month regarding future of Better Care Programme. There is a current risk for ongoing financial planning without this clarity. • The report includes a significant piece of work on the discharge pathway with COVID requirements, especially the most complex individuals which there are still challenges around. • Due to the COVID impact, there have been a number of developments and delays. • There have also been delays for the development of Potters Court extra care housing however this is now rapidly progressing again, and hoping to move forward with it in quarter 4. • Ensuring carehomes are fully support from Healthcare. • Challenges around LD Complex packages were noted. MS asked regarding the discharge hub and if there will be issues around Covid-19 positive patients going into care homes. SR outlined that work is underway looking at this, including looking at alternative placements. GS recognised the risks of not knowing what our future funding is, however thanked the system for all the hard work that has been put in to support our residents. GS noted how critical the sustainability work is. The funding has been available to support this work, but we need to assure ourselves that we can secure a sustainable market that suits our needs. Cllr Fielker expressed the concerns around the risks for the voluntary	

	sector. SR summarised that if we are happy with the content of this, we will use this information as part of our ongoing national submission. The Board supported the Better Care Highlight report for Quarter 1 and 2.	
5.	**Advice, Information and Guidance (AIG) update**	
	AL joined the meeting to provide an update on AIG. The services carried on through the Covid-19 emergency; however it took some time to shift to an online offer due to not having the IT resilience to support this originally. There has been a focus on a self-serve, self-manage approach, which allows time to focus on people with more complex needs. MK expressed concerns around people being at a disadvantage if they don't have the digital capability which leads to an issue around access. It was noted that there is work taking place as part of the digital engagement strategy looking at how to support people to become more digitally engaged. However there are still people who might not want to engage at all. MK added that it would be good to include the AIG offer on GP practice websites. There was a discussion around what the online offer looks like. AL updated that the online offer includes information that people can access without using the actual service and video appointments. In addition we are working NHS digital around having a secure platform that GP's can use to have their consultations. Cllr Fielker and GS both agreed that more promotion is needed for the service. Reminding people what local services are available is important. AL will take all comments back and discuss with the partners.	
6.	**JCB Terms of Reference**	
	SR provided an update on the changes to the JCB Terms of Reference The Board agreed to approve these JCB Terms of Reference at the current time but noted due to CCG changes going forward, they will need to be reviewed again.	
7.	**Better Care Steering Board Minutes**	
	The minutes of the Better Care Steering Board on the 2nd June 2020 were noted as for information.	

8.	**Date of Next Meeting**	
	17th December 2020, 09:30 – 10:30, Microsoft Teams	

Joint Commisioning Board - Action Tracker (Public)					
Date of meeting	**Subject**	**Action**	**Lead**	**Deadline**	**Progress**
17/10/2019	Quality Report	SR to provide a briefing at a future meeting on staffing / workforce within Mental Health / SHFT	Stephanie Ramsey	Nov-20	was scheduled for March, however Meeting was cancelled due to Covid19 response, all items to be reviewed and rescheduled, to be incorporated in MH briefing at meeting in November . Update given. Close
17/10/2019	Performance Report	Deep dive session to take place at a future meeting for the Associate Directors to talk through each of their areas	Stephanie Ramsey	Jan-21	was scheduled for March, however Meeting was cancelled due to Covid19 response, all items to be reviewed and rescheduled.

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DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Quality Update**		
DATE OF DECISION:		**17th December**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Carol Alstrom	Tel:	07787005624
	E-mail:	carol.alstrom@nhs.net		
Director	**Name:**	Stephanie Ramsey	Tel:	023 80296914
	E-mail:	stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY

This paper provides an update on quality in health and care services in Southampton and is seeking the re-approval of the Joint Commissioning Board for the ongoing use of the Provider Failure and Provider Exit Procedure. This procedure has been developed in line with nationally recognised guidance to support this type of event, and involves both health and social care teams to respond, particularly in the case of a large provider e.g. a care home with nursing or a home care provider who provides home care to a large number of health and social care funded service users. This procedure has been updated since the last presentation in 2018

RECOMMENDATIONS:

1.	(i)	Note the quality report
	(ii)	Approve the Provider Failure and Provider Exit Procedure

REASONS FOR REPORT RECOMMENDATIONS

2. The quality report is an update for Joint Commissioning Board on quality concerns and good practice in the City and is intended as an information only item to provide assurance to the Board

   The Provider Failure and Provider Exit Procedure has been developed by the Integrated Commissioning Unit Quality Team following national best practice and local experience of provider failure or exit. This means that the procedure has been tested to ensure it is applicable to care homes and home care providers, for both provider failure (a situation where the quality or business provided breaks down) and provider exit (a situation where a decision has been made for a provider to exit the local market). It has also been updated taking into consideration the impact of the Covid-19 pandemic, and cross border working agreements.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. The quality report is an update for Joint Commissioning Board on quality concerns and good practice in the City and is intended as an information only item to provide assurance to the Board

DETAIL (Including consultation carried out)

4. **Quality Report**

   This short update provides an overview of the current good practice and challenges for quality of services that are commissioned by the Integrated Commissioning Unit (ICU) between Southampton City Council and NHS Southampton City Clinical Commissioning Group.

5. **Good Practice**

Currently across Southampton social care providers in the care home and home care market are considered overall to be providing good care. The ratings profile below has only had one change since October 2019 as one residential care home has moved from inadequate to requires improvement. CQC are currently only completing inspections when there is a significant risk situation in a provider. CQC are now using their Transitional Regulatory Approach, this focuses on safety, how effectively a service is led and how easily people can access the service. It includes:

- a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so the CQC can continually monitor risk in a service
- using technology and our local relationships to have better direct contact with people who are using services, their families and staff in services
- targeting inspection activity where the CQC have concerns

After reviewing information that the CQC have about a service, they will have a conversation with the provider either online or by telephone. This is not an inspection and they do not rate services following a call. This call helps the CQC to decide whether they need to take further regulatory action at this time, for example an inspection.

The current profile of CQC ratings across Southampton is

	Outstanding	*Good*	*Requires Improvement*	*Inadequate*	*Not yet rated*
Nursing Homes	0	9	0	0	0
Residential Homes	1	41	8 (7)	0	4
Home care providers	2	42 (36)	5	0	2

Note - Figures in () indicate position at last report

A small number of providers continue to be monitored by the ICU Quality Team to ensure that care standards are meeting the Care Quality Commission (CQC) and locally expected requirements. This has become more challenging to do during the Covid-19 emergency and visits have only taken place in very exceptional circumstances. A system of virtual quality reviews has been developed and these are enabling the team to monitor and support services. When needed risk assessed face to face visits are taking place with appropriate personal protective equipment and social distancing. Alongside this our normal intelligence gathering processes continue.

6 The Integrated Commissioning Unit has been proactively supporting the care home and home care sector throughout the pandemic. A well-established weekly video conference has been set up and provides training and general updates on the latest guidance and requirements for care homes. The latest sessions have covered vaccinations, visiting protocols and lateral flow testing. These sessions continue to be extremely popular with the care home and home care sector providers. A question-and-answer session relating to Infection Prevention and Control is included each week which has generated a significant amount of feedback from the sector.

Training in the use of Personal Protective Equipment and NEWS2 (RESTORE2), an assessment of vital signs for residents, has continued to be rolled out. There are only 4 further care homes left in the City to complete their NEWS2 training now and plans are in

	place for this to be completed.
7	The wider ICU Quality Team supporting health providers has continued to monitor, review and support providers through the pandemic. The approach has changed to involving ourselves much more in provider meetings rather than expecting providers to attend meetings with us. This has proved extremely successful and provider engagement remains good. A learning and sharing forum meets regularly including Hampshire and the Isle of Wight health providers and this has proved extremely valuable sharing learning over a larger network than normal. The team has also been actively involved in the restoration and recovery work for NHS Services, with the main areas of focus being quality impact assessments and identification of harm or potential harm due to delays to treatment times, to date no instances of significant harm have been identified. At the start of the Covid-19 emergency period, Continuing Healthcare Assessments were halted and a temporary hospital discharge process was put in place. This saw the NHS taking on funding for all patients with complex needs. That process has been reviewed and a new system came into effect on 1st September 2020 which reduces the funding period by the NHS to 6 weeks. Since 1st September CCG and Council colleagues have been working together to proactively clear this backlog and so far good progress is being made.
8	The Provider Failure and Provider Exit procedure has been developed by the Integrated Commissioning Unit Quality Team with involvement from Commissioning Managers, Placement Service and Adult Social Care Safeguarding experts.
RESOURCE IMPLICATIONS	
Capital/Revenue	
9	There are no specific resource implications of this paper. The provider failure and provider exit procedure requires Council and CCG staff to undertake additional roles similar to those of managing a significant incident or emergency planning type situation.
Property/Other	
10	None noted
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
11	The Council has a statutory power and responsibility to safeguard individuals receiving services within the Southampton City boundary
Other Legal Implications:	
12	None noted
CONFLICT OF INTEREST IMPLICATIOINS	
13	No conflicts of interest are noted
RISK MANAGEMENT IMPLICATIONS	
14	The Council has a responsibility as a commissioner of services to ensure the quality of those services meets an acceptable standard. In addition the Council has a statutory responsibility under the Care Act to ensure mechanisms are in place to safeguard adults, who may be vulnerable, and are receiving care within the City boundary.
14	**Areas of Concern** The main areas of concern at this time relate to the impact of COVID-19 on care homes and home care providers, and the restoration and recovery of NHS services.

