JOINT COMMISSIONING COMMITTEE

Date: WEDNESDAY 29TH JANUARY 2020

Time: 2.30PM

Room: BEVAN ROOM ST PETER'S HOUSE, SILVERWELL STREET

Contact/Ext No: Kate Smith

AGENDA

Part A: Open to press and public

Business Items				
No.	Item	Presented by	Decision	Time
1.	Declarations of interest	Chair	Noting/ endorsing	10 mins
2	Apologies for absence			
3	Minutes of the previous meeting (enclosed)			
4	Monitoring of Decisions (enclosed)			
5	Social Prescribing Update (enclosed)	Mel Maguinness/ Rachel Tanner	For information and comment	15 mins
6	CHC Policy (enclosed)	Mel Maguinness	For noting	15 mins
7	DTOC and HOOP service: system supporting housing roles (enclosed)	Mel Maguinness/ Rachel Tanner	For approval	15 mins
8	Forward Plan (enclosed)	Kate Smith	For comment	5 mins

JOINT COMMISSIONING COMMITTEE

MEETING, 4th DECEMBER, 2019

Representing Bolton Council

Councillor Susan Baines
Councillor Andrew Morgan
Mrs Rachel Tanner, Deputy Director of People/ Director of Adult Services
Ms Lisa Butcher, Head of Finance, Children and Adults
Ms Suzanne Gilman – Assistant Director, Public Health

Representing Bolton Clinical Commissioning Group

Dr Wirin Bhatiani – CCG Chair
Ms Melissa Maguinness – Director of Transformation /Deputy Chief Officer
Dr Jane Bradford – Clinical Director, Governance & Safety
Mr Alan Stephenson, Lay Member
Ms Su Long, Chief Officer
Mrs Kelly Knowles, Deputy Chief Finance Officer

Also in Attendance

Ms Kate Smith – Transformation Lead

Apologies for absence were submitted on behalf of:

- Dr Helen Wall, CCG GP Board Member
- Mr Ian Boyle, Chief Finance Officer, Bolton CCG
- Ms Sue Johnson, Director of Corporate Resources, Bolton Council
- Ms Bernie Brown, Director of People, Bolton Council
- Councillor Christine Wild
- Ms Helen Lowey, Director of Public Health, Bolton Council

- Dr Barry Silvert, Clinical Director – Commissioning, Bolton CCG

Councillor Susan Baines, in the Chair

1. DECLARATIONS OF INTEREST

Councillor Andrew Morgan declared an interest in item 6 – Equipment in Care Homes Policy.

2. MINUTES OF PREVIOUS MEETING

The minutes of the proceedings of the meeting of the Committee held on 23rd October 2019 were submitted and signed as a correct record.

3. MONITORING OF DECISIONS

Kate Smith, Transformation Lead, submitted a report which monitored the progress of decisions taken at previous meetings of the Committee.

Resolved – That the monitoring report be noted. Kate Smith updated that the Joint Personal Budgets contract had been awarded and commenced

4. QUARTER 2 FINANCE REPORT

Lisa Butcher, Head of Finance Bolton Council and Kelly Knowles, Deputy Chief Finance Officer, submitted the Financial Monitoring Report 2019/20 Q2 detailing the total pooled budget for end of Q2.

The committee was advised of a forecasted overspend of £7.7m by the end of the financial year. This was being mitigated by LA contributions and CCG contingency of £5.1m.

Resolved : That the report is noted.

5. EQUIPMENT IN CARE HOMES POLICY

Rachel Tanner, Deputy Director of People Bolton Council, submitted the Equipment in Care Homes report. The Policy detailed the provision of equipment setting out clear responsibilities.

Resolved : That the Policy is approved

6. FORWARD PLAN

Kate Smith, Transformation Lead, submitted the Joint Commissioning Committee Forward Plan for 2019/20 for noting.

Resolved – That the forward plan be noted.

7. EXCLUSION OF THE PRESS AND PUBLIC

The Committee agreed to passing the appropriate resolution under Section 100(A)(4) of the Local Government Act 1972 that the press and public be excluded from the meeting during the consideration of the following items of business since it involves the likely disclosure of the exempt information stated. The items below are not for publication by virtue of paragraph 3 of Part 1 of Schedule 12(A) to the Local Government Act 1972. The public interest test has been applied and favours exclusion of the information from the press and public:

8. SUPPORTED LIVING FRAMEWORKS : CONTRACT EXTENSION

Rachel Tanner, Deputy Director of People Bolton Council, submitted the Supported Living Frameworks Contract Extension. The report outlined the call off agreements for supported living services contracts for Learning Disability and Autism Supported Living Services in order to undertake a review of supported accommodation as part of the Supported Housing Strategy.

Resolved –

(i) That the utilisation of the option to extend each of the call off agreements for Learning Disability and Autism Supported Living Services be approved as detailed in the report

(ii) That a review of supported living services and future options for the delivery of these services is carried out as detailed in the report

9. HOMELESSNESS SERVICES CONTRACTS

Rachel Tanner, Deputy Director of People Bolton Council, submitted a report which requested a mini tender exercise to be undertaken with regard to Single Emergency Accommodation Framework Contract and the Homeless Prevention Contract as part of the wider Adult Homelessness services. This would enable these contracts to be brought into line with other contracts. This would also enable the development of a strategic approach to the existing Social Inclusion Contracts for Adult Homeless Services.

Resolved :

(i) That a mini tender exercise through the existing Framework Contracts for the establishment of new contracts for both the Homeless Prevention Service and also the Single Emergency Accommodation Service be approved up to the 31st of March 2021 and as detailed in the report.

(ii) Note the variations required to the contract for the Family Intervention Team, the extension to the Mental Health Supported Housing Services, and the Streetlife service to ensure they end simultaneously with the Homeless Prevention Contract and single Emergency Accommodation Service Contract.

10. DYNAMIC PURCHASING SYSTEM FOR HOME SUPPORT AND/OR COMMUNITY BASED SUPPORT SERVICES

Rachel Tanner, Deputy Director of People Bolton Council, submitted a report which updated the Committee of the current position regarding the commissioning of home support and/or community based support and sought approval to tender a Flexible Purchasing System to support existing contractual arrangements.

Resolved- That the Deputy Director of People, Bolton Council is authorised to:

(i) Tender a Flexible Purchasing System for Home and/or Community Based Support Services for Adults to support existing contractual arrangements.

(ii) To appoint qualifying providers to the Flexible Purchasing System on conclusion of the tender and to periodically approve the inclusion of additional providers in accordance with the terms of the Flexible Purchasing System and to enter into

contracts with the providers on the advertised terms and conditions.

(iii) To enter into contracts with those providers listed in Appendix 1 for the provision of Home and / or Community Based Support Services to the recipient service users.

And authorised:-

(iv) the Council's Borough Solicitor to carry out all necessary legal formalities.

Report to:	**Joint Commissioning Committee**		
Date of meeting:	29th January, 2020		
Report of:	Kate Smith, Transformation Lead		
Contact officer:	Kate Smith	**Telephone number**	
Report title:	**Joint Commissioning Committee Monitoring Report**		
Non confidential This report does not contain information which warrants its consideration in the absence of the press or members of the public			
Purpose:	To report the details on the progress made regarding recent decisions taken by the JCC		
Recommendations:	To note the Monitoring Report		
Decision:			
Background documents:			
Date:	29th January		

Consultation with other CCG/Council officers		
	CCG Officer	LA Officer
Finance	N/A	N/A
Legal	N/A	N/A
HR	N/A	N/A
Equality Impact Assessment required?	N/A	

Date of meeting	Item and decision	Action and Progress
23/09	**Social Prescribing : Funding update** The JCC endorsed the Social Prescribing funding proposals as set out in the report.	Update brought to this (29/01/20) meeting
04/12	**Equipment in Care Homes policy** The JCC Approved the Equipment in Care Homes Policy	Implemented.
04/12	**Supported Living Framework Contract Extension** The JCC Approved: (i) The utilisation of the option to extend each of the call off agreements for the services detailed (ii) A review of supported living services and future options for the delivery of these services is carried out as detailed in the report	Revew of supported living including future options in train.
04/12	**Homelessness Services Contract** The JCC Approved: (i) A mini tender exercise through the existing Framework Contracts for the establishment of new contracts for both the Homeless Prevention Service and also the Single Emergency Accommodation Service up to the 31st of March 2021 and as detailed in the report. (ii) The variations required to the contract for the Family Intervention Team, the extension to the Mental Health Supported Housing Services, and the Streetlife service to ensure they end simultaneously with the Homeless Prevention Contract and single Emergency Accommodation Service Contract.	Work is currently underway on the mini tender exercise in respect of the Homeless Prevention Framework Contracts. Officers have updated providers of the intention to extend the contracts of the Family Intervention Team, Mental Health Supported Housing Services, and the Streetlife Service. Formal extension letters will be sent out week commencing 27th of January.

04/12	**Dynamic Purchasing Scheme for Home Support and/or Community Based Support Services** The JCC Approved: (i) To Tender a Flexible Purchasing System for Home and/or Community Based Support Services for Adults to support existing contractual arrangements. (ii) The appointment of qualifying providers to the Flexible Purchasing System on conclusion of the tender and to periodically approve the inclusion of additional providers in accordance with the terms of the Flexible Purchasing System and to enter into contracts with the providers on the advertised terms and conditions. (iii) To enter into contracts with those providers listed in Appendix 1 for the provision of Home and / or Community Based Support Services to the recipient service users. And authorised:- (iv) the Council's Borough Solicitor to carry out all necessary legal formalities.	The tender is due to be published by procurement on the North West Chest imminently.