	For care homes and home care providers the risk of staff being infected with Covid-19 remains very real. Testing is improving and has allowed the identification of staff who are infected. The main risk is that a large group of staff in one care home or home care provider are infected at the same time and are required to quarantine. Plans are in place to support a care home in this situation through mutual aid and bank / agency staff from partners across the Southampton system. This has happened recently for one home care provider; however this was successfully managed using support from the home care provider retainer contract. For NHS services restoration and recovery work is underway and locally good progress is being made. The quality team are part of the restoration and recovery work streams and are working with providers to identify risks and where patients may have come to harm. At this time no significant instances of harm have been highlighted in Southampton.
POLICY FRAMEWORK IMPLICATIONS	
15	The information contained within this report are in accordance with the Councils Policy Framework plans

KEY DECISION?	**N/A**	
WARDS/COMMUNITIES AFFECTED:	**N/A**	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Provider Failure and Provider Exit Procedures	

Documents In Members' Rooms

1.	Not applicable	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**No**
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.	Not applicable	

PROVIDER FAILURE AND PROVIDER EXIT PROCEDURE

Guidance for
Southampton City Council and
NHS Southampton City CCG Staff

UPDATED DRAFT December 2020

Subject and version number of document:	Provider Failure Procedure V03 This procedure identifies actions to be taken in the event of actual or prospective failure / exit of one or more providers of care which appears likely to occur in circumstances where the Provider may not be able to plan and implement an orderly and structured run-down of their services.
Owner of this document:	Associate Director of Quality, Integrated Commissioning Unit
Operative date (first created):	11th June 2018
This document applies to:	Care Home, Home Care providers and other adult social care providers within Southampton City boundaries Southampton City Council NHS Southampton City CCG
Policy Implications:	Guidance for Internal Use Policy to be shared with staff who may be involved with this process
Consultation Process	Integrated Commissioning Unit Adult Social Care
Approved by:	Joint Commissioning Board
Date approved:	TBC December 2020
Next review date:	TBC December 2022

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1. Introduction

1.1 This procedure provides guidance about how to manage and oversee the events when a provider service is failing or is at risk of failing. The document has been produced with support and guidance of officers from Southampton City Council (SCC) and NHS Southampton City Clinical Commissioning Group (CCG) and is underpinned by the 4LSAB Multi Agency Adult Safeguarding Policy and Procedures June 2020. The procedures are also based on guidance by ADASS (the Association of Directors of Adult Social Services) for dealing with provider failure and supports the implementation of the Care Act (2014).

1.2. Failures and exits of care providers from the local market are comparatively rare events and present particular challenges in that City Council and NHS intervention would be required immediately, and the assessment and transfer of residents to alternative care providers may need to take place within a very short time frame.

1.3. The impact of the changes to provision upon service users and their relatives and carers should be managed in the best 'person-centred' way possible by working to the framework set out in this document. Every effort should be made to cater for the specific identified needs of each service user, and wherever practicable to keep 'friendship groups' together and take time and great care to minimise the disruption for these very vulnerable service users and maximise the time available for preparation. Further good practice guidance is set out in research by ADASS (the Association of Directors of Adult Social Services) and the University of Birmingham on achieving positive outcomes during moves, especially with unplanned or short-notice failures.

1.4. Any assessment and planning processes involving vulnerable adults affected by a potential failure will also be need to be underpinned throughout by the principles of the *Mental Capacity Act 2005*

1.5. Failures and exits may be caused by a number of factors - for example:

- Closure by Regulators
- Termination of contract by Commissioners
- Loss of premises due to damage
- Closure by Owners due to increasing financial pressures; or the outright failure of their business leading to the appointment of a Corporate Insolvency Practitioner e.g. a Receiver, Administrator etc.
- Business/organisational redesign and transformation
- Service provision failure due to a pandemic resulting in large numbers of provider staff having to self-isolate

1.6. Any resulting requirement for transfer of service users to alternative care facilities would be dependent on the assessed needs of the service user and the availability of spare capacity in the local market. The preferred and expressed choices of location and of care provider of service users/carers should be gained and fully taken into account.

1.7. Lead responsibilities for dealing with different categories of resident will fall as follows (see also ***Section 6,*** below):

- Council-funded and self-funded – Local Authority
- Continuing Healthcare funded – NHS
- Joint funded – Local Authority or NHS with largest % of funding split to lead
- Out of City Local Authority – Local Authority to identify relevant funding authority and agree responsibility for managing transfer

This procedure can be applied to all types of provider services, including,

- Residential Units
- Supported Living

- Home Care and Support
- Day Services
- Other key services

And the timescale of the potential closure can be

- Immediate and/or unplanned
- Longer term planned closure by a set date

1.8. Actual or prospective failure or exit of a single provider imposes stress on a local care market, whereas the failure of a medium or large corporate Provider - often involving several Care Services in the same area at the same time - will present enormous challenges that may require the involvement of a number of NHS's and Local Authorities to identify alternative capacity and to maintain service provision.

1.9. **It is recognised that every situation is different and it is up to the responsible statutory sector Managers to decide the best approach for the situation presenting at the time, interpreting this Operational Procedure flexibly to suit the specifics of the case while still being guided by its principles.** Any case-specific 'contingency' or 'resilience' planning will to a large extent be determined by the time available prior to failure, and the Lead Officer will need to adapt procedures and use available resources to minimise disruption to Service Users as far as possible.

1.10. Factors such as the cause of the failure or exit, the timescale, local availability of provision and staffing resources, will all affect the feasibility of using a standard management approach - however, the Management Checklist in ***Appendix A*** provides a useful framework.

2. Aim and Purpose of this Operational Procedure

2.1. The main aim of this document is to provide a framework for Managers to ensure:

- Service users/adults at risk are fully protected and their wellbeing and safety is at the forefront of planning and action.
- that there is effective and coordinated planning and communication between all parties involved in the proposed and/or actual failure arrangements
- that the financial responsibilities of the Council and the CCG are considered throughout and the consequences of a provider closure are effectively managed.

2.2. This Procedure identifies actions in the event of an unplanned or potential care provider failure, including the officers responsible for these actions.

2.3. It is intended as a generic approach to situations of this type. There should be a coordinated and agreed plan for any provider failure event.

2.4. The options for alternative provision will depend upon individual circumstances and are listed in ***Section 8.***

2.5. In the case of unplanned failures or exits affecting a major service Provider that overwhelms the ability of SCC and the CCG being able to relocate service users, SCC and the CCG may also want to consider activating Emergency Planning procedures for the City Council and partners.

2.6. The procedure for emergency failures resulting from fire, flooding, explosion etc. will be dealt with as part of major Emergency Planning responses (if required), and care providers' business continuity plans.

3. Definition of Failure and Provider Exit from the Market

3.1. The failure may be as a result of a decision by the Care Quality Commission (CQC) under their powers to require an emergency closure; or through a decision by commissioners to decommission care (e.g. as a result of a major event such as serious safeguarding concerns), resulting in the care provision closing. This may also cover other failures as outlined above.

3.2 Provider exit from the market may arise in circumstances where organisations make a planned decision to withdraw from providing care within the city.

3.3. This Procedure will be implemented as part of a Contingency or Resilience Plan in situations where failure or exit is a serious prospect whether that is confirmed or not, or where the timescale before prospective or actual failure cannot yet reasonably be determined. Reference should be made to the Management Checklist ***(Appendix A)*** to determine which sections are relevant in the specific circumstances of the current case.

4. Activation of the Procedure

4.1. The decision that results in a failure of Care Provision may come from a variety of sources; for example:

- It may be invoked by the Care Quality Commission under its powers.
- A decision to decommission care leading to failure may be taken by the Director of Quality and Integration or the Service Director – Adults, Housing and Communities. The formal decision to activate this Procedure will come from the same lead personnel, and the expectation is that SCC and the CCG will agree activation and work in partnership.
- The Provider may give the appropriate 'Contract Termination Notice' period under their Contract.
- The Provider may themselves decide that the financial position of the individual service, or their overall portfolio of services, is becoming so very acute that it cannot continue to operate for a period sufficient to market the business and attract a new owner, nor to effect a planned 'orderly run-down' of the operation, i.e. one that would probably require a timescale of some months before failure.
- The Provider's business may have become "insolvent" (i.e. it can no longer meet its bills as and when they routinely fall due for payment, *and/or* its liabilities materially exceed its assets and there is no reasonable prospect of that being reversed in a realistic time-frame). In these circumstances the Directors/Owners have a legal duty not to continue trading while insolvent, so they should follow one of several Corporate Insolvency processes, which are likely to result in the appointment by the Courts of an Administrator or Receiver. That Officer's principal duty is to maximise the return for the Creditors (the people to whom the business owes money). Therefore, they will often be willing to continue to operate the services(s) for a short period in hope of finding a buyer of it as a 'going concern' since that will generally fetch more than a dissolved business – but they will not do so indefinitely.
- Where closure is necessitated following significant and/or severe safeguarding concerns/enquiries, resulting in a decision that the provider is unable to provide safe care to its service users, and/or the inability of the provider to comply with an agreed action plan to rectify deficits, placing service users at risk of harm. Such a circumstance may be opposed by the provider, so that contract procedures will have been need to be activated.

4.2 Situations of the above nature do sometimes arise "out of the blue", but more typically there will have been an accrual of "warning signs" over a period of time, and/or the services management and staff may have openly shared word that its future is at real risk, possibly accompanied by media reports. SCC and CCG Officers should be alert to such signs and

should notify their senior management so the implications can be considered and the likelihood assessed.

4.3 As soon as failure notification is received or real risk of potential failure is identified, the City Council Divisional Head of Service – Adult Social Care, and the CCG Associate Director of Quality/Deputy Chief Nurse must be **notified immediately** by telephone with confirmation in writing (email).

4.4 Staff passing information to either of these "Leads" **must** ensure it has been received and acknowledged. If they are unavailable contact should be made to their nominated deputy. It is 'not acceptable' to leave a message with administrative staff.

4.5 The SCC or CCG Lead will instruct appropriate Officers to verify the failure or potential failure with CQC, and/or the Care Providers Owner, and determine what other relevant parties need to be contacted, by whom, and when.

4.6 Where the failure is related to the alleged or substantiated abuse of one or more vulnerable adults, the SCC Adult Social Care representative and Adult Safeguarding Lead must be notified. Safeguarding Alerts must be made in accordance with the 4LSAB *Adult Safeguarding Policy and Procedure,* to Adult Social Care Connect for triage and transmission to the appropriate adult social care team.

4.7 The SCC or CCG Lead will immediately co-ordinate a Joint Incident Steering Group Meeting to take place at the earliest practicable opportunity, to initiate action under this procedure and agree a plan of action. In view of the potential implications for the health and well-being and safety of service users, the relevant Officers must treat the situation as necessitating their personal involvement at a very high priority. In order to ensure timely involvement of all key parties, including CQC, this may occasionally necessitate 'virtual' meetings such as through teleconference, and/or the nomination of appropriate 'deputies'. See ***Section 7*** 'Joint Incident Steering Group' for meeting membership.

4.8 Dependent upon the urgency of the situation, it may be necessary to convene such a meeting outside of normal office hours. Provider failures that occur outside of normal office hours should be referred to SCC and CCG on call arrangements as outlined in Appendix C

5. Key Contacts

5.1. The 'Key Contacts' who should be notified and invited to the initial Joint Incident Steering Group Meeting are:

Divisional Head of Service - Adult Social Care
Associate Director of Quality / Deputy Chief Nurse – CCG
Safeguarding Adults Lead SCC
Lead Commissioner Placement Service
Head of Safeguarding CCG
Quality and Safeguarding Team representative

6. Responsibilities and Roles

6.1. NHS Southampton City CCG is the responsible agency for fully health funded service users receiving care from providers at risk of failure is, or equivalent. This also includes responsibility for coordinating arrangements on behalf of service users whose care is fully funded and commissioned by other health bodies, i.e. "Out of Area" CCGs.

6.2. Southampton City Council is the responsible agency for part-funded and fully social care funded service users whose places have been commissioned or funded by the Council. Southampton City Council also has responsibility for supporting all self-funded service users within the City to find alternative provision and for ensuring that any move is well managed. The funding of care services via personal budgets should also be recognised and personal budget holders affected by any potential failure should be given information about options open to them, and asked how they wish to be involved in the obtaining replacement care.

6.3. Southampton City Council will take responsibility for co-ordinating and ensuring the immediate welfare of all service users funded or commissioned by other Local Authorities; however, funding responsibility and the detailed longer-term care planning of affected service users will remain with the placing authorities.

6.4. SCC and CCG Quality Team will take co-ordinating and communications responsibility for managing any project group arising from a sudden home failure within the Southampton City boundary.

6.5. All officers will need to commit to the process and identify any impact upon usual work to their line manager. Officers will need to confirm their delegated authority throughout the process to ensure timely decisions can be made.

7. Joint Incident Steering Group

7.1. The first meeting of the Steering Group is to be arranged at the earliest practicable opportunity following the identification of a provider failure (or potential failure). The chairing arrangements will be confirmed at the first meeting. This first meeting must take place within 3 working days of the Incident being notified.

7.2. The first meeting will confirm who will be the Council's Lead Officer for the Group. The Lead Officer will:

- have responsibility for ensuring that all decisions are made and implemented in a timely manner.
- ensure minutes are taken of each meeting with agreed actions (timescales noted), and circulated to team members and copied to the relevant heads of service
- the Group will decide on the frequency of its meetings, agreeing a core group of members who are kept informed and responsible for the proactive cascade of information to colleagues in their own service area (e.g. copy appropriate emails and reports to relevant people who are not necessarily group members but may have a 'need to know')
- Issues relating to publicity and the release of information will be considered, and a suitable balance struck so that where failure is not yet a certain outcome, the situation is not exacerbated and the Provider's entitlement to 'commercial confidentiality' is not infringed
- the Group will also discuss, if deemed appropriate, potential measures to prevent or delay failure e.g. short-term additional funding or assistance from SCC or the CGG

7.3. At the first meeting an Operational Group will be agreed to lead the work on the closure, reporting to the Steering Group. The operational group is responsible for identifying all affected service users and ensuring all service users are supported to move to alternative provision in a timely manner. The chair of the operational group will become a member of the JISG if not already. A full database of all affected service users will be compiled

7.4. Those staff who may participate in the operational group include:

- ICU Quality and Safeguarding team representative

- CCG Continuing Care representative
- SCC Procurement representative
- SCC Adult Social Care representative
- SCC Safeguarding representative
- Care Quality Commission
- Lead Minute Taker
- Communications Lead
- SCC legal representative (note: NHS do not maintain this function 'in-house')

It may be appropriate also to invite other "interested parties" to certain meetings, or parts of meetings, where they have a specific contribution to make, but not as "ongoing" participants. These could include, for example:

- Finance Lead (CCG and SCC)
- Relevant provider management
- NHS Trust Representative or Safeguarding Practitioner
- Advocacy representative
- Family / Carers representatives
- South Central Ambulance Service representative
- Hampshire Constabulary
- Southampton City Council Health and Safety representatives
- SCC Market Development Lead –where failure may have significant impact upon the local market

8. Potential Options for Alternative Service Provision

8.1. Potential options may include:

- Spot purchase from other Care Providers
- Reserving services in other suitable locations
- Consultancy advice from a specialist practitioner
- Input or support from an appropriate related provider to work with the failing provider.
- Temporary staffing, (e.g. via local Agencies or other providers)
- Temporary management, (e.g. via using a consultancy company)
- TUPE staff and transfer service user group serviced to an alternate provider
- Alternative contracted management/nursing team provision
- Short-term additional funding
- Fee variation over and above normal 'expected to pay' rates to secure suitable service provision
- Other actions as deemed necessary based on individual circumstances
- Person Budget/ Direct Payments

8.2 The Group will allocate responsibility for researching and pursuing these options depending upon the specific circumstances of the case.

8.3 It should not simply be assumed - especially in the case of a Provider operating a number of services, and/or where an Insolvency Practitioner is acting - that any payments we make which are intended by us for supporting the continuation of service provision at a specific service will necessarily be applied for that purpose, in that location, by the Provider or Insolvency Practitioner. An explicit written agreement must first be sought and obtained. Payments may need to be withheld by commissioners and only paid when situation is resolved.

8.4 Wherever possible all transfers of service users between care providers should occur within normal working hours.

9. Cross Council Border Co-operation

9.1 Southampton City Council is a signatory to the Memorandum of Co-operation for sharing information and support to strengthen market oversight issued by the Association of Directors of Social Services – South East and is committed sharing information on actual or possible provider failure. Early contact between key contacts at affected authorities should take place to support appropriate management and the Integrated Commissioning Unit has systems in place to support this information sharing particularly with Hampshire County Council.

Appendix A

Management Checklist

The following checklist provides a **framework for managing care provider failure.** ***Please note that this list is not exhaustive.*** The Joint Incident Steering Group must determine actions as necessary based on the circumstances, noting that the checklist is for use with both Home Care and Care Home providers.

The checklist should also be used in the event of a **potential failure where the timescale is unknown.** In this case, although all aspects should still be considered, and appropriate preparatory work based on these points should be begun where necessary, not all points will yet be applicable until the position clarifies.
This checklist should be used to create an individual action plan for each provider failure event

See Appendix C for an example of immediate actions where a home care provider failure occurs and appendix D for a detailed Operational framework for all necessary actions when a care home provider is closed.

Date initiated:
Name of Service(s):
Steering Group Members: (Confirm Chair)

	Action	Responsibility			Applicability
		SCC	CCG	Provider	
		Initials of Responsible officer			Care Home – CH Home Care – HC Both - All
1	**Steering Group** For Group membership – see Section 7				All
1.1	Assemble Team and plan the work				All
1.2	Appoint Team Leader(s)				All
	Initial work/clarification				
2.1	Establish timescales for failure(s)				All
2.2	Establish number of Service Users affected, and User category. Gain information about the source of funding for each service user (SCC, SCCG, Other Local Authority, Other CCG, Self-funder, Personal Budget) It is vital to ensure that accurate				All

	information about funding sources is obtained and cross-checked with SCC and CCG records.				
2.3	Liaise with Placements Service to gain information about resource availability in other services				All
2.4	Liaise with provider and other Home Care agencies to seek opportunities for staff TUPE and grouped transfers of service users				HC
2.5	Consult and advise other Local Authorities as necessary				All
2.6	Establish tasks and timescales and allocate them				All
2.7	Allocate lead workers, (preferably based on site/liaison officer in the case of home care) with equipment and management support requirements				All
2.8	Consider equipment issues: mattresses, furniture, hoists, packing boxes etc. Who owns it? Can it be transferred? Does any belong to the community equipment service?				CH
2.9	Arrange a meeting with Owners/registered manager/other relevant parties				All
2.10	Clarify if the service provider has a Business Continuity Plan in place as part of the contractual arrangements that can be used. In the current circumstances, is it still viable				All
2.11	Agree when and how Service users and Carers are informed (and by whom) of the need to change provider at an early stage.				All
2.12	Ensure that the Owner allows free and open access by professionals to the service over the relocation/reallocation period				All
2.13	Agree the 'need to know' information that should be shared with other parties e.g. care professionals; GP; NHS urgent care lead; other potential Care Providers[1]				All
2.14	Formal scripts to be developed with the lead Communications Department for: - • staff working with service users and relatives • provider staff				All

[1] [***Note*** that even though a Provider may be considered at serious risk of 'business failure', their affairs are still covered by the principle of ***'commercial confidentiality'***, and care should be taken that without the Provider's agreement specific information is not disclosed to third parties which might actually precipitate the business's final demise].

	• press • partner organisations • safeguarding adults board				
2.15	Consider the need for independent advocacy and other community support for service users/carers				All
2.16	Identify key Care Provider Management staff to be involved				All
2.17	Identify site(s) for offsite meetings for Management Team/Care staff if required				All
2.18	Identify other agencies to be involved				All
2.19	CCG to activate Serious Incident Procedure if required. SCC to follow Incident Procedure, and in addition, does this situation meet the criteria for a Serious Incident? If so, invoke that policy.				All
2.20	Consider whether failure of this Provision is likely to have a have a significant impact on overall local market supply for this type of service				All
2.21	Contingency Planning. Be aware of the potential for an escalation in the decline of the service provider; planning needs to include contingency plans for a rapid and unpredicted decline in the ability of the provider to offer a service.				
2.22	Ensure all officers have considered the impact of the failure process upon other work streams and escalated as necessary to line manager				All
3	**Service Users**				
3.1	Prepare an accurate database of all service users, and their needs – and confirm numbers with provider. Also any special factors e.g. such as 'friendship groups' where it may be desirable to keep people together if possible; home care runs/delivery approach; and provider RAG rating. Current placement/packages costs and fees to be included				All
3.2	Confirm where responsibility lies for assessing any Self-Funding, Personal Budget or Out of Area service users				All
3.3	Check current Registration category				All
3.4	Set up operational team to assess service users to identify possible changes in need or category of care				All
3.5	Check if any very frail people and those nearing end of life need exceptional arrangements.				All