Report to:	**Joint Commissioning Committee**		
Date of meeting:	29th January, 2020		
Report of:	Melissa Maguinness, Director of Transformation/Deputy Chief Officer CCG; Rachel Tanner Deputy Director of People/ DASS Council		
Contact officer:	Kate Smith	**Telephone number**	
Report title:	**Social Prescribing Update Report**		
Not confidential This report does not contain information which warrants its consideration in the absence of the press or members of the public.			
Purpose:	This report provides an update on the progress to implement interim funding arrangements and programmes for social prescribing.		
Recommendations:	The Joint Commissioning Committee is recommended to:- • Note the Update		
Decision:			
Background documents:			
Date:			

Consultation with other CCG/Council officers Please complete this section with a Name or N/A		
	CCG Officer	LA Officer
Finance	Kelly Knowles (reviewed previous report on funding arrangements)	Lisa Butcher (reviewed previous report on funding arrangements)
Legal	N/A	N/A
HR	N/A	N/A
Equality Impact Assessment required?		

1. INTRODUCTION & BACKGROUND

1.1 This report outlines the progress made on implementation of interim Social Prescribing proposals which the JCC approved on 20th September, 2019. The approach approved was to invest in a collaborative, holistic model of asset development (including social prescribing) which meets the needs of neighbourhoods and the locality. Updates are provided on the following areas:

- Creation of a community asset map: Development of a digital first model to enable people to be signposted or referred to the community assets
- Development of community assets: Supporting the new collaborative commissioning approach to enable sustainable delivery of VCSE services in neighbourhoods (the Bolton Fund).
- Connection of people to assets: Development of the whole public sector workforce to enable a culture of understanding self-care, social prescribing, holistic assessment and the ability to connect people to community assets

1.2 An update on the development including a reminder of the funding allocated (full table at Appendix 1) is included in the report.

2. UPDATE ON PROGRESS TO DATE

2.1 Creating a Community Asset Map

The proposal agreed by the JCC included £25, 000 (non recurrent funding from the Transformation Fund) set aside for the development of a digital first platform, so a wide range of community assets can be accessed, either through self-referral or through a health or social care referral. The platform will be a function which allows connection electronically to on-line information about all existing assets. The understanding of all existing assets will also include data from the CANs, Peer Navigators and other sources.

Since that time, Greater Manchester Health and Social Care Partnership have been successful in a bid from NHS Digital for one year's funding to make available a Social Prescribing platform for the 10 localities across GM to utilise. The GM team are currently part way through the procurement process. Following the rollout and future development post the one year's funding it will then be a decision for localities to fund the service thereafter. Given this development, Bolton is committed to working with this platform as a basis by which we can develop our own asset map whilst using the funding to potentially develop further localised options ensuring that the platform functions reflect local need.

It has been agreed that the key functionality required for the platform includes the following;

- Interoperability to pull data to connect existing platforms, such as EMIS and other GP systems. This will also include Liquid Logic for care management system.
- Ability to refer direct to social prescribing from EMIS
- Delivery integrated online directory of service for community based offers from existing directories
- Ability to record and monitor social prescribing activity and outcomes
- Referrals to link workers from across the system and ability to self-refer

2.2 Developing Community Assets

JCC supported the establishment of a new programme, the “Bolton Fund”, to support the development of prevention within neighbourhoods with additional investment of £800k over two years. It was noted that there was also the potential to include further investment; namely the Prevention and Carers’ Grants. Six key priority areas have been agreed, which are aligned to Bolton’s Vision 2030 priorities:

1. *Our children get the best possible start in life, so that they have every chance to succeed and be happy.*
2. *The health and wellbeing of our residents is improved, so that they can live healthy, fulfilling lives for longer.*
3. *Older people in Bolton stay healthier for longer, and feel more connected with their communities.*
4. *Businesses and investment are attracted to the borough, matching our workforce's skills with modern opportunities and employment.*
5. *Our environment is protected and improved, so that more people enjoy it, care for it and are active in it.*
6. *Stronger, cohesive, more confident communities in which people feel safe, welcome and connected.*

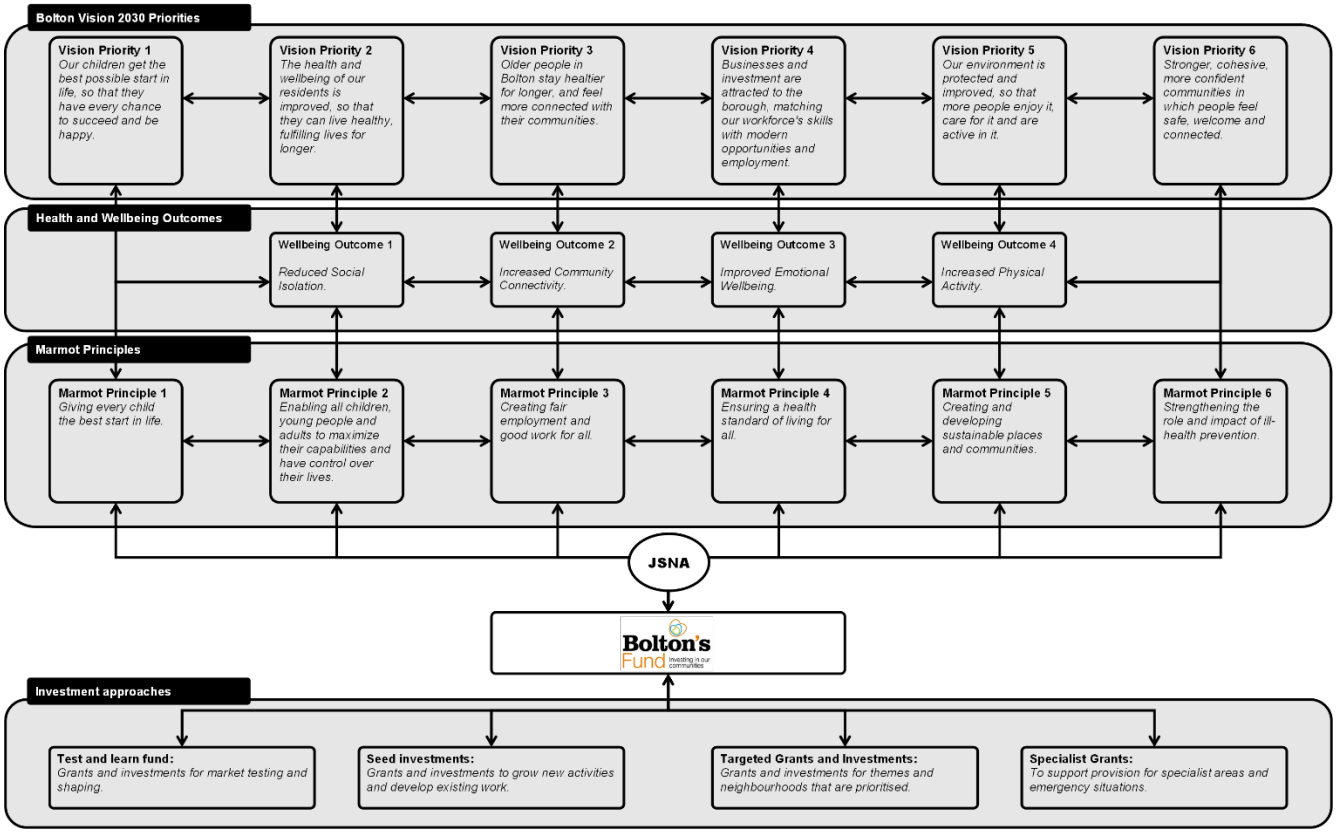
Bolton CVS is leading the process on behalf of the locality, working in collaboration with Bolton Council, Bolton CCG, Bolton at Home, Bolton Together and voluntary, community and social enterprise (VCSE) sector leaders through a co-design process. This programme is driving the delivery of specific outcomes which are ultimately reported to the Health and Wellbeing Board (through the JCC and Partnership Board). The new way of working with the VCSE is supporting providers to work in collaboration to deliver improvements in population outcomes, aligned to needs identified through the JSNA and community intelligence. One of the principles of this new way of investment is to support providers to better understand and address health and social inequalities in Bolton, encouraging collaboration within the sector and providing support that enables groups and organisations to develop their plans and strategies to identify new income for ongoing sustainability.

The process has been agreed and the first tranche of grant funding was allocated for the 3 identified priority outcomes for children and young people; smoke free homes, improved oral health and increased physical activity and healthy weight in December 2019. 35 applications from the VCSE were evaluated by a panel, of which 19 of which were awarded investment totalling £70k.

The next priority is for connected communities, which will be launched in February 2020, subject to final approval.

The diagram below outlines how the programme aligns to local priorities:

How the Bolton's Fund works:



2.3 Connect People to Assets

The JCC supported the proposed approach to ensure that we were enabling people across all our communities to be connected to services, groups and networks ensuring that our staff were given the skills and engagement techniques to do this. The proposals agreed included developing a locality wide programme for all health, social care and wider public sector staff to be enabled to have a different conversation with people about what is important to them. It is also included development of workforce training and supporting the roll-out of the Peer Navigator posts whom work with some of our most disadvantaged communities.

2.3.1 Different Conversation Training

£75,000 was allocated to progress this work. The aim is for staff across the public sector to be enabled to connect people to community assets, focusing on personal strengths and resources and helping people to meet their personal aims and individual outcomes. The first priority was agreed as the core workforce within the emerging nine neighbourhoods. There would then be a comprehensive plan developed to roll this out across all public sector staff.

OD and workforce leads including those supporting the development of the Integrated Care Partnership who are delivering the new model of care in neighbourhoods, and other partners are currently pulling together an outline proposal regarding the key aims and specification. It should be noted that this is being undertaken in the context of a developing OD plan across the Integrated Care System of which the 'Different Conversation' training for staff is a core component. The key principles by which we are developing the specification include:

- A focus on self-care and independence: “Work with me to support myself and live as well as I can”
- Listen and Connect: Recognising and drawing on the strengths of the individual and what matters for the person and their family/carers
- Place Based Approach- “know your community”: Understanding the place you work in – its strengths, assets and challenges
- Support seamless service provision: taking responsibility for your actions and co-ordinating support/ case ownership: Ensuring there is ‘ No wrong front door’ and that people only have to “tell their story once”
- Staff are empowered to do what is right for the person in front of them, recognising and pulling in everyone’s strengths
- Engendering a culture of testing, learning and adapting
- Supporting the ICS agreed Values and Behaviours detailed as shown in the diagram below:

We are beginning to fully design and cost the programme to support the first phase of training for staff (in health & care neighbourhoods) taking the learning from elsewhere including the restorative practices work recently undertaken in Bolton.