	Identify any unbefriended service users				
3.6	Identify service users wishing to change provision/ move sooner rather than later				All
3.7	Identify service users who should be assessed early in the project work due to their predisposition to stress, anxiety or complexity, or for other factors				All
3.8	Ensure all necessary Mental Capacity Assessments of service users are Identified and carried out, particularly focussing on decisions about accommodation, and Best Interest Decisions. Accompanying record of Best Interests decision making process to be made. IMCAs appointed for those lacking family/friends.				All
3.9	Identify need for advocacy services to support service users.				All
3.10	Identify service users with active 'Deprivation of Liberty' (DOLS) authorisations. Ensure the provider as Managing Authority refers all those who are DOLS-liable to SCC/Other DOLS Teams for new assessments/ authorisation.				CH
3.11	Identify Service Users with Health and Welfare Deputies, and those with Powers of Attorney for Health and Welfare decisions, and ensure contact is made with the relevant parties				All
3.12	Establish if any service users/carers are subject to current Safeguarding enquiries.				All
3.13	Establish details of all service users with Money Management arrangements in place with SCC, to include Appointeeship, Service user Affairs.				All
4	**Financial Responsibilities**				
4.1	Ensure managers have the ability to commit all resources to the failure process including financial as well as staffing				All
4.2	Any Out of Area funded Service Users? Make external commissioners aware of situation, and confirm whether they wish the Steering Group to act on their behalf to relocate Service Users				CH
4.3	Identify SCC-funded service users, and identify any Section 117 MHA funded residents.				CH
4.4	Identify NHS-funded service users				All
4.5	Identify whether there are any private self-funded Service Users / Personal Budget users and who will take responsibility for their care. Check capacity and their representation *(see*				All

	3.8. above)				
4.6	Take advice from legal services about any relevant contractual, financial and other statutory matters; this to include notice/contact termination periods.				All
4.7	Identify service users with Deputyship in relation to financial affairs, all Enduring Powers of Attorney and all those with Lasting Powers of Attorney for Property & Affairs. Contact relevant parties and ensure records of their involvement are made, particularly in relation to any changed cost to new placements.				All
4.8	**SCC Finance Tasks** Check duration of any notice period for/by provider. Providers may be paid in advance by SCC; action is needed to ensure resulting overpayments are able to be recouped and Service Users are correctly charged. Ensure Care Placements Team and Payments Team are fully advised of provider failure. Ensure paris financial tasks are amended for all funded placements/packages				
5	**Carers and 'Significant Others'**				
5.1	Ascertain the names, addresses and telephone numbers of relatives, friends and representatives, as appropriate				All
5.2	Identify Carers who may themselves have special factors to consider – own health, Out of Area etc				All
5.3	Seek fullest involvement of relatives/' significant others' in the relocation/reallocation process				All
5.4	Consider necessity for commissioning advocacy for carers affected (but bear in mind resources implications before proceeding)				All
5.5	Consider and where necessary undertake carers assessments				All
5.6	Clarify which service users are unbefriended, and enable them to be represented.				All
6	**Consultations/Information Management**				
6.1	To ensure the process runs smoothly it is essential that all groups are consulted: • Service Users • Care Staff • Families/representatives				All

	• Portfolio holders/councillors in relevant ward/with relevant portfolio • Public/press, via Communications lead • Appropriate internal staff all agencies				
6.2	Ensure Residents meetings are arranged with appropriate levels of management representation				CH
6.3	Ensure Relatives meetings are arranged with appropriate levels of management representation				CH
6.4	Ensure clarity of roles for each agency in meetings with service users, residents, relatives and staff				CH
7	**Relocation/reallocation (if decision is made to close/cease trading in the city)**				
7.1	Re-assessment of service users and adequate resource requirements to complete. Team of staff to be set up to assess, coordinate and manage all moves and changes of providers. Where necessary/possible, named staff members to be allocated to Service users. Reviews of new placements/packages to be carried out.				All
7.2	Group service users to reflect TUPE transfer arrangement to another Home Care provider – where this is possible				HC
7.3	Check choice (s) of area/services available that are compatible with service user need/ category with resident/carer				All
7.4	Maximise resident/carer ability to make an informed choice about compatible area/services/Homes available, in adherence to the principles of the *Mental Capacity Act*				All
7.5	Are there friendships between service users that need to be maintained?				CH
7.6	Ensure new provider is registered for the category of care required and can meet needs				All
7.7	Liaise with CQC, CCG, SCC staff to ensure information is known about potential/actual new Care Providers, establish clear and complete knowledge about the service quality and performance of these organisations.				All
7.8	Offer opportunity for service user/carer to view/visit/trial visit Care Provider				CH
7.9	Seek care staff help to inform/visit potential provision with service users				CH

	where applicable				
7.10	Decision by service user/carer on new provision and date to move				All
7.11	Arrange help to take or escort service user to potential new providers on placement if needed				CH
7.12	Arrange schedule transport to new provision, in and out of area e.g. car/minibus/ambulance including identify cost and who pays.				CH
7.13	Consideration of equipment issues, and arrangements for its transfer and installation *(see also 2.7 above)*				CH
7.14	Ensure service users are accompanied by someone familiar on the day of the move, including carers if possible				CH
7.15	Use current Care staff to the fullest; passing on their knowledge of service users to new providers, escorting, transporting etc				CH
7.16	Staff handover to new providers – verbal and written. Care summaries, including care plan that details health and social care needs				All
7.17	Respect Care staff friendships with residents and likely concerns for their future welfare. Find opportunities for current Care Staff to verbally discuss service users care needs summary with receiving Care Staff, where appropriate				CH
7.18	Maintain a log of decisions and movement of service users				All
7.19	Move/reallocate service users at their own pace/convenience as far as possible.				All
7.20	Establish a programme of Social Worker/ Nursing reviews and resource implications to ensure service users well-being after the move.				CH
7.21	Medications and treatment details to go with residents				CH
7.22	Particular attention to be made to ensure correct identification of relocated service users				CH
7.23	Any changes of GP and new provision to be recorded in all appropriate systems of all necessary organisations involved				CH
7.24	Placements made Out of Area should be notified to the receiving NHS/Local Authority				CH
7.25	Provider Service User information/case files/summaries/transfer with service users where possible or copies made and transferred				All
7.26	Consider how many family members/friends might visit the resident				CH

	in the new care provision; can we assist them to do so?				
7.27	Notify Department of Work and Pensions of change of Home				CH
7.28	Liaise closely with the ICU Contracts Team (new contracts need to be issued, old contracts terminated)				All
7.29	Consider a plan for time scales of moves, to enable new providers to gradually accommodate new residents over a period of time. However, this also needs to take account of (a) anxieties of Service users/carers and (b) ability of failing provider to maintain a diminishing service.				CH
7.30	Consider the desirability of temporary/second moves, in part to allow choice for service users, where availability of preferred provider is delayed.				CH
8	**Quality Assurance**				
8.1	Ensure there is an effective process for recording and resolving complaints and disputes, and that itis widely understood and universally applied between the 'interested agencies'.				All
8.2	Conduct a debrief after every incident to identify good practice, lessons identified and further actions to be taken				All
8.3	Seek feedback during and after the event from service users and their representatives				
8.4	Ensure operational staff are supported and offered supervision, particularly to respond to conflict and criticism from other parties				All
9	**Record Keeping**				
9.1	Designate an administrative lead to collate all records				All
9.2	Maintain a record of meetings, decisions made				All
9.3	Service User outcomes should be recorded, particularly with regard to their health and emotional well-being				All
9.4	Maintain a risk log that is reviewed throughout the failure process				All
10	**Lessons Learned**				
10.1	All agencies should participate in a Review of the process once the procedure is completed. The outcome of this de-brief should be to identify recommendations for future inter agency learning, including policy, procedure and practical guidance				All
10.2	The Review should produce a Report and				All

	Recommendations to be submitted to the relevant groups and management levels within each agency, including the Local Adult Safeguarding Board				
10.3	Consideration of referral to the LSAB Case Review or Monitoring and Evaluation Group should be included in the de-brief and review.				All
Additional Notes:					

Appendix B

Glossary

Care Homes Consultancy
Care Home Consultancy companies offer support to Care Homes in a range of areas e.g. business review, addressing specific problems, compliance auditing, cost reduction, planning for the future etc.

Care Quality Commission (CQC)
The Care Quality Commission (CQC) is an independent regulator of health and social care in England. The CQC regulates health and adult social care services provided by NHS, local authorities, private companies and voluntary organisations. The CQC also protects the rights of people detained under the *Mental Health Act 1983.*

Deprivation of Liberty Safeguards (DOLS)
These Safeguards form an additional element to the *Mental Capacity Act*. They provide legal protection for those vulnerable people aged 18 or over who are, or may become, deprived of their liberty in a hospital or care home, whether placed under public or private arrangements. They relate to people who lack capacity to consent to particular treatment or care that is recognised by others as being in their best interests, or which will protect them from harm. Where this care might involve depriving people of their liberty in either care homes or hospitals, extra safeguards have been introduced to protect their rights and to ensure that the care and treatment they receive are in their best interests. They do not apply to people detained under the *Mental Health Act.*

Deputy
Someone appointed by the Court of Protection with ongoing legal authority to make decisions on behalf of a person who lacks capacity to make particular decisions.

Enduring Power of Attorney
A 'Power of Attorney', generally, is the legal authorisation to act on someone else's behalf in a legal or business matter. An ***Enduring*** Power of Attorney in our current context deals with the donor's property and financial affairs. It will have been have been set up while the donor has capacity, and it was/will be activated by the Court of Protection when the donor's capacity to take decisions is at issue. An EPA does not come to an end if the donor becomes mentally incapable of managing his or her own affairs. The attorney named under an EPA ***does not*** have the power to make decisions about personal care and welfare. Since 2007 these have been replaced by ***Lasting*** *Powers of Attorney (see below),* though existing EPAs will continue to operate, and those signed before 2007 but not yet registered may still be registered.

Independent Mental Capacity Advocacy (IMCA)
The *Mental Capacity Act 2005* provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. In response the Government created provision for the Independent Mental Capacity Advocate (IMCA) service. The purpose of the IMCA Service is to help vulnerable people who lack capacity who are facing important decisions made by the NHS and Local Authorities about serious medical treatment and changes of residence e.g. moving to a hospital or Care Home. NHS bodies and Local Authorities will have a duty to consult the IMCA in decisions involving people who have no family or friends.

Lasting Power of Attorney
A Lasting Power of Attorney is a legal document. It allows a person giving it (the 'donor') to appoint someone they trust as an 'attorney' to make decisions on the donor's behalf. A

Lasting Power of Attorney cannot be used until it is registered with the Office of the Public Guardian.
There are **two different types** of Lasting Power of Attorney:

- **A Health and Welfare LPA** allows the donor to choose one or more people to make decisions for things such as medical treatment. A Health and Welfare Lasting Power of Attorney can **only** be used if the donor lacks the ability to make decisions for him/herself.
- **A Property and Financial Affairs LPA** lets the donor choose one or more people to make property and financial affairs decisions for them. This could include decisions about paying bills or selling their home. They can appoint someone as an attorney to look after their property and financial affairs at any time, **or** they can include a condition that means the attorney can only make decisions when the donor loses the ability to do so.
  *[See also '**Enduring** Power of Attorney', above]*

Mental Capacity Act (2005)
A law providing a framework for people who lack capacity to make decisions about themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.

Safeguarding of Vulnerable Adults
Relating to the legislation, policy and procedures *(especially the 4LSAB Multi Agency Adult Safeguarding Policy and Procedures 2020)* that deal with the safeguarding of adults.

APPENDIX C
Home Care Provider Exit/Failure Immediate Action Plan - Example

Key – PL – project lead, ASC – Adult Social Care, C – Commissioners, H – Housing, EPPR – Emergency Planning Lead/support, D – Director support, PS – Placement Service, ORG – System Resilience rep, A – Admin support

Now	**Lead Officers**	**Progress and escalation**	**Lead Officers/escalation**
Coordination of Response Development of project coordination hub	C	Agreed project leadership, representatives and provision of hub	
Service user list Refresh of Service user list with renewed rag rating. Request service user information from Provider directly. Initial contact with service users/families to provide reassurance	ASC C ASC	Suspension of all other call offs from current framework and URS except in exceptional circumstances. PS identify current resource availability – home care, res, nursing and pass to identify lead officer.	
Transfer planning Work with other care providers to identify transfer options Identify potential to transfer care in rounds under TUPE arrangement. Begin transfers of any high-risk cases to available capacity Immediate review of TUPE options within SCC. Establish immediate timescale for	C C & ASC PS PL PL	Identified staff make contact with all providers to ascertain options for increasing capacity quickly to include • use of overtime and bank staff • rapid recruitment • early use of staff in process of recruitment subject to risk assessment • transfer of resources from low risk packages	

failure with provider/receiver			
Additional support Collate information on Extra Care Housing element to identify: • TUPE options • Support tasks which could be picked up by other means (SCC internal service, housing management provider) • SCC and Saxon Weald Liaison with system partners to brief and seek escalation and support arrangements. Briefing of SVS regarding risk of provider failure, requesting advice regarding approaching CVSE groups/orgs Self funder information – request scale of provision from provider to self funders in the city Establish with provider/receiver/national agencies	H ORG PL PL PL and D	Partners to be contacted to identify resource that can be brought in for short term cover including bank staff • SCC internal team • Health trusts • Voluntary sector Desk top review of all service users to identify any carer or informal support which could be used in the short term where appropriate Contact carers support service to identify additional advice and support available for carers. Contact providers including health trusts to open discussions on potential TUPE transfers. Immediate reporting requirements - CCG Serious incident reporting	

external support arrangements.			
Communications Redraft external and internal coms messages – including for service users, partners, public and council Agree contact approach with provider for service user communications and reassurance Daily sitrep reporting to key groups and partners Briefing of key representatives in SCC	PL with communications support ASC PL D		
Monitoring Start log of actions, concerns and complaints – all actions to be logged Clarify immediate reporting requirements	A PL with ORG and EPPR		
Evaluation Review of incident to determine lessons learned	PL		

APPENDIX D
PROCESS FOR EMERGENCY HOME CLOSURE; Operational Plan

Task	Who responsible
Identify lead manager to co-ordinate the process. A deputy should also agreed.	Service Manager
Set up central major incident room so that all staff assigned roles are together in one place. Ensure IT etc is available and accessible.	Lead co-ordinating manager
Coordinate all activity about service users on a Database, which is updated daily. This to contain full information about service user's needs, views and wishes; outline assessment, including mental capacity, and to be used to record progress with assessments, planning, new providers and subsequent reviews.	Lead co-ordinating manager
Establish Team and assign specific roles to each staff member: • Lead co-ordinating manager • Deputy co-ordinating manager • Reassessments • Mental Capacity Assessment • Best Interests Meetings • Vacancies • Financial matters and advice • Placements and new care home liaison • Moving and handling assessment and equipment • Transport • Family liaison • Medication, personal belongings and packing • Case record update • Staff support • Media/councillor/MP enquiries • Business support	Lead co-ordinating manager
Briefing session at beginning of day	Service manager and lead co-ordinating manager

• What will happen • Timescales • Permissions • Inform co-ordinating manager of issues / problems • Assign roles Agree plans for briefing / updates later in the day	
Establish core group of specialist practitioners to provide support during the move care manager, OT, nurse, mental health, business support	Lead co-ordinating manager
Consider need for Business Support to assist Operational Process	Lead co-ordinating manager
Designate senior manager to keep directors and councillors briefed and link to legal, communications Development of media statement	Lead co-ordinating manager Lead co-ordinating manager and Communications team
Liaise with CQC to whom they will communicate the decision, when information can be released This to be communicated amongst designated staff	Service Manager Lead co-ordinating manager
Prepare script for all staff dealing with family and other queries, to be circulated to all relevant teams Brief relevant teams SPA, Complaints	Lead co-ordinating manager
Leads to inform their teams and senior practitioners to brief their teams	Team leaders and senior practitioners
List of mobile numbers for leads and designated staff	Lead/deputy coordinating manager
List of contact details for other agencies as required • District nursing • Ambulance service • Equipment service • Removals • Legal • Out of Hours services • Transport	Lead/deputy coordinating manager
Consider requesting police presence regarding media, families and property if necessary	Lead co-ordinating manager / Team Leaders
Despatch designated staff members and team leaders to the home to	Lead co-ordinating manager

oversee transfer including family liaison, service user support, medication and packing	
Lead OT to do moving and handling assessments and identify any specialist equipment required by the resident in the new home. Liaise with home and where needed equipment service	Lead OT
Conduct risk assessments for staff presence at premises and escort duty A log of SW at the property to be maintained. SW to call in to sign off if going on/off shift	Lead/deputy co-ordinating manager
Each service user to be assigned to a named social worker who will oversee their transfer. Once the move is complete this must be notified to the lead co-ordinating manager Designated team leader for updating case records is informed and updates PARIS	
Prepare rota of staff prepared to work late and / or at the weekend	Lead co-ordinating manager/deputy
Identify emergency care home team and resources to pay for this, e.g. escorts, home manger, care staff, nurses	Lead co-ordinating manager
SCC “appointed” home manager and care team will enter premises when the order is through as SCC will now have responsibility	SCC Home Manager
Advance agreement regarding additional costs and budget codes for: • Placements • Overtime for staff and child care • Travel costs for families • Taxis and other transport • Private ambulances • Packing boxes • Removals	Lead co-ordinating manager
Practical arrangements • Removal van • Packing boxes • Negotiations regarding use / loan of specialist equipment • Blankets	Lead Coordinating Manager/deputy

• Food and drink (residents and staff) • Mobile phones for staff	
Hold debriefing sessions for all staff involved, in the move and the safeguarding investigation to cover: • Emotional aspects • Effectiveness of process • Lessons learnt • Employee support	Lead co-ordinating manager

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1. Integrated Commissioning Unit (ICU) Summary Performance Report — Nov 2020/21

Achieving Transformation Change

↑	25% Prev Yr = 18%	% of pregnant women who cease smoking by time of delivery
↑	66 Prev Yr = 114	Number of Permanent admissions to residential & nursing homes (65+)
	16% Target ≤ 4%	% acute beds occupied per day by patients who are MOFD
↑	10,318 Target ≤ 13,140	Number of Non-Elective Admissions
↑	1,251 Prev Yr = 1,692	Falls & Fraity (65+) Admissions <24hr

Quality

↓	33% Target ≥ 80%	% Full Continuing Healthcare Assessments completed ≤28 days
↑	100% Target ≥ 85%	% Continuing Healthcare Assessments taking place in community
↑	91% Target ≥ 90%	% of placements that are sourced through the Care Placement Team
↑	5.9% Target ≥ 5.9%	% people with common mental health conditions accessing IAPT
↑	37.8% Prev 12 mths = 31.7%	Alcohol - % of clients completing treatment and not re-presenting

KEY

Compared to Previous Year

- ↑ Better than previous year
- ↓ Worse than previous year
- → Same as previous year

Compared to Target

- Within 10% of Target
- Target Achieved
- <10% below target

2. ICU Workstream Progress

a. Achieving Transformation Change

Significant activity during the first 6 months of this year, despite the workload pressures associated with Covid. The 5 Year Health & Care Strategy has been refreshed following an assessment of the impact of COVID on our plans and a new implementation plan was signed off by JCB in Sept.
Significant work undertaken to implement the Government's new Discharge Model including the establishment of a Southampton community hub/single point of access - business case under development for longer term post 20/21. 17 additional Discharge to Assess beds were brought on line quickly during Q1 and a business case was approved for an additional 20 in August - commencing w/c 19 october. Therapy input to these beds also being developed.
The model for integrated care teams has also been developed during Q2 and is about to be piloted in 3 PCNs - Living Well Partnership, North and Central and West.
The Enhanced Health in Care Homes model has been rapidly extended to all Southampton Nursing Homes in line with the national requirement in June. Work is now underway with PCNs to agree the long term model moving forward.
IAPT referrals are now back up to expected levels and work has re-commenced at pace to mobilise the new Long Term Conditions IAPT pathways for people with cardio and gastro conditions
Work is also underway on the transformation of community MH Services for patients with SMI working in partnership with PCNs
Mental Health Support Teams in schools have gone live for two teams in the West and Centre of the city and are now accepting referrals. Recruitment has commenced for two more teams on the East.
There has been significant work with providers of day services for people with LD to support them in re-opening their services for clients. This has included the development of an escalation framework and support with individual and environmental risk assessments.
The new Joint Equipment Service was mobilised in July following a re-procurement and work has commenced on a review of the use of the DFG which will report to JCB in December.
Considerable work has also been undertaken with the voluntary sector during Q1 to help facilitate their response to the Covid pandemic and this has continued during Q2 through restoration and recovery.
So:Linked for example have restarted the work they had commenced prior to Covid on community conversations from September to scope the local offer and proposals for a Place Based Giving Scheme are under development

b. Procurement & Market Mananagement

Number of workstreams in train including:
• Development of a 'Southampton CV-19 Adult Care Market Impact Statement' in progress to support budget/ business planning for the coming FY, and to enable productive and continuous engagement with the provider market regarding the challenges of CV-19 and how these will be managed within service delivery models and funding envelopes going forward.
• Work required to facilitate dissemination of the 2nd round of infection control grant funding to local ASC providers is underway.
• Continuing to monitor the local care market for signs/ risks of provider and/ or system market failure, with a review of the city's provider failure protocol underway to ensure this remains fit for purpose with a CV-19 context.
• Preparations underway for annual re-opening of the home care framework, and for the process to appoint lead providers to 2 areas that don't currently have one.
• A number of consultants and temporary staff are being procured at short notice to support urgent priority ASC workstreams. The risk that this may have an adverse impact on the limited capacity available in the ICU's small health and care category procurement team and its ability to deliver work plan projects with a procurement-related dependency is being closely monitored.
• Procurement work in underway on reopening of the IFA and post-16 framework agreements, a call-off for home care at an LD supported living scheme as well as tenders for smoking cessation and dementia friendly communities, and an Appropriate Adults scheme in collaboration with HCC. Transparency notice (VEAT) published for Domestic Violence with the proposal to award a 1 year contract to incumbents from 01.04.21.