2.3.2 Peer Navigator Programme

Good progress has been made with the Peer Navigator programme with a Memorandum of Understanding (MOU) developed between Bolton at Home, Bolton CVS, Bolton Council and Bolton CCG. Funding of £60k has been allocated to this programme which will see the recruitment of 12 Peer Navigators (2 in 6 of the key areas) who will all be appointed by the end of March 2020. The initial pilot which ran in Johnson Fold delivered the following outputs.

- Increased drugs awareness for families and communities
- Development of crèche facilities for families
- Development of women's groups to provide peer support and combat social isolation
- Development of Men in Sheds group, for isolated men in the community
- Commencement of youth groups, supported by local people
- A significant increase in the numbers of people from the area accessing services including, housing, debt advice, the local pantry, drug and alcohol support, mental health services, GMP and social service support

All of which are contributing to the high level outcomes of improving health and wellbeing and reducing inequalities, specifically: reducing social isolation, reducing substance misuse, increasing employment, developing connected and cohesive communities and supporting the reduction in the proportion of families living in poverty.

2.3.3 Social Prescribers in Primary Care Networks

In order to bring together the local aims of neighbourhood working and the requirements of the national GP Contract for Primary Care Networks (PCN), an agreement was made in 2019/20 that each of the 9 PCNs would have a named senior individual from the Health Improvement Practitioners Team to meet the requirements of social prescribing. This included involvement in multi disciplinary teams at the Practice, signposting and motivational coaching of people referred to them.

For 2020/21, most of the PCNs have decided to move away from this arrangement and use the GP contract funding from April 2020 to appoint personnel. The implications for the Health Improvement Practitioner Service and the arrangements for neighbourhood working with PCN appointed staff are being worked through.

3 IMPACTS AND IMPLICATIONS

3.1 Legal and HR – No impact has identified.

4 EIA

4.1 Under the Equality Act 2010, the CCG and Council must have due regard to:

- Eliminating unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act;

- Advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and

- Fostering good relations between people who share a protected characteristic and people who do not share it.

4.2 It is therefore important to consider how the proposals contained within this report may positively or negatively affect this work.

4.3 An initial screening for equality implications was undertaken as part of the original proposals, therefore based on this the report does not require an Equality Impact Assessment to be completed.

5 **RECOMMENDATIONS**

The JCC is recommended to:

(i) Note the update on Social Prescribing

Appendix 1: Action Plan

Executive Oversight provided by M Maguinness and R Tanner

ACTION	Who	By When	Budget
1. Develop community assets			
1.1 Ensure grants at the different levels coordinated and awarded with CVS responsibility	R Tanner, M Maguinness, G Gallagher, D Knight	End Oct 2019	£800k
2. Create a community asset map			
2.1 Bring information together from CVS, CANs, HIPs, peer navigators, focused care workers, staying well team, Bolton Council (my life in Bolton), Bolton CCG (Nic Onley & Commissioning team), Bolton FT (comms team, GMMH, etc, to create a directory	P Beech D Knight,	End Dec 2019	N/a
2.2 Develop a costed proposal for a web-based directory reviewing what is in place in neighbouring boroughs	P Beech	End Oct 2019	£25k est.
3. Connect people to the assets			
3.1 Agree "a different conversation" aims and specification, to have core elements with early help approach, etc.	K Smith	End Nov 2019	
3.2 Design and cost programme and first phase of training for staff (in health & care neighbourhoods) work	ICP Exec	End Dec 2019	£75k
3.3 Transition 9 HIPs into new role description – 1 per neighbourhood reporting to PCN Clinical Director (for a 6 month trial)	L Helsby, S Liversedge, S Wilson	End Sep 2019	£138k
3.4 Invest in peer navigators & commence roles jointly with Bolton@Home. 4 areas initially, with ongoing plan for rollout.	K Smith	End Oct	£60k with match funding from Bolton at Home

Report to:	**Joint Commissioning Committee**		
Date of meeting:	29th January, 2020		
Report of:	Melissa Maguinness, Director of Transformation/Deputy Chief Officer CCG; Rachel Tanner Deputy Director of People/ DASS Council		
Contact officer:	Jayne Waite	**Telephone number**	
Report title:	**CHC (Continuing Healthcare for Adults) Policy**		
Not confidential This report does not contain information which warrants its consideration in the absence of the press or members of the public.			
Purpose:	This policy sets out the commissioning principles that Bolton CCG (CCG) will work to when commissioning individual packages of care for patients eligible for NHS Continuing Healthcare (CHC) funded by the NHS		
Recommendations:	The Joint Commissioning Committee is recommended to:- • Note the Update		
Decision:			
Background documents:			
Date:			

Consultation with other CCG/Council officers Please complete this section with a Name or N/A		
	CCG Officer	LA Officer
Finance	N/A	N/A
Legal	N/A	N/A
HR	N/A	N/A
Equality Impact Assessment required?	N/A- this has been considered as part of the CCG process	N/A- this has been considered as part of the CCG process

Content

1. Executive Summary
2. Framework for Decision Making
3. Key Principles
4. Roles and Responsibilities of the Commissioner
5. Patient and Family Involvement
6. Continuing Healthcare funded packages of care at home
7. Personal Health Budgets (PHB)
8. Fast Tracks
9. Discharge to Assess/Spot Purchase
10. Changes OF Circumstance
11. Right to Refuse
12. Exceptional Circumstances
13. Reviewing Panel
14. Appeals

1. Executive Summary

I.1.1 This policy sets out the commissioning principles that Bolton CCG (CCG) will work to when commissioning individual packages of care for patients eligible for NHS Continuing Healthcare (CHC) funded by the NHS.

I.1.2 It explains how the CCG will commission care in accordance with the National Framework for NHS Continuing Healthcare and NHS- funded Nursing Care (October 2018, revised) ("national framework") taking into account the legal requirement for the CCG to act efficiently, effectively and fairly in allocating its limited resources between all of the patients for whom the CCG has commissioning responsibility.

I.1.3 "NHS Continuing Healthcare" means a package of continuing care arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in the national framework. The actual services provided as part of that package must be seen in the wider context of best practice and service development for each client group. Eligibility places no limits on the settings in which the package of support can be offered or on the type of service delivery.

I.1.4 The concept of a 'primary health need' has been developed. Where a person's primary need is a health need, the NHS is regarded as responsible for providing for all their needs.

I.1.5 This policy applies to all new patients who are eligible for CHC, and in some cases to existing patients whose care needs have changed considerably since their last CHC review. It does not apply to children under the age of 18.

This policy has been developed to ensure that:

I.1.6 Any package of care which is offered to be commissioned by the CCG meets the assessed care needs of an individual who is eligible for CHC.

I.1.7 As far as is reasonably practicable, a person-centred approach is taken by the CCG in making decisions about a care package to be funded by the CCG for that individual, taking into account choices expressed by the individual, their family or a representative.

I.1.8 Decisions are made in a way that is fair, balancing the CCG's duties to the individual and to all the other patients for whom the CCG has commissioning responsibility.

1.9.1 Where a person qualifies for CHC, the CCG has a duty to offer a package of health and social care services that meets the individual's assessed health and associated social care needs in a way that is considered reasonable. The duty to make and maintain the offer and, if accepted, to commission care in

accordance with the offer, continues for as long as the individual is eligible for CHC.

1.9.2 In all instances, the CCG will need to satisfy itself that any health and social care services that are to be commissioned by the CCG for an individual will be provided in a location which is:

a. Clinically appropriate to providing the package of health and social care which the CCG has assessed is reasonably required to meet the individual's assessed health and associated social care needs; and
b. Able to provide a safe and sustainable package of care.

1.9.3 In most circumstances, CCG staff will work with the individual and/or their family or representative to seek to identify a range of potential locations and care options, which are appropriate to meeting the individual's assessed needs. The CCG will communicate those potential options to the individual and any representative identified by the individual.

1.9.4 Under this policy, the CCG will generally use home care providers and care or nursing home providers that it has assessed as able to meet procurement and contractual requirements.

1.9.5 The CCG has a statutory duty to break-even financially. When making decisions about commissioning services, the CCG must balance a range of factors including individual choice and preferences, quality, safety and value for money. Throughout the decision-making process, the CCG needs to recognise the need to achieve best value in its use of financial resources, in order that it can share finite NHS resources equitably across all patients for whom it has commissioning responsibility.

1.9.6 The CCG will take account of an individual's views and wishes regarding where their care package is provided, when determining whether their case is exceptional and justifies a higher cost being incurred to provide care. This will include considering an individual's particular reasons and family circumstances, and whether there are compelling circumstances. However, in reaching this decision the CCG must be satisfied that the proposed overall cost of the care package is proportionate and a justifiable use of CCG funds in comparison to the cost of commissioning a package of care for the individual in another location.

2. Framework for Decisions on Assessing and Arranging Provision

2.1.1 This Policy recognises that Bolton CCG, as the commissioner, has an obligation to commission care for Eligible Individuals (Eligible Individual means someone who is assessed as being eligible for CHC pursuant to the National Framework) to have NHS CHC fully funded by the NHS under the NHS Commissioning Board and CCG (Responsibilities and Standing Rules) Regulations 2012 (as amended).

2.1.2 The context for this Policy is provided in the form of The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care - Department of Health, 2012, revised 2013, updated and re-issued 2018 (The National Framework).

2.1.3 Bolton CCG will continue to apply the principles and guidance within The National Framework in its assessment and decision making processes with regard to the eligibility of individuals to have their care needs met through the use of NHS funding. This includes ongoing case management, review and reassessment of the individual's needs.

2.1.4 Within the law, the commissioner is the appointed body to determine the appropriate setting in which care may be provided for Eligible Individuals, in so doing the CCG will take account and consider all reasonable requests of the individual's wishes and preferred outcomes.