c. Quality

The overall quality of health and care providers in Southampton continues to be good. Support to the care home and home care sector that was in place prior to the Covid-19 pandemic has enabled the ICU to mobilise and engage rapidly and regularly with the sector and ensure that proactive support and advice including interpretation of national guidance is in place in the City.
Monitoring the quality of care has changed during the pandemic and the use of virtual quality reviews, attending provider meetings via video conferencing and a range of other methods of gathering intelligence has become the new normal. Where necessary face to face risk assessed visits have taken place to support providers.
The first phase of the infection control grant to care homes saw a commitment to supply each home with an iPad cart to facilitate contact between health and care professionals and support contact with families by residents. Almost all homes in the City accepted the offer of an iPad (4 declined) and these remaining 4 are available as back up in case of failure. One has also been issued to a care home just outside the City providing designated beds for Southampton care home residents.

d. Strengthening Commissioning Integration

There are 11 proposals which make up the Strengthening Integrated Commissioning work-stream, dealing with a wide range of areas. A number of these have either paused completely or significantly accelerated as part of the COVID-19 response and in light of CCG reform. A short piece of work to update the work-streams will now be undertaken to refresh the plan with a briefing proposed for JCB in December 2020.

3. Key Performance Indicators

a. Integrated Care (Better Care)

RAG Summary	Last Yr	Target
Green	7	1
Amber	0	1
Red	3	5
n/a	4	6

				Previous Year			Target		
Period	Indicator	Actual	19/20	+ / -	%	Target	+ / -	%
M7	% acute beds occupied per day by patients who are MOFD	16				4	13	357%
M7	% patients discharged home with support against the total number of patients discharged	80				85	-5	-6%
M7	% patients discharged on pathway/support level 2 (IIC) within 48 hours of becoming MOFD	52				90	-38	-42%
M7	% patients discharged on pathway/support level 3 (complex, chc) within 72 hours of becoming MOFD	24				85	-61	-72%
M7	Total Non-Elective Admissions	10,318	13,267	-2949	-22%	13,140	-2822	-21%
M6	NEL Admissions (under 18s) - UHS only	641	1,670	-1029	-62%			
M6	NEL Admissions (18 - 64 yrs old) - UHS only	6,560	7,354	-794	-11%			
M6	NEL Admissions (65+ yrs old) - UHS only	4,794	5,810	-1016	-17%			
M5	Permanent admissions to residential homes aged 65+	66	114	-48	-42%			
Q2	% of People with Learning Disabilities receiving a Physical Health Check	11	23	-12	-53%	14	-3	-23%
Q2	60% of people with an SMI receiving a full annual physical check	21	18	3	15%	45	-24	-53%
M6	A&E Attendances to Residential & Nursing Homes	341	462	-121	-26%			
M6	NEL Admissions to Residential & Nursing Homes	376	477	-101	-21%			
M8	% of clients in rehab/reablement who do not need ongoing care	41	47	-7	-14%			

b. Prevention and Early Intervention

RAG Summary	Last Yr	Target
Green	7	4
Amber	2	0
Red	0	0
n/a	0	5

				Previous Year			Target		
Period	Indicator	Actual	19/20	+ / -	%	Target	+ / -	%
M5	Falls and Frailty (65+)	1,251	1,692	-441	-26%			
Q2	IAPT - % with common mental health conditions accessing IAPT	5.9	5.2	1	13%	5.9	0	0%
Q2	IAPT - % who complete IAPT moving to recovery	50.0	50.0	0	0%	50.0	0	0%
M7	% LARC (all 4 methods) at Integrated Sexual Health Service	41	44	-4	-8%	35	6	17%
M7	% of HIV tests completed as part of an STI screen	82	86	-5	-5%	75	7	9%
Q2	% of pregnant women who cease smoking time of delivery (YTD)	25	18	7	36%			
M6	Alcohol - % of all clients completing and not re-presenting	37.8	31.7	6.1	19%			
M6	Opiates - % of all clients completing and not re-presenting	6.0	4.3	1.7	40%			
M6	Non-opiates - % of all clients completing and not re-presenting	33.1	28.4	4.7	17%			

c. Commissioning Safe & High Quality Services

RAG Summary	Last Yr	Target
Green	3	2
Amber	0	0
Red	2	2
n/a	0	1

				Previous Year			Target		
Period	Indicator	Actual	19/20	+ / -	%	Target	+ / -	%
M7	≥85% of CHC assessments taking place in an out of a hospital setting	100	93	7	8%	85	15	18%
M7	≥80% of Full CHC assessments completed within 28 days	33	62	-29	-47%	80	-47	-59%
M7	<44 cases of Healthcare Associated Infections (Community): Cdiff (cumulative)	15	15	0	0%	21	-6	-29%
M7	Zero cases of Healthcare Associated Infections (community): MRSA (cumulative)	1	1	0	-	0	1	-
M7	% of Providers with a CQC Rating of good or above published in month (cumulative)	71	68	3	4%			

d. Managing and Developing the Market

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

				Previous Year			Target		
Period	Indicator	Actual	19/20	+ / -	%	Target	+ / -	%
M4	Care Placement - ≥90% funded adult placements are sourced via Team	91	90	1	1%	90	1	1%
M4	Avg days from referral received to placement start date (Home Care)	5	11	-6	-50%	14	-9	-61%
M4	Avg days from referral received to placement start date (Res/Nursing)	5	8	-3	-36%	14	-9	-65%
M8	Total number of home care hours purchased per week	24,716	22,909	1807	8%	0	0	0%
M6	% Home Care clients using a non framework provider	35	18	17	90%	20	15	74%

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

Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Wheel Chair Service	There is a risk that due to the current wheelchair provider struggling to achieve the 18 week waiting time for children or provide wheelchairs for adults in a timely way, there are prolonged waits . This is primarily due to difficulties recruiting and retaining qualified clinical staff within a challenging national workforce position. Whilst it cannot be proven that this is impacting on patient safety, it does have an impact on quality and poses a reputational risk for the CCG.	High	DC	Further to a robust and competitive procurement process, the new contract which commences 1 April 2021 has been awarded to Millbrook Healthcare. The service has been redesigned and is underpinned by NHSE's model specification and the Operating Model for NHS Commissioned Wheelchair Services developed by the National Wheelchair Managers Forum. Further enhancements to the specification have been made following learning from existing local wheelchair service provision and from other wheelchair services nationally, recommendations from an Independent Occupational Therapist with both wheelchair services and equipment experience, extensive public engagement, and market engagement. Key changes/adaptations to the model include: - continued development of individual wheelchair budgets - the provider must provide and actively promote the essential features of Personal Health Budgets within the wheelchair service to support a local offer of Personal Wheelchair Budgets which will ensure services are personalised and offer increased choice and control for service users accessing the service - broadening the offer of the service to children under three years of age - the provider will accept referrals for children under 3 years if they have postural support needs or functional wheelchair support needs which cannot be accommodated in a normal commercially available buggy that a parent would normally be expected to fund. (Currently this age range is met via the Individual Funding Request process). - a greater utility of digital initiatives - a number of digital implementations have been mandated from the point of service commencement which are currently lacking within existing service provision. This will be supported by further digital innovations being included within the Service Development and Improvement Plan (SDIP). - increased use of Direct Issue & Community Prescribing - the provider will be expected to develop and implement a Trusted Assessor model with local health and care providers. This has been implemented in other areas nationally and a local pilot of this approach is in its infancy. The approach aims to maximize utility of highly skilled community therapists, enabling them to directly prescribe wheelchair equipment to reduce the need for unnecessary repeat assessments within the wheelchair service. This improves patient experience by negating additional patient contacts, but also helps support the wheelchair workforce where there is a nationally recognised shortage. - Supporting inpatient care – the provider is expected to work with local Acute Hospitals to provide training and develop appropriate sub-stores of equipment to support timely discharge from hospital. (The provider is expected to take a similar approach in the provision to specialist schools within the geography). In addition a number of contract changes have been made to provide greater transparency, including the move to a block and variable payment mechanism (a block price relating to fixed costs (i.e. premises, IT etc.) and a variable payment for equipment which will include a handling fee payable on the successful acceptance of a wheelchair from the end user) and a new set of KPIs which provide visibility of the whole pathway. Work is now underway to plan for mobilisation. A working group focussing on children and school clinics has been meeting fortnightly since the end of July. Criteria have been agreed jointly between the Wheelchair Service and community therapists about when to see a child in school clinic as opposed to the wheelchair depot; the planning/triage process for considering children jointly between the wheelchair service and community therapists has been reviewed and a new process being put in place; communication processes have been improved. School clinics are due to start back up again in both Cedars and Rosewood the week before October end of term. Work on reviewing the caseload by school is currently underway between the Wheelchair Service and Community Therapies with a view to identifying demand versus capacity. In addition to preparing for the new contract, work is also progressing under the current contract to review the impact of COVID. During COVID the service has offered virtual assessments, triage and consultations using telephone or video technology. These are being evaluated with a view to embedding what has worked well into future practice. The service is now offering face to face appointments for non urgent clients as well as urgent and has produced a recovery plan. During the COVID period significant advancements have been made in clearing the triage waiting lists but owing to appointment cancellations and the inability to offer face to face appointments to everyone there are waiting lists later in the pathway that are the focus of recovery. A waiting list initiative with the provider has also been agreed to the end of this financial year and will bring in additional capacity - 3.3 additional WTE and 112 additional clinical appointments per month. This commenced in September and is being targeted this month on the waiting list high priority cases; how this resource is targeted going forward will be reviewed on a monthly basis between the service and commissioners. The service is now fully staffed with the final 2 clinical vacancies which are currently being filled by locums due to start in November. The locums will stay on until the end of the financial year in order to provide the additional capacity for the waiting list initiative.
Home Care	Risk that dom care market is unable to keep pace with increasing demand resulting from growing complexity (e.g. more QDS double up clients) and strategic drive to keep people independent. Risk of provider exits from the market adding to challenge around capacity, which has been exacerbated by CV-19 related cost pressures and demand levels. This is key system enabler and where there are sustainability, capacity and quality issues this impacts on patient choice, quality of care to clients, DTOC, use of residential care and ability to support other priority work areas such as the expansion of extra care housing. Additional staffing issues have been highlighted as a result of recent challenges around Right to Work.	Moderate	CP	The new framework has increased capacity and additional hours are purchased from a 'retainer service' which provides rapid access and responds to peak need. The local market has responded favourably to growth in demand, with sustained and substantial growth in the number of hours per week of home care that SCC is purchasing over the last 18 months. October 2020 is showing 2551 more hours per week on average than April 2019, constituting growth of 11% during this period. The potential for short-term exits is a constant risk but the process for dealing with this is now well established and we also continue to see strong interest from new providers in entering the care market in Southampton. The new framework allows an annual re-opening to encourage new entrants to the market and ensure any potential loss in capacity is mitigated. The establishment of 'lead provider' roles across the 5 areas in the city and provides a platform for further developmental work and sustainability in the city. These lead organisations are in strong position with both capacity and recruitment in 3 out of the 5 areas and are able to take on additional packages of care, reflected in the placements waiting list numbers being lower. Planning is underway to re-fill the lead provider roles in the remaining two areas. Winter planning is underway, and the retainer service has been re-commissioned as a block contracted bridging service to provide a greater level of assurance that any short term capacity needed to facilitate hospital discharge or other pathway step downs is available when needed. 'Right to work' issues are being investigated and managed through safeguarding and provider failure processes.