2.1.5 Although the CCG is not bound by the views of the local authority on what services the individual requires, any local authority assessment under the Care Act 2014 will be important in identifying the individual's needs and in some cases the options for meeting them." (Paragraph 172 of the national framework)

3. Key Principles

3.1 The CCG is committed to commissioning care services that meet clinically acceptable quality of care standards and that evidence value for money.

3.2 The CCG will make decisions with regard to Eligible Individuals that:

i. take into account all relevant factors and are robust, fair, consistent and transparent providing non-discriminatory equity of access to care services;
ii. are based on objective assessments of individuals' clinical needs and safety;
iii. have regard for the safety and appropriateness of care services to those involved in delivery of such care;
iv. involve the individual and family or appointed representatives wherever this is appropriate and possible, particularly when nearing the end of life;
v. take account of the need to utilise NHS resources in the most cost effective and efficient manner;
vi. strive to support the offering of choices to individuals where it is reasonable and affordable to do so having regard to the above factors; and
vii. consider personalised support and care when commissioning services.

3.3 In addition Bolton CCG, when commissioning care services for Eligible Individuals, will apply the following principles:

i. That care needs assessed under the CHC National Framework will be met;
ii. That all legal obligations will be fulfilled including specifically those outlined in the NHS Commissioning Board and CCG (Responsibilities and Standing Rules) Regulations 2012 (as amended)).
iii. That the 'Fast Track' pathway tool, or other relevant processes will be applied where the Eligible Individual's clinical condition is either rapidly deteriorating or may be entering a terminal phase
iv. That relevant and applicable legislation (such as Mental Capacity Act and the Disability Discrimination Act) will be complied with.

3.4 Access to NHS services depends upon an individual's assessed needs and not their ability to pay. The CCG will not charge a fee or require a co-payment from any NHS patient in relation to their assessed needs. The principle that NHS services remain free at the point of delivery has not changed and remains the statutory position under the NHS Act 2006.

3.5 The CCG cannot allow personal top-up payments to an NHS fully funded care package, where the additional payment relates to services assessed as meeting the needs of the individual and covered by the fee negotiated with the service provider (for example, the care home) as part of its contract with the CCG.

3.6 Any funding provided by the individual for private services must not contribute towards costs of the assessed need that the CCG has agreed to fund. Similarly, CHC funding must not in any way subsidise any private service that an individual chooses outside of the identified care plan.

3.7 However, where service providers offer additional services which are unrelated to the individual's assessed CHC needs; the person may choose to pay for these additional services themselves. Examples of services that will in most cases fall outside NHS provision include hairdressing, aromatherapy, beauty treatments and entertainment services. However, such services can also include additional healthcare services that the CCG has assessed are not reasonably required and therefore will not be funded by the CCG.

3.8 Where more than one suitable care option is available (such as a care or nursing home package and a home care package) the total cost of each package will be identified and assessed against the overall cost effectiveness of comparable alternatives. While there is no set upper limit on the cost of care, the expectation is that the most cost effective option that meets the individual's assessed needs will be commissioned. The CCG will consider the

views of the individual and their family or representative as appropriate and act on all reasonable requests to the best of its ability.

3.9 The CCG will keep the package of care under review. A review will occur at least annually or if the needs of the person change. The provision of a package of care in one location is not a guarantee that care will be provided in that location for life and it may become necessary to revisit with the person and / or their representative the provision of a package of care in an alternative location.

3.10 The NHS discharges its duty to individuals by making an offer of a suitable care package whether they choose to accept the offer or not.

4 Roles and Responsibilities of the Commissioner

4.1 The CCG has an obligation to meet the assessed care needs of Eligible Individuals in a way that is considered to be reasonable and affordable whilst also in accordance with the commissioner's relevant legal obligations.

4.2 The CCG will maintain transparent and robust processes to ensure that the assessment of an Eligible Individual's care needs complies with the National Framework.

4.3 When considering how and what care services can be commissioned, the Commissioner has a responsibility toward taxpayers to comply with its own Prime Financial Policies to ensure that commissioning decisions take full account of the most cost effective options available, whilst also ensuring the assessed care needs of Eligible Individuals are met.

4.4 The CCG will make a reasonable offer of care to Eligible Individuals, which meets care needs assessed under The National Framework, complies with its own Financial Policies and takes account of the rights and preferences of the individual. The CCG will consider the appropriateness of funding care services from a variety of care settings which may include an individual's own home or a residential setting.

4.5 Where a person has been assessed as needing a placement within a care or nursing home, and the CHC team operates an agreed rate with Providers, the expectation is that individuals requiring the placement will have their needs met in a home with an agreed rate. The CCG's duty is to meet the assessed needs of the person. The person has a right to ask for a particular package of care, or they, or their family or representative, may wish for a care or nursing home outside of the CCG's preferred providers. The CHC team will consider this option, as long as the fee for the bed is reasonably equitable with that of the fee agreed with preferred provider of care or nursing homes, and the home can meet the patient's assessed care needs.

4.6 The CCG will generally not fund a placement at a care or nursing home if its costs are significantly more than a preferred provider on the CCG's preferred provider list. The CCG will consider whether any exceptional circumstances apply which would allow it to fund a placement where costs are higher than those of the preferred provider threshold. Where there is no placement available on the preferred provider list, the CCG will offer a placement in a care or nursing home outside the preferred list.

5 Patient and Family Involvement

5.1 The CCG will discuss care provision options including care settings with Eligible Individuals and where appropriate their family, carer, appointed representative or other relevant individuals and will take their views and preferences into account. Consideration will be given to any care options proposed on behalf of the individual which address the assessed care needs of the individual. Where there is a variation in the costs associated with different care options, the CCG will seek to accommodate the preferences of the individual as far as is considered reasonable and affordable to do so, to ensure that the individual's assessed needs are met having regard to the above factors.

5.2 Whilst there is no financial limit on CHC, the CCG will take into account the equitability of requests for funding. Where there are concerns that an individual may not have capacity to make decisions with regard to how their care needs can be met, the CCG will arrange for a Mental Capacity Assessment to be undertaken in accordance with the Mental Capacity Act 2005 and The National Framework.

5.3 Where an individual lacking capacity has no immediate family to support the decision making process, the CCG will offer, under the provisions of the Mental Capacity Act 2015, support from and consult with an independent advocate as part of its assessment of best interests (ordinarily this will either be an IMCA[1] or a suitable person from the local advocacy services, dependent upon the nature of the decision to be made).

5.4 In considering the offer of an appropriate care setting for a person who lacks capacity, the CCG will ensure that a Best Interests Meeting is held in accordance with the provisions of the Mental Capacity Act 2015 Code of Practice, that those with an interest in the welfare of the person are invited to the meeting and a Best Interests decision will be made as to an appropriate care setting for the person.

5.5 Where a decision cannot be reached on the appropriate care setting, the CCG will take appropriate advice and where necessary will make an application to the Court of Protection to authorise the lawfulness of the proposed placement.

5.6 In considering the appropriate care setting with patients and their family (and in order to make a reasonable offer of care for an Eligible Individual) the CCG will consider issues that may arise in relation to:

i. Any valid and applicable Lasting Power of Attorney that may have been made by the Eligible Individual;
ii. Any valid and applicable Advance Decision (also known as a 'Living Will' or 'Advance Directive') that may have been made by the Eligible Individual.
iii. Any Advanced Statement of Wishes previously prepared by the Eligible Individual

6 Continuing Healthcare Funded Packages of Care at Home

6.1 Where consideration is being given to the commissioning of care in a proposed domiciliary care setting such as an Eligible Individual's own home, the CCG will consider specific factors before making a reasonable offer of care.

6.2 The CHC team will take account of the following factors when considering whether or not to commission a care package (this list is not exhaustive):-

i. The individual's views and those of their family or representative of the benefit to the individual of living at home.
ii. The likely impact on the individual of any potential move, including psychological, emotional, personal, social and developmental needs.
iii. The preference of the individual to die at home when they have an advanced, progressive, incurable illness.
iv. Whether the location of the placement is close to family members who play an active role in the life of the individual.
v. The cultural or linguistic needs of the individual.
vi. The needs of individuals placed out of area before they became eligible for NHS CHC.
vii. Length of stay in the existing placement.
viii. Consideration of the likely length of the care package and what change in needs might trigger the need to relocate to alternative provision.
ix. Availability and suitability of alternative care arrangements and the long-term sustainability of these alternative arrangements.
x. The availability of contingency or replacement services if the care package breaks down.
xi. The extent to which care can be delivered safely and without undue risk to the person, the staff or other members of the household (including children).
xii. The acceptance by the CHC team and each person involved in the person's care of any identified risks in providing care and the person's acceptance of the risks and potential consequences of receiving care at home.

xiii. Where an identified risk to the care providers or the person can be minimised through actions by the individual or their family or representative, those individuals agree to comply and confirm in writing they agree with the steps required to minimise any identified risk.

xiv. The individual's GP's agreement to provide primary care medical support.

xv. The willingness and ability of family, friends or informal carers to provide elements of care where this is part of the care plan, and the agreement that no individual should be under pressure to offer such support, and the CCG does not make assumptions about any individual, group or community being available to care for family members.

xvi. The cost of providing the care at home in the context of cost effectiveness with other comparable services.

xvii. Whether the higher cost is reasonable, taking into account local market rates.

6.3 The CCG does not have the financial resources to provide a safe and effective 'hospital at home' service. The CCG will not normally commission 24/7 care outside of a residential setting. Where such care is requested by family choice the CCG will consider the reasons for this choice and such exceptional circumstances as are presented.

6.4 CCG staff will work with the individual and/or their family or representative to identify a range of potential locations and care options, which are appropriate to meet the individual's reasonable assessed needs. The CCG will communicate those potential options to the individual and any family member or representative identified by the individual.

6.5 People who are eligible for CHC may have a complexity, intensity, frequency and unpredictability in their health needs which can present challenges to the safe delivery of care in their homes. A care or nursing home may be more appropriate for people who have these levels of need. Care or nursing home placements benefit from direct oversight by registered professionals and the 24-hour monitoring of people. If the clinical need is for registered nurse direct supervision or intervention throughout the 24 hours, the care would often be expected to be provided within a care or nursing home. This could include the requirement for 1-2 hourly intervention and/or monitoring for turning, continence management, medication, feeding, manual handling or for the management of significant cognitive impairment and the provision for waking night care.

6.6 When considering the appropriateness of a home based package of care an assessment of the care options will be undertaken including costs to determine the appropriateness of the package. Detailed consideration will be given to the person's needs and how their needs could be met in different care setting options taking into account the range of factors set out in section 6.2, underpinned by the CHC legal framework and NHS principles.

6.7 At all times, Eligible Individuals with capacity to make decisions about their residence, care and treatment retain their right to decline any offer made by the Commissioner and to make and fund their own private arrangements.

6.8 The CCG recognises that exceptional circumstances may require exceptional consideration but will retain its obligation to make best use of NHS resources on behalf of taxpayers. The Commissioner will consider **exceptionality** on a case by case basis.

7 Personal Health Budgets (PHB)

7.1 Eligible Individuals may also be eligible for a Personal Health Budget (PHB) in certain situations. The provision of a PHB is covered in the CCG's Personal Health Budget Policy.

7.2 In deciding the appropriateness of offering a PHB, the CCG will consider the provisions of this Policy and the CCG's Personal Health Budget Policy.

8 Fast Tracks

8.1 The eligibility criteria for CHC for Fast Track application are defined within the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care. Care provision for individuals assessed on the Fast Track will be subject to the same principles as set out in the relevant sections in this policy dependant on needs.

8.2 Since Fast Tracked individuals are deemed to be near End of Life, the CCG will support the principle of individuals having the right to choose the setting for their end of life care.

8.3 If, upon review, the Eligible Individual is deemed to no longer be eligible for full CHC, the CCG reserves the right to amend the offer of care provision in line with this Policy.

9 Discharge to Assess/Spot Purchase

9.1.1 Following a hospital admission an individual may require a period of assessment whilst their future care needs are identified. The CCG will fund this period of assessment in the first instance in a Discharge to Assess care facility (in a designated Intermediate Care facility). Where there is no placement available, at the Discharge to Assess care facility or in cases where exceptionality is demonstrated the CCG may agree to temporary spot purchase a bed in a Bolton Nursing Home. Where a spot purchase bed is agreed this will be within Bolton Nursing Homes or a package of care funded at an equivalent weekly rate as Bolton Nursing Homes.

9.1.2 Both these types of funding are offered pending full assessment for CHC eligibility and can be withdrawn without an MDT or panel decision. Both Discharge to Assess and spot purchase types of funding will not be subject to the same principles as set out in this Policy and are offered at the discretion of the Funded Care Team management.

9.2 Individuals with capacity to make decisions about their residence, care and treatment retain their right to decline any offer made by the Commissioner and to make and fund their own private arrangements.

10 Changes of Circumstance

10.1 The NHS has a responsibility to regularly review the care needs of Eligible Individuals in order to ensure that the care services being commissioned for them remain appropriate or to consider how those services may need to change. An initial review should take place 3 months after the first assessment. Thereafter care plans should be reviewed as a minimum on an annual basis. The outcome of such reviews must be adequately communicated to the Eligible Individual and where appropriate their family or carer.

10.2 Eligibility to have care funded by the NHS is not a permanent arrangement and remains subject to regular reviews and confirmation of continuing eligibility. The health and/or health needs of Eligible Individuals may improve or stabilise to the extent that they no longer meet the eligibility criteria for NHS Continuing Healthcare.

10.3 Where, upon reassessment, evidence no longer supports an individual's eligibility for NHS Continuing Healthcare, or where evidence supports the moving from NHS Funded Nursing Care (FNC) to NHS Continuing Healthcare (CHC), the Commissioner will review the case before making a decision and communicating this to the individual and or where appropriate their family or carer.

10.4 Details of individuals no longer eligible or newly eligible for NHS CHC will, with the consent of the individual, be forwarded to the Adult Social Services within the Local Authority so that an assessment can be arranged to determine the extent to which the individual may qualify for Social Services funded care.

10.5 The CCG will liaise effectively and with sufficient notice with the Local Authority to ensure that any transition of responsibilities for commissioning care services are coordinated effectively by an appointed Case Manager and that there are no gaps in care provision.

10.6 Individuals no longer eligible for NHS CHC may be eligible for NHS FNC which will be considered by the CCG in accordance with The National Framework.

10.7 The CCG reserves the right to review the care setting following a change in circumstance in line with the provisions of this Policy.

11 Right to Refuse

11.1 An individual is not obliged to accept the CCG's offer of care. The CCG will have discharged its duty to individuals by making an offer of a suitable CHC care package whether or not individuals choose to accept the offer.

11.2 For example, the CCG may discharge its duty by offering to provide a package of services for an individual in one or more appropriate care settings, irrespective of whether this is the individual's preferred location.

11.3 If the CCG's offers of appropriate care packages are refused by the individual or someone with legal authority to act on behalf of the individual, the CCG will have recourse to local Safeguarding Policies and Procedures and the Mental Capacity Act, as appropriate.

11.4 Where an individual exercises their right to refuse, the CCG will ask the individual or their representative(s) to sign a written statement confirming that they are choosing not to accept the offer of care provision.

12 Exceptional Circumstances

12.1 The CCG accepts that, on occasion, there are exceptional circumstances which can affect the normal decision making process as outlined within this Policy. The grounds for and appropriateness of exceptionality, will be determined by the individual merits of each case by the CCG. The CCG may invoke a referral to a specially convened meeting of the AFCP (the Panel) to decide on any exceptional circumstances. There can be no exhaustive description of the situations which are likely to come within the definition of exceptional circumstances. The onus is on the Individual making the request to set out the grounds for exceptionality clearly for the panel.

12.2 Exceptional refers to a person to whom the general rule should not apply. This implies that there is likely to be something about their assessed needs/situation which justifies funding for a patient which is not routinely available to other patients and is not part of the established care pathway contained within this policy. As a general principle in making a case for exceptionality, the patient or their representative must demonstrate that the patient is significantly different to the general population of patients with the condition or assessed needs in question and that the patient is likely to gain

significantly more benefit from the intervention that might normally be excepted for patients with that condition or those assessed needs.

13 Reviewing Panel

13.1 The CCG will review and consider all high cost or complex packages of care by way of an Adult Funded Care Panel (AFCP or 'Panel') the evidence for and appropriateness of individuals to have their assessed care needs met through NHS funding.

13.2 The Panel will scrutinise the evidence gathered and where considered necessary, the Commissioner may request the wider MDT to undertake further assessment or to provide further evidence in regard to individuals' assessed needs.

14 Appeal

14.1 In line with its legal obligations, Government guidance and this Policy, the CCG will make a reasonable offer of care to Eligible Individuals. In the case of such offer either being considered to be inappropriate, unreasonable and/or unacceptable to the Eligible Individual, this should be notified to the CCG as soon as possible and in any event within 7 days, outlining the reasons or objections to the offer of care. Any appeal against a proposed package of care will not of itself delay any discharge from hospital or other setting, if that is clinically indicated. During the appeal process it may be necessary for the individual to reside in a step down / other placement until the outcome of the appeal and a final care setting has been determined. The commencement of an appeal will not in any way prejudice the Eligible Individual who will at all times be offered a package to meet their needs.

14.2 Upon receipt of a request to reconsider its offer of care, the CCG will review the request as soon as possible and in any event within 5 working days and arrange for a review to take place within 28 days depending on the reasons and clinical urgency in regard to the decision making process for that particular case and the relevant factors informing the decision. Any appeal against a proposed package of care will not of itself delay any discharge from hospital or other setting, if that is clinically indicated. During the appeal process it may be necessary for the individual to reside in a step down / other placement until the outcome of the appeal and a final care setting has been determined.

14.3 A decision taken by the AFCP will not be reviewed on the grounds that the individual or family or representative simply disagrees with the decision.

14.4 Appeals are not a re-hearing of the case or the decision itself, and panel decisions will only be reviewed on one or more of the following grounds:

i. Procedural inaccuracies and/or inconsistencies (i.e. the procedures outlined in this policy were not applied correctly or consistently when the decision was made).
ii. Irrationality (i.e. relevant factors were not taken into account or irrelevant factors were not excluded when the decision was made).
iii. Illegality (i.e. the decision making panel acted outside of its authority or the decision does not comply with the law).

15 Following its review, where the CCG determines to uphold its decision and offer of care, this will be confirmed to the Eligible Individual, advising of the further appeals process e.g. peer review by another CCG or Independent Panel Review and ultimately the Parliamentary and Health Ombudsman (PHSO). They will also inform the Eligible Individual of the right to make a formal complaint and how such complaint may be made in accordance with the NHS complaints process.

Report to:	**Joint Commissioning Committee**		
Date of meeting:	29th January, 2020		
Report of:	Mel Maguinness, Deputy Chief Officer CCG		
Contact officer:	Paul Beech	**Telephone number**	
Report title:	**DTOC and HOOP service, system supporting housing roles**		
confidential This report does contain information which warrants its consideration in the absence of the press or members of the public.			
Purpose:	This report provides an update and request to consider options for service continuation.		
Recommendations:	The Joint Commissioning Committee is recommended to:- • To consider the options and recommendation		
Decision:	Approve an option as set out in the report		
Background documents:	Year 1 Evaluation Report (appended)		
Date:			

DTOC and HOOP service, system supporting housing roles

Background

The Housing options for Older People (HOOP) and Delayed Transfers Of Care (DTOC) officers work together to provide an invaluable service to people in real need of support, guidance and practical assistance relating to housing issues.

The aim of the HOOP post is to work closely with people over 60 with a housing requirement to help find a solution to their housing needs and aspirations by enabling them to make informed choices. Such solutions may include moving to more suitable/appropriate accommodation or remaining in their current accommodation with additional support/services such as Technology Enabled Care, home improvements and Staying Well.

The aim of the DTOC post is to reduce the number of delayed transfer of care cases through proactive housing interventions and to prevent readmissions through appropriate interventions and support that helps the customer continue to remain living independently and safely at home.