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Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Hospital Discharge	There are a number of risks associated with implementation of the Government's new Discharge Model and the impact of moving to discharging patients when they are medically optimised and of COVID which appear to be increasing the complexity of patients. Particular risks include: - Capacity to meet increased demand and complexity in the care market - particularly where patients are also Covid positive - Potentially compromising quality of care and outcomes for clients - with the focus being on MOFD and speedy discharge - Performance/Reputational Risk - high numbers of people who are MOFD still in hospital as a % of total occupied beds - compared with other acute hospitals	High	DC	Significant progress has been made in implementing the new government Discharge Model. This is overseen across the Southampton and SW Hants system by the Onward Care system Leadership Group who in turn report to the S&SWH Bronze Command group. The key requirements of the national model have been scrutinised and RAG rated and an action plan has been put in place to address key gaps. This includes work in the following areas: - Earlier decision making in hospital about discharge: - Implementation of case management role consistently across the Trust - Improve quality of discharge Review of failed discharges and implementation of improvement plan - Ensure patient initiated follow up and/or safety netting telephone call day after discharge consistently implemented across Trust - Ensure timely and high quality transfer of information to primary care is consistently implemented across all wards - Deliver Mental Capacity Act training to ensure quality MCA assessments undertaken to inform Best Interest decisions - Implementation of discharge areas - Homelessness - Review of existing protocols/processes and identification of gaps and areas for improvement – to include ensuring that no patient is discharged onto the streets or to a night shelter - Develop and embed protocols/processes working with the wards - Community Rehabilitation Bed Capacity - Increase capacity - Seacole Bid - Implementation of consistent D2A model across S&SWH - Agree key principles/consistent model across S&SWH - Commission increased D2A bed capacity for SL3 using one agreed specification across S&SWH with KPIs relating to response times for assessment/admission - agreement to commission 20 more D2A contract beds in Southampton - 10 coming on line w/c 19 October. Remaining 10 still to be sourced - Exploring Trusted Assessment model to support timely discharge - Link into and influence HIOW-wide work on promoting the Home First messages and ethos across the workforce and general public - Therapy Capacity - UHS and Community Reablement and Therapy teams to review onward care referral processes - Review workforce system wide and develop proposals for the best utilisation of current resources - Pilot a prioritised tiered approach to patients on SL2 and SL3 using TOFD instead of MOFD - Stroke capacity - Review of current flow and discharge process - Increase ESD capacity subject to finance approval - 7 day working – need to increase discharges over the weekend - System wide review of service operation within acute and community required to achieve 7 day working – ongoing – action plan under development - Patient Transport Services - Review the requirements for patient transport in delivering the Government's Hospital Discharge Policy and undertake gap analysis - Work with patient transport services to address any gaps and develop a coordinated and sustainable model moving forward - Community Equipment Review the requirements for community equipment services in delivering the Government's Hospital Discharge Policy and undertake gap analysis - Work with the community equipment providers to address any gaps
Make Care Safer	There is a risk that the sustainability of high quality Mental Health services in the City via Southern Health Foundation Trust (SHFT) and Solent NHS Trust will not be maintained There is a risk that there is an increased demand in psychological support services due to heightened anxiety levels caused by current COVID-19 then this could result in some service users not being able to access services resulting in service users being at risk of harm.	Moderate	CA	New Divisional Director of Nursing in place for Southampton - internal candidate who is an experienced Mental Health Nurse Significant out or area placement reduction during Covid-19 response, focus on maintaining this position Additional capacity in NHS111 Mental Health Nurse Triage Service, and web access now available Changes to Psychiatric Liaison Service with ED diverts in place responding to Covid-19, discussions underway to reinstate pathways Confirmed attendance of quality manager at Southampton based quality meeting and learning from deaths forum for SHFT, new patint safety lead appointed for Southampton division, 24/7 MH Triage arrangements in place (NHS111) and psychiatric liaison within University Hospital Southampton NHS Foundation Trust . The Lighthouse mobilised to be virtual, maintaining access 4pm-midnight 7 days per week. Supported 202 virtual visits during April. Supported over 600 virtual visits during April-June with 130 unique contacts. Greater use of digital technology for assessment, psychological treatments and patient care Pilots to try virtual GP referral meetings Increase in presentations from people not previously known to services or who haven't accessed secondary care support for a number of years IAPT ('Steps to Wellbeing') Increased use of digital technologies based on national guidance during lockdown. Working towards restoring face to face appointments, and will identify those who cannot access telephone or online treatment options surge in referrals relating to emotional and mental health – anxiety, depression, trauma – anecdotally this is already impacting on capacity in primary care and secondary care Explore opportunities for accelerated integration through Primary Care Network development bringing together primary care, IAPT, secondary care mental health services and voluntary sector CAMHS - During COVID there has been a significant decrease in referrals received and this has enabled Solent to reduce both initial waits and those waiting for treatment - Evidence highlights that there is likely to be a significnat increase in emotional and mental health issues in the wake of COVID and it is likely that CAMHS will see a significant increase in referrals when CYP return to school. This will continue to be monitored - The service has increased their remote offer but continue to see initial and high risk/vulnerable young people face to face. The move to remote contact has seen a decrease in WNBs as well as an overall increase in contacts

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Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Reliance on temporary staff in the Placement Service	Operation of the Placement Service is currently reliant on a number of temporary staff due to pilots which are being run by the service (invoice query resolution, D2A). As a result, the service is experiencing higher levels of staff turnover and service quality/ levels are at risk.	Moderate	CP	Recurrent funding for posts at risk is being sought through the ASC budget challenge process.
Looked After Children	As Responsible Commissioner NHS Southampton City CCG commissions Solent NHS Trust to coordinate statutory health assessments for looked after children (LAC) placed out of area (OOA) . Due to the demand placed upon LAC services nationally, these children and young people are either not receiving a statutory health assessment or it is severely delayed. This can impact upon the health and wellbeing of the LAC particularly where there are additional vulnerabilities such as mental health issues.	Low	KE	Dedicated Solent LAC Health Team staff working with Out Of Area health providers to progress health assessment timescales (Update- current capacity issues within the Solent LAC health team mean that this dedicated team has reduced temporarily and is impacting on the timeliness of responses). Robust Solent LAC OOA process in place, Close oversight on OOA by the Designated Nurse and Monitoring via CRM / CQRM / Corporate Parenting. (Update- issues with OOA cases are discussed on a case by case basis as required, with escalations responded to as appropriate. The CCG SG team receive regular placement change information for in area and OOA LAC children. Regular data reporting has been paused for the Solent LAC health team during Covid, as has the service spec review for CPMS/LAC) NHSE and Designated Nurse for LAC Regional group undertaking focused work to monitor and identify strategic options. (Update- ongoing regional discussions in relation to this. In response to Covid-19, areas receiving OOA LAC children during the pandemic have been advised that they must continue to see OOA children for IHA's and cannot refuse this, however acknowledging that delays are likely.) Health Assessments for LAC part of "hotspot" report to CRM to maintain focus. There have been Improvements in timescales for assessments recently.(Update- routine data reporting has been paused during Covid-19, therefore no hotspot data received since March 2020). Given the concerns raised in relation to out of area health assessments regionally and nationally, other areas are undertaking health assessments more readily however delays continue due to the lack of priority for children place in other areas in comparison to their own area children (Update- as above- Solent LAC health team have some ideas re OOA children as a result of working differently during Covid-19, however these would require agreement in other areas nationally and is therefore not a quick fix). Some improvements noted within specific areas nationally due to relationship building by the Solent admin lead for OOA. (Update- as above, some temporary capacity challenges). Solent still required to undertake a scoping of those LAC placed out of area to ensure they have oversight of those with outstanding health needs. This work will be necessary prior to the further development work to explore the feasibility of a health questionnaire for those children in stable placements (no update) OOA Questionnaire introduced within the LAC health team. Ongoing dialogue with NHSE regional and national team to resolve areas with delays. (Update- as above, Covid-19 has impacted much of the progression of this regional work. The questionnaire has been used widely during Covid-19 by Solent LAC health team as a way of reaching children to complete RHA's both within and OOA. Moving forwards, face to face assessments will be preferred wherever possible, however having a questionnaire is a useful option to offer for those who would otherwise decline to engage or prefer not to have a F2F assessment).