Both services go hand in hand in allowing people to plan for the future to ensure they can access information on future housing options, enabling them to make informed decisions before a point of health and social care crisis.

Key outputs and outcomes; (see page 17 and 18 of the Year 1 Evaluation Report – appendix 1)

- Provide a single point of contact for housing to assist / co-ordinate hospital discharge to avoid multiple reporting to and from different services.
- Actively engage patients / families / carers to plan timely discharge at the earliest point of admission.
- Participate in multi-agency activity to assist a co-ordinated approach to meeting the client's needs to live independently at home.
- The DTOC officer has improved the key safe process which has ensured that the previous waiting time for this to be arranged (estimated conservatively as being an average of 5 days) has reduced to the same day.
- 65 cases were identified as reduced delay of hospital discharge where the support being given by the DTOC officer meant that the patient was more likely to be discharged from hospital once medically fit.
- Patients feel more confident to be discharged as DTOC/HOOP supports the individual during their hospital stay and after they leave hospital.
- 160 DTOC cases led to a reduced delay in hospital discharge being supported to move or stay in their own home.

Continuation of HOOP post

The Local Authority funded the 2-year pilot project for the HOOP post through the Bolton Care and Repair service. As a result of the evidence set out in the Year 1 evaluation report,

the Local Authority has recently committed to continue to fund the HOOP post and make the role permanent as part of the established Bolton Care and Repair Service.

Risk to Cessation of DTOC post

Bolton Community Homes (BCH) funded the 2-year pilot project for the DTOC post through BCH reserves. BCH are unable to commit to continuing to fund the project on a permanent basis due to embarking on supporting other projects.

The risks identified if the posts ends;

- Ensuring efficient and effective discharge from hospital is one of the key strategic objectives in Bolton's Locality Plan, as part of Transforming Urgent Care.
- Housing that is no-longer fit / suitable is a factor which can delay discharge and can also often result in re-admission.
- Would lead to more nursing staff time and social worker time being taken up trying to assist patients with housing issues to ensure they can be discharged when medically fit.
- Flow of patients through a hospital due to delays in discharge.
- Wasted investment in unnecessary care for every day that a patient is kept in hospital longer than necessary.
- Longer stays in hospital are associated with increased risk of infection, low mood and reduced motivation.
- Cannot ensure patients are discharged to suitable accommodation, that supports their health and wellbeing, which in turn can also prevent readmission.
- Patients would be medically fit but unable to leave hospital as their current property is unsuitable and there is no provision for their housing options to be explored.

Options

- **Option 1- To fund the DTOC post going forward at a cost of £47.5k per annum.**
- **Option 2- Not to fund the DTOC post and cease the operation of the service**

Recommendations

The DTOC post has shown benefits to the system as a whole and not one particular provider. To continue this support and integration of housing It is recommended to investigate options of a tripartite or quadripartite funding option in the system from the following organisations;

- **NHS Bolton CCG**
- **NHS Bolton Foundation Trust**
- **Bolton Council**
- **Bolton at Home**

To Note – If an agreement on funding can be reached, consideration to host organisation will need to be confirmed. Bolton at Home is willing to continue to host the role to provide continuity.

Report title:	Year 1 Evaluation of HOOP and DTOC Services

Purpose of the report:
To provide an evaluation of the HOOP (Housing Options for Older People) and DTOC (Delayed Transfer of Care) Service after year one of the two year pilot.

Bolton at Home

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1. Summary

1.1 Funding for the HOOP post for 2 years has come from the Care and Repair budget. Funding for the DTOC post for 2 years has been approved by the BCH board. Management costs are not included as these will be absorbed within existing structures. A breakdown of the cost of the HOOP and DTOC service can be found at section 5.

1.2 The service went live in July 18 after recruiting to the two posts, working on test cases and promoting the service from April 18.

1.3 In the first year of operation the service has received **484** referrals. Of these **213** were for HOOP and **271** for DTOC. It has become apparent within the first few months of operation that the Officers are providing a valuable service to both the health care and housing professionals and people who access the service. The service is providing a co-ordinated and joined up approach to offering high quality advice and practical solutions to allow people to either move to suitable accommodation or stay put in their own home.

1.4 In the first year we have estimated savings to the public purse of **£1,384,629** for a **£95k** investment which can be shown as for every **£1** that is invested, a minimum of **£14.50** has been saved. These savings are based on the benefits of supporting people to move into suitable accommodation or supporting them to stay in their own home, reduced stays in hospital and the wider benefits this brings to health and wellbeing. In addition there were **156** people who received advice and signposting about their current situation that will have benefits in the future.

1.5 The HOOP and DTOC service has made very real differences to people's lives in the short time that it has been operational. Both Officers in the posts are passionate about breaking down the barriers faced by people relating to health, social care and housing.

1.6 It is often hard to quantify some of the wider benefits the service brings to stakeholders and customers. Case studies have been included to try to bring to life the benefits of the service to supplement the information provided on the estimated savings to the public purse.

2. Introduction

2.1 The aim of the HOOP service is to work closely with people over 60 with a housing requirement to help find a solution to their housing needs and aspirations by enabling them to make informed choices. Such solutions may include moving to more suitable/appropriate accommodation or remaining in their current accommodation with additional support/services such as Technology Enabled Care, home improvements and Staying Well.

2.3 The aim of the DTOC service is to reduce the number of delayed transfer of care cases through proactive housing interventions and to prevent readmissions through appropriate interventions and support that helps the customer continue to remain living independently and safely at home.

2.4 Both services go hand in hand in allowing people to plan for the future to ensure they can access information on future housing options, enabling them to make informed decisions before a point of health and social care crisis.

2.5 The HOOP and DTOC officers work together to provide an invaluable service to people in real need of support, guidance and practical assistance relating to housing issues.

3. Service Delivery Framework

3.1 Two posts were recruited to:

Housing Options Advisor – Older People (HOOP)

- Based within Care and Repair working closely with housing services, health and social care colleagues as well as the voluntary and private sector to secure successful housing solutions for older people.

Housing Options Advisor – Delayed Transfer of Care (DTOC)

- Based at the Hospital working closely with the Hospital Discharge team to ensure housing solutions can be found for patients who cannot be discharged to their current home due to the home environment.

3.2 The HOOP and DTOC Service framework has similarities to the North Manchester model where intervention is based on three levels:

- **Level 1 -** Giving out general information on a one to many bases at a group or local event, this includes giving out leaflets and advice.
- **Level 2 -** One to one over the phone enquiries which require a greater level of information gathering, advice and support. Personal information will be required to enable the HOOP and DTOC officers to offer support and where necessary sign posting the customer to other services. Initial contact will include a brief assessment with the referrer/customer via phone or email
- **Level 3 -** Face to face assessment with the customer who requires a more in depth person centred housing solution. Liaising with other agencies on behalf of the customer either in the community or on a hospital ward

4. Outcomes of the Service

4.1 The following outcomes were identified for the service and have been used to shape service delivery and monitoring:

4.2 HOOP

- Older people enabled to retain independence as a result of making informed choices about accommodation and support and care needs
- Older people enabled to maintain good health and wellbeing, thereby avoiding accommodation related acute health problems for example falls; will be enabled to delay or avoid unnecessary care home admissions and reduce the length of time spent in hospital as a result of housing related issues.
- Support for older people across all tenures wishing to downsize to more suitable accommodation
- More effective use of family accommodation as a result of downsizing by older people to more suitable accommodation
- Access to expert advice and services to adapt and repair their homes thus improving safety and quality of life
- Access to information about local services and community networks which will enable older people to remain independent and active within their local community and therefore helping to reduce social isolation
- Support wider Bolton strategies such as Health and Wellbeing Strategy and Locality Plan in addition to the Greater Manchester Population Health Plan

4.3 DTOC

- Provide a single point of contact for housing to assist / co-ordinate hospital discharge
- Actively engage patients / families / carers to plan timely discharge at the earliest point of admission
- Develop pathways with related housing services, case manage, recording and monitoring to prevent re-admissions
- Avoid multiple reporting and 'ping pong' by different services of the same client
- Raise awareness with front line health and care staff. Develop appropriate information. Participate in promotional events
- Participate in multi-agency activity to assist a co-ordinated approach to meeting the client's needs to live independently at home
- Ultimately reduce DTOC by pro-active housing interventions
- Provide face to face assistance to older and more vulnerable clients who require re-housing (or links to HOOP project if that is implemented)
- Develop innovative solutions e.g. links with the voluntary sector to assist with issues such as social isolation, garden maintenance.
- Refer to other agencies when relevant e.g. GM Fire & Rescue
- Develop excellent working relationships and overcome issues such as data sharing
- Re-launch / links with Homeless Discharge Project
- Understand the housing options available and pathways and also understand the health processes relating to patent discharge
- Support and potentially resource ongoing work with regard to Hoarding.

5. Value for Money – Cost of the Service

5.1 The cost of the HOOP and DTOC Service is **£95k** for a 12month period.

(£47.5k per officer) See breakdown below:

Subjective Activity	Cost per officer (k)
Advisor salary cost incl. on costs	£36
Allowances incl. car / travel	£1
Admin / support incl. OD/HR/Finance	£5
Publicity	£1
IT (mobile working equipment, services and support)	£2.5
Total per annum	**£47.5 (per officer)**

Case Level	Number of Cases	Proportion of Officers' time spent on Cases (estimate)	Average cost per case (estimate)	Total Breakdown of costs
1	760	5%	£5.62	£4,275
2	103	10%	£83.00	£8,550
3	381	85%	£190.75	£72,675
Total spent on casework				**£85,500**
Plus 10% Estimated Cost of Operational Service Set-up Costs (i.e. Officer time not spent directly on casework e.g. performance data compilation)				£9,500
Total Spend				**£95,000**

The first 6 months saw more promotional work take place to publicise the service (level 1 casework) and make links with relevant services and Housing and Health professionals. As the referrals grew there was less need to promote the service so time spent on level 1 work reduced.

However, the officers still spend time attending meetings to ensure links remain strong with other health and housing professionals. There has also been a shift between the time spent on level 2 and 3 cases, with more level 3 cases received.

6. Referrals and Profile of Customers

6.1 Breakdown of referrals

Referral source	HOOP	DTOC	Overall
Hospital Discharge Team	4	187	191
Bolton at Home	53	14	67
Social worker	25	17	42
Adult social care	23	14	37
Voluntary/com sector	29	1	30
Staying well	23	-	23
Care and repair	8	10	18
Homelessness Team / Bolton Council	16	2	18
Mental health team/Health Service	14	12	26
Other	6	13	19
Self-referral/family referral	12	1	13
Total	**213**	**271**	**484**

6.2 Main reason for accessing the service

Main Reason	HOOP	DTOC	Total
Risk of homelessness	14	11	25
Hospital discharge	1	80	81
Want to move - home unsuitable	107	59	166
Health related issues	18	4	22
Social care related issues	3	4	7
Isolation/loneliness	11	1	12

Main Reason	HOOP	DTOC	Total
Seeking practical help	3	62	65
Care related issues	10	4	14
Housing related finance issues	5	7	12
Move closer to family	8	1	9
Issues with existing housing provider	5	6	11
Point of contact for housing options	0	20	20
Other	28	12	40
Total	**213**	**271**	**484**

6.3 Tenure of those accessing the service

Tenure	HOOP	DTOC	Total
General Housing - owner	77	85	162
General housing - private rented	25	20	45
General - social rented	75	82	157
Specialist housing - social	3	25	28
Sheltered housing - social	23	2	25
Care home - private	0	1	1
Care home - social	0	4	4
Shared ownership	1	0	1
Living with family/friends	5	1	6
Homeless	2	37	39

Tenure	HOOP	DTOC	Total
Lodger	0	8	8
Other	0	5	5
Unknown	2	1	3
Total	**213**	**271**	**484**

6.4 Destination tenure of those that moved

Tenure	HOOP	DTOC	Total
General Housing - owner	2	0	2
General housing - private rented	1	0	1
General - social rented	3	2	5
Specialist housing - social	6	4	10
Sheltered housing - social	24	2	26
Other	1	15 *	16
Total	**37**	**23**	**60**

*for example B&B, Hostel properties

Of the 60 number of people that moved 20 went from private accommodation to more suitable social housing. This means additional support can be given to these people with the aim of improving their health and wellbeing and reducing the need for other health services.

6.4 Outcomes

This table shows the main outcome for the customer when cases have been closed. (definitions for the outcomes can be found at Appendix 1).

Main Outcome	HOOP	DTOC	Total
Advice Given	86	70	156
Homelessness prevented	**4**	**3**	**7**
Improved financial position	**5**	**10**	**15**
Supported to move	**37**	**23**	**60**
Supported to stay	**23**	**54**	**77**
Reduced delay in hospital discharge	**1**	**83**	**84**
Not engaged with the service	7	4	11
Deceased	8	4	12
Other	-	10	10
Total	**171**	**189**	**360**

11 customers chose not to engage with the service after initial advice was given. This represents only 3% of the cases closed in the first year.

7. Savings and Additional Benefits of the Service

7.1 It is a challenge to measure savings and benefits of the service as savings are not cashable and some savings realised through the advice element of the service may be realised over a number of years. We have used case studies to demonstrate the real impact on people accessing the service and we have also looked at how we can demonstrate savings to public budgets in health, housing and social care.

7.2 We have identified potential savings due to assisting people to move into suitable accommodation and/or preventing people from needing to go into relatively high cost care or stay in hospital based on the outcomes measured in the above table (in bold) for each case. We have also identified savings made to discharging someone from hospital who would have been in for longer had it not been for the intervention of the DTOC officer.

7.3 We have used a combination of the AGMA model unit costs database and *Unit Costs of Health and Social Care* to calculate savings to the public purse.

7.4 Potential Savings Identified:

Benefits	Number of cases	Total savings
Cost savings through reduced use of residential care	24	**£683,176**
Cost savings through move from hospital to specialised housing	10	**£15,300**
Reduced cost of accidental falls	48	**£96,672**
Reduced delay in hospital discharge	84	**£88,740**
Ongoing social/health worker involvement	23	**£52,624**
Prevention of statutory homelessness	7	**£17,507**
Health professional time savings	160	**£12,123**
Improved well-being of individuals • Increased confidence / self-esteem • Reduced isolation • Positive functioning (autonomy, control, aspirations) • Emotional well-being	54	**£539,000**
Potential Savings Identified		**£1,505,142**
Less outgoings		
Cost of officers		**-£95,000**
General needs tenancies [1] (assuming full HB is being received)	5	**-£25,038**
Minor adaptations – key safes	19	**-£475**
Total savings		**£1,384,629**

- **Delay moving into residential care**

[1] *Private registered provider Social housing stock in England: Statistical Data Return 2017/2018, p3 cost of general needs rent per week.*

We helped **24** (over 60+) who had mobility issues and serious health problems move from general housing/living with family to sheltered/specialised housing.
If the move enabled these people to delay a move into residential care for 12 months this would be a saving of **£683,176** (based on residential costs minus cost of sheltered/specialised housing) LA Residential care cost £51,272. HA sheltered costs are £7852 per person per annum. [2]

We have assumed that the 7 home owners who we supported to move would be self-funders if going into residential care therefore we have reduced the cost of residential care in our calculations accordingly.

- **Move from hospital to suitable specialised housing**

We helped **10** patients move from hospital to suitable sheltered/specialised housing. If we assume that the intervention saved 5 bed days per case then this equates to **£15,300.**

- **Risk of falls**

35% **48** of those who we supported to move or to supported to stay in own home (with appropriate adaptations/support etc.) were identified in the initial risk assessment as having a risk of falling. If we make the assumption that if we had not helped them to move to suitable accommodation or stay in their own home with support that they would have fallen then this would equate to savings of **£96,672** based on the average inpatient costs of £2,014 for hospital admissions due to injuries from a fall (any type), people over 60.

- **Reduced delay in hospital Discharge**

Fitting key safes

Of these there were **19** key safes fitted – The DTOC officer has improved the key safe process which has ensured that the previous waiting time for this to be arranged (estimated conservatively as being an average of 5 days) has reduced to the same day. This means that individuals can be discharged from hospital more quickly. This leads to a positive impact on wellbeing, reduces potential risk of infection by staying in hospital and frees up bed spaces.

If we assume that in the 19 instances that key safes have been fitted they would have taken 5 days to fit without the DTOC officer intervening. This could have cost the NHS an extra **£29,070**. This is based on the cost of an excess bed for a non-elective inpatient per day (£306) [3]

Following case from hospital

65 cases were identified as reduced delay of hospital discharge where the support being given by the DTOC officer meant that the patient was more likely to be discharged from hospital once medically fit as patients feel more confident to leave as DTOC/HOOP supports the individual during their hospital stay and after they leave hospital.
Cautious estimate of 3 bed days per case saved (hospital). This would have cost the NHS an extra **£59,670** This is based on the cost of an excess bed for a non-elective inpatient per day (£306)

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[2] *Unit Costs of Health and Social Care 2010 p52 and 57*

1.9 Housing Association Sheltered for Older People costs (capital and revenue)
1.4 Local Authority residential care for older people (establishment costs)

[3] *Reference Cost Collection: National Schedule of Reference Costs - Year 2015-16 - NHS trust and NHS foundation trusts (https://www.gov.uk/government/publications/nhs-reference-costs-2015-to-2016), p10*

Customers can also go on to move house and receive further preventative work from HOOP.

- **Ongoing reduction in social worker involvement**

23 people who we supported to move, reduced the delay of their hospital transfer or supported to stay in their own home were referred by Adult social care or their social worker. If we calculate for these people due to HOOP and DTOC support that they are now having 1 hour less a week social work involvement this would save **£52,624** per year[4].

- **Prevention of statutory homelessness**

HOOP/DTOC officers ensured that **7** people who accessed the service did not need to present as homeless.
Homeless application - based on the average one-off and on-going costs associated with statutory homelessness this equates to £2,501 per case [5] and **£17,507** in total
This is just the cost based on processing the application. Benefits to the individual for their health and wellbeing and ongoing savings to NHS would be significantly higher.

- **Health professional cost savings**

The DTOC officer assists nursing staff and other stakeholders in reducing the delay of hospital discharge relating to housing issues. If the DTOC officer was not in post this would lead to more nursing staff time and social worker time being taken up trying to assist patients to ensure they can be discharged when medically fit. If we assume that the **160** DTOC cases that led to a reduced delay in hospital discharge, being supported to move or supported to stay in their own home resulted in a saving of 1 hour of nurses time and 1 hour of social worker time per case this would generate a saving of **£5083**[6] and **£7040** respectively.

- **Wellbeing enhanced and isolation reduced**

When a case is opened by the service the issues and risks experienced by the customer are recorded and these form the basis for the type of support the service can offer.

These issues can affect wellbeing although to fully understand this we would need to conduct a wellbeing assessment at the beginning of our involvement and on closure of the cases to clearly demonstrate this impact. This is being planned for future development of the service.

However, we can make some assumptions based on the additional outcomes recorded when cases are closed.

We recorded that **40** people had their wellbeing and independence enhanced and **14** had experienced reduced social isolation following intervention from the service. This does not include those that received advice through level 2 cases.

We also have only recorded these additional outcomes where we have worked intensively with customers and have been able to identify wellbeing and isolation issues being enhanced through discussions with customers and other stakeholders or through cases studies. We do not currently follow up further with customers after the case is

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[4] *Unit Costs of Health and Social Care 2018 p 139*
11.1 Social Worker (adult) – hour rate

[5] *(New Economy cost database) Research Briefing: Immediate costs to government of loss of home (Shelter 2012)*

[6] *Unit Costs of Health and Social Care 2018 pg 157*
13. Hospital-based nurses – hour rate

closed so there may be numerous more customers who go on to experience enhanced wellbeing and reduced feelings of social isolation in the near future.