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Meeting Minutes

Better Care Southampton Steering Board
1st September 2020, 14:00 – 16:00
Virtual Meeting on Microsoft Teams

Present:

Dr Mark Kelsey (Chair)	SCCG Chair	SCCCG
Matt Stevens (MS)	Lay Member	SCCCG
Sarah Olley (SO)	Director of Operations, Southampton	SHFT
Stephanie Ramsey (SR)	Director of Quality and Integration	SCCCG / SCC
Hayden Kirk (HK)	Clinical Director Adults Southampton	Solent
Sarah Turner (ST)	BCS Programme Lead	BCS
Naz Jones (NazJ)	Locality Lead	East Locality
Jane Hayward (JH)	Director of Networks	UHS
Mike Windibank	Chief Operating Officer	SPCL
David Noyes (DN)	Chief Operating Officer	Solent
Dr Fraser Malloch (FM)	PCN Clinical Director / GP	Central PCN
Donna Chapman (DC)	Associate Director System Redesign	SCCCG/SCC
Jo Ash (JA)	Chief Executive	SVS

In attendance:

Hannah Gehling (HG)	Administrator	SCCCG

Apologies:

Dr Ali Robins (AR)	Chief Executive Officer	SPCL
Andrew Smith (AS)	Business Manager & Locality Lead	Solent/Central Locality
Julia Watts (JW)	Locality Lead	East Locality
Sundeep Benning (SB)	PCN Clinical Director/GP	West PCN
Phil Aubrey Harris (PAH)	Associate Director of Primary Care	SCCCG
Matthew Prendergast (MP)	PCN Clinical Director/GP	North PCN
Sanjeet Kumar(SK)	PCN Clinical Director/GP	West PCN
Chris Sanford(CS)	PCN Clinical Director/GP	Living Well Partnership
Sara A'Court(SA)	GP Clinical Lead for West Locality / West PCN Clinical Director	West PCN
Janine Gladwell (JG)	Senior Transformation Manager /West Locality Lead	Solent
Adam Cox (AC)	Clinical Director Southampton	Southern Health
Dr Nigel Jones (NJ)	PCN Clinical Director/GP	East PCN
Janet Ashby (JAy)	Head of Transformation	SPCL
Grainne Siggins (GS)	Executive Director Wellbeing (Health and Adults)	SCC
Dr Sara Sealey (SS)	Locality Lead / GP	East Locality
Tristan Chapman (TC)	Director of Improvement and Partnerships	UHS

Item	Subject	Action
1.	**Welcome and apologies**	
	MK welcomed everyone to the meeting. Introductions were made and apologies for absence were noted, as above.	
2.	**Declarations of Interest** *A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship*	
	No conflicts of interest were declared.	
3.	**5 Year Health and Care Strategy**	
	DC reminded Board members of the 5 year Health and Care strategy COVID impact assessment that had been presented to a previous meeting and the resulting priorities which had been agreed in June. Since then each of the workstreams have developed implementation plans for 2020/21, which are now being presented to the Board for approval prior to ratification by Joint Commissioning Board in September. DC and SR took people through the implementation plans. Key points of note: - JH: clarification of what work has slipped due to COVID. DC highlighted that this had been shared with the Board in June. - NJ: how do the workstreams join up with PCN work. **Action: MK and SR to discuss the 5 year Health and Care strategy with the PCN CDs.** - ST: how do we ensure that the enabling workstreams are complementing the work of the life course workstreams and how do we avoid duplication with wider STP work. **ACTION: each of the workstreams to review the enabler implementation plans and identify any specific "asks" that are not included. To report back to the next Board meeting for a discussion on the enabling workstreams.** - JH: the implementation plans currently make very little reference to acute elective care recovery. MK noted that the Health & Care Strategy is focussing on Southampton specific priorities and needs to be read alongside the ICP plans which focus on the S&SWH system, rather than duplicate. However it was felt that there would be benefit in cross referencing with the S&SWH Elective Care Programme to	**MK/SR** **DC with Clare Young Agenda - Oct** **DC with**

	ensure that any key priorities are included. **ACTION: meeting to be set up involving Tristan Chapman, Emma Lewis and a primary care rep to review.** - JA: noted that with any future waves of COVID there could be an impact on the workstreams, causing some pieces of work to be put on hold. **ACTION: DC to review the implementation plan with a view to highlighting those actions which will need to progress regardless compared to those which may go on hold again.** The Better Care Steering Board approved the implementation plans in principle subject to the above actions. JA queried next steps in terms of communicating the strategy. DC stated that Public Health still need to update their sections in the strategy, but the aim is to relaunch the strategy and the implementation plan together in the Autumn. The intention is then to bring progress updates for each workstream back to the Board on a 4 month rolling timeframe. This will also include the KPI dashboard.	**Clare Young** **DC with Clare Young**
4.	**Impact of COVID on Health Inequalities**	
	In the absence of Andrew Mortimore who was unable to attend, SR provided an overview of this paper which had been presented to Health and Wellbeing Board, highlighting the impact of COVID on the city's existing health inequalities. Key points noted by the Board: - MK questioned whether tackling health inequalities had been sufficiently addressed in the Health and Care Strategy implementation plans. DC reported that public health are involved in the workstreams. She also highlighted that the KPI dashboard includes health inequality measures. - NazJ highlighted that in addition to pre-existing need and health inequalities COVID has also created new need and inequalities in some populations, e.g. those who are shielding. Some of these patients have low mental health now due to the isolation. - JH felt that the paper does not focus enough on digital exclusion and the impact this has had on some groups during the Covid pandemic. She also felt that the impact of schools not being open (e.g. on education outcomes, child development and employment) is missing	

	in the paper. - HK advised that there is an STP COVID inequalities symposium on 22 October and queried how we can feed into this. He noted that there is a need to consider where we should focus our efforts in terms of tackling health inequalities. SR advised that Kate Lees from Southampton public health team is our link at the symposium. - NazJ noted that there is an opportunity to share this information with the public as COVID has created fear and there seems to be a lack of clarity of what they are and are not able to do. **Action: SR to update Andrew Mortimore with the updates and questions.**	
5.	**Progressing local plans and priorities**	
	ST presented an update on the locality projects which had previously been agreed at the Board. A summary of these projects can be found in the slides embedded below.  ITEM 6.0_20200901 BCSB Locality projec The West locality stopped both their projects during COVID. ST explained that she is really grateful to Solent and the practices who are leading the virtual wards projects. There had been a lot of input and the group were meeting every three weeks. The group shared a new questionnaire and remit through the governance at Solent. COVID has left the virtual ward projects in limbo as the front line staff have been lost meaning that the group has lost the insight and knowledge. When the project was piloted in the West we would want it to go city wide. The East locality have reviewed all their projects. And met with the PCN CDs to agree how projects to take forward and how the locality can support the PCNs. Two projects being progressed are the Wound Care and Social Prescribing. Central and North have all 4 projects on pause and have a meeting arranged with the two PCN CDs to discuss future working.  ITEM 6.1_20200901 Locality Leadership I The current model of care for Southampton was shared and the output is	

based on the responses from the questionnaire sent out to Better Care Southampton colleagues.

The options are:

- Do nothing
- localities integrate into Primary Care Networks (PCN),
- Localities disbanded and
- a mixed model approach

SR thanked ST for all her work and support. The Board wished to hold a decision over to the next meeting in October pending the outcome of the discussions with Central and North PCN CDs.

MK questioned what is the implication for the resource we have put in.

DN explained that he is hesitant to agree anything until the Board know what North and Central want to do. DC stated bearing in mind the projects were signed off here, a number of projects are being picked up by a city wide group. The virtual wards had a lot of progress made. ,

MK explained that the people who are helping the localities previously, might be different due to the new suggested way of working. ST stated that there needs to be a discussion on how we work together. The East want to retain the resource as is and West want a project manager who organises and facilities the insight and outcome work. The right people need to be available for the task and finish group.

MK asked if the west clinical lead would step up to lead the PCN in the development of virtual ward or integrated care teams through to end of March. Action: ST said she would pick up that conversation with Dr Sara A'

HK stated that the reality is reflecting that there are some of the risks with not being able to meet the demand of the city. Some of the strategic work is being dropped, but it is on the radar but staff could not be released back to the project at this point in time.

MK questioned if there were any plans for post March. ST stated that each area will be in a different position, and each area could bid for money to sustain their current work. SO explained that we know there are certain funds which are provided each year. A Task and Finish group should be put together to ascertain what funds could be allocated or bid for to support future working This work should be relaunched with the strategy. The communication needs to be made clear across the whole system once the

	outcomes of the localities is known. **Action: ST to pick up with the comms team once a decision about localities is understood.**	**ST**
6.	**Workforce Group Mandate – Southampton, ICS, H&IOW**	
	ST provided a briefing to the Board on the workforce agenda – presentation embedded below: ITEM 8.0_BCS Workforce - NHS Peo This draws on the NHS People Plan "We are the NHS: action for us all" recently published by NHSEI. This plan makes clear the intention to see an increased role for systems to work with their constituent parts. There are a list of detailed asks of employers and systems within four categories to be delivered during 2020-21. Each local system is asked to develop a local People Plan in response to the national plan. Locally there has been a Workforce group reporting to the Better Care Steering Board. However this has been paused. There is therefore a need to agree whether or not this group should continue and what its function and membership should be. MK stated that most things will need to be done at an organisational level and come together at a Hampshire and IOW level. MK was of the view that there does not need to be an additional Southampton level plan as well. SR explained that she has been talking to GS who is keen for a Southampton specific workforce group and plan to continue. SO questioned whether the group should be Southampton and South West systems. It was suggested that a small group should meet including GS and ST to consider the need for a Southampton specific group and if required what the focus and membership should look like. **Action: Meeting to be set up – to include GS, ST and other key colleagues – to discuss.**	**ST/GS**
7.	**Minutes of the Previous Meeting & Matters Arising**	
	The minutes of the Better Care Southampton Steering Board on 02/06/2020 were approved.	

8.	**Any Other Business and items for future meetings**	
	None raised	
Date of next meeting: Tuesday 6th October 2020, Seminar Room, NHS Southampton City CCG, Oakley Road, Millbrook, Southampton, SO16 4GX		

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