The New Economy model apportions the cost benefits of improved well-being of individuals over the following areas per year [7]

- Increased confidence / self-esteem £3,500
- Reduced isolation £8,500
- Positive functioning (autonomy, control, aspirations) £3,500
- Emotional well-being £3,500

- **Costs of major adaptations**

14 customers were supported to stay in their own homes by the HOOP/DTOC officers by facilitating the arrangement of major adaptations through the Care and Repair service. Some of these costs can be offset by rehousing in difficult to let properties already adapted. In total we have referred 5 cases to Care and Repair which has led to a Disabled facilities grant cost of £28,552.94.

[7] (*New Economy cost database)Based on apportioning the willingness to pay value for the QALY impact of depression across all the domains of wellbeing as set out in the National Accounts of Wellbeing.*

8. Wider benefits

8.1 There are a number of wider benefits that have not been included within the cost savings above but can be attributed to input from the HOOP and DTOC services.

8.2 The service has helped customers to leave their larger general let tenancies and downsize to more appropriate sheltered properties which has freed up family accommodation.

8.3 Properties that have already been adapted and other hard to let homes are being let out to HOOP and DTOC customers due to the service matching particular needs to the properties available and then supporting customers to bid to get the right property for them. This reduces the time properties are left vacant.

8.4 Both officers have significantly improved links and co-ordination between key workers across health and housing. This is difficult to quantify but involvement from the officers in casework will reduce the involvement of stakeholders such as housing officers, housing options officers, support and sustainment and other hospital/social care staff have not been listed in the savings in section 7.

8.5 The service assists in sustaining tenancies as the officers help with financial barriers and signposting to other services.

8.6 Both officers act as key workers and advocates for the individual. This helps to empower individuals and also allows one point of contact for other key stakeholders which saves time and means a more streamlined service which benefits everyone involved.

9. Future development of the service

9.1 In future, it will be important to contact key stakeholders and customers to understand their experiences of the service. This would be possible by asking specific questions at key points of service provision. The feedback would help determine whether the service is under or over providing at each stage and help develop the offer to customers. This exercise will also help identify areas where potential savings could be made.

9.2 Initially, feedback would be collected from the main stakeholders, for example, those that make the most referrals. These individuals are assumed to have the most knowledge in relation to what works well and what could be improved. Following this exercise, direct customer feedback would also be useful. However, given the vulnerability of some service users, this would need to be handled with some sensitivity.

9.3 In addition, clearer measures of customer well-being could also be introduced. This exercise would involve measuring customer well-being through a pre-designed survey at the start and end of service provision. The changes in customer perception could be included as an outcome and ultimately a benefit of the service.

9.4 There is potential (with further resources) to contact people 6 months to a year after case closure to further understand the impact of the HOOP and DTOC services. This could also help to understand where people go following advice

given by the service in level 2 cases. This will help to evaluate how effective different types of interventions.

9.5 By evidencing the success of the pilot we can further present to bodies such as NHS, Heath and Housing Steering group and Bolton Community Homes (BCH) to attract funding to make the posts permanent and to bring the service into mainstream Bolton at Home services.

9.6 We are investigating opportunities to link in with Mental Health Services to offer similar support surrounding mental health hospital discharges. This could include signposting, advice and follow up case work which would include preventing readmission.

9.7 There are opportunities to work with Accident and Emergency to aid prevention of repeat visits to A&E by the same people. Offering support at this point may prevent admittance and reduce repeat visits.

9.8 Referrals are increasing and as the pilot moves on and the officers become more confident with the aims of the service, we can take on more cases. Added to this, the officers have created many networks that they can utilise when deciding the refer cases on to other agencies or indeed, closing the case as we have provided advice and information and set the customer up for accessing their rehousing options.

9.10 Linked to the above, as demand grows we need to look at future planning for the service with a view to introducing more posts into the service to meet our expected growing demand.

Appendix 1

Definitions for HOOP/DTOC Outcomes

When closing a case we need to consider the highest possible outcome achieved for the customer. This is the main outcome. Some guidance has been set out below to support the officers in making the decision at case closure.

Main Outcome	Description
Supported to move	The officer has actively worked to support the customer to move, working in partnership with the relevant services, to secure suitable accommodation. This will range from assisting the customer through the bidding process and securing a property to also include practical help to move.
Supported to stay in own home	This outcome is selected when the officer has ensured that the customer's home environment is improved to become suitable to avoid further stays in hospital, and/or to prevent a move to high cost housing. Examples include ensuring necessary repairs are completed at the home, adaptations are arranged to allow the customer to stay at home, enhancements to safety such as Careline are installed.
Homelessness prevented	This outcome is selected if the customer is homeless and the officer, in partnership with relevant services, secures suitable accommodation. This can also be selected if the officer works with the customer's landlord to prevent an eviction which would lead to the customer being homeless. If the Customer is identified as homeless in hospital and the officer signposts them to Housing Options or other relevant services but does not get involved in assisting to secure accommodation for the customer then Reduced Delay in Hospital Discharge is likely to be the highest outcome in these instances.
Reduced delay in hospital discharge	This outcome should be selected if the action taken by Officers directly results in a reduced delay in hospital discharge but the intervention would not meet the definition of supported to move or supported to stay in own home. Examples of this would be fitting a key safe which has the aim of speeding up the discharge process by allowing care/nursing staff immediate access which would mean they no longer needed to stay in hospital. Also, if we have made links to other services such as Housing Options or social services to ensure that they have help and support to enable the patient to be discharged safely and in a way that minimises the likelihood of them being re-admitted. Often just the knowledge that the DTOC officer is involved with the customer and links have been made to ensure they receive support when they are discharged means the customer is discharged earlier than if DTOC officer was not involved.
Improved financial situation	If the advice or actions given by the officers directly improves the customer's financial situation such as accessing and maximising suitable benefits, grants, payments or ensuring they are referred to

Main Outcome	Description
	other services and we work in partnership to ensure the customer's financial situation is improved.
Not engaged with service	This is when a referral is received by a family member or health/housing professional but after an initial conversation with the customer they decide not to pursue any further support on offer. If the officers work with the customer for more than just an initial conversation and they undertake casework defined as level 3, but the customer decides not to take up an offer of a property or adaptation etc. this would fall under Advice Given – as the customer has engaged with the service but made a decision not to accept the solution offered at this time.
Advice given	All Level 2 outcomes will be Advice Given based on the definition of level 2 cases – these will be signposting by nature. Any Level 3 Advice Given outcomes will be if none of the other outcomes listed are relevant and will include where level 3 casework has taken place and the main interventions of the officer have been to signpost and/or refer to the relevant services and make necessary links. Examples would include providing practical housing advice such as what options are available and referring on to partners, registering on Pinpoint and completing paperwork etc. to ensure that everything is in place to allow them to make informed decisions. Providing advice and practical assistance when the customer may not have the capacity to undertake tasks themselves.
Deceased	If the customer passes away before the intended outcome such as re-homing can take place but casework has taken place.
Other	Select other as a last resort but include a description so these outcomes can be reported.

Appendix 2 Case studies

Re-housed from nursing care
The client had been in nursing care for the 5 years and actively looking for a property for 3 years with support from various professionals.

They had been offered several properties over the last 3 years but none had been suitable to meet them social/physical and housing needs.

The OT referred the case and the DTOC officer worked with the allocated OT and social worker and within 10 weeks we had secured a property that met all the client's needs.

The client has now moved out of their nursing home bed and is living in the community after 5 years in nursing care, with a support package.

Supported to move and prevention of eviction
The referral route came via Homeless welfare. It was clear that due to the customer's current health condition and lack of support their would benefit from our new service. They were over 60 and had been served with a section 21 (Notice to quit by their private Landlord).

We went out to discuss and advise them on their housing options. We then sourced a suitable ready to let property in a sheltered under one roof scheme. We worked closely with key stakeholders to facilitate a swift move. We helped them to maximise their income.

The outcome of the service intervention is that within two weeks from referral the customer is settling well and making new friends and neighbours with the support of the their own Sustainment and Support Officer.

Reducing delay of hospital discharge
Patient lives in an Irwell Valley property they had already been in hospital 6 weeks and there discharged had already been delayed due to their own complex lifestyle.

The social worker was having an issue getting a key safe fitted this could have delayed this person discharged up to another 3 days. Officer arranged for a key safe to be fitted on the same day of referral ensuring the discharge could go ahead.

Both the DTOC officer and the social worker supported the person home as not to delay the discharge any further. They uncovered major financial safeguarding issues which were reported through appropriate channel.

DTOC officer liaised with the Irwell Valley Neighbourhood Housing Officer, who in turn gave them the number of their own Debt, Advice Support officer for Irwell Valley. Together with the social worker, debt and advice officer for Irwell Valley we supported this person to sort out their benefits, ensure they had food and electric.

The officer then registered the person on pinpoint and informed the social worker of the current Extra Care Housing vacancies. The social worker will support the person to secure an Extra Care Housing Flat.

Rehoused private tenant to social housing

Referral came from social worker a 60yr old man with terminal illness needing to find new home before the winter months set in as the property he is in doesn't have adequate heating which could endanger his life due to the strong treatment they were receiving.

Officer made first checks on Pinpoint to find that they were registered and high needs pending. Arranged a visit, contacted Landlord to ask if anything can be done to help with the heating but this is more due to the property being open plan as the heating is working fine. Officer negotiated terms of termination and also put this in writing for client to sign.

Officer established that there was an outstanding debt with the Housing Association they wanted to be rehoused to. They spoke to management in housing income management and came to an agreement with them. Then spoke to client who was happy with this. The client has now received a provisional offer for a sheltered bungalow and looking forward to moving in. Officer arranged for all references etc. and again liaised with landlord.

The client was referred via DTOC officer. He had been living in his car and now sofa surfing and also has a terminal condition. Officer contacted homeless welfare to see if they knew of the client and worked with them to understand his high needs due to him being homeless.

Officer kept in regular touch with him making sure he was aware of what homes were available. Explaining what type of property and where he bid on an Onwards sheltered property.

Officer went to check this out and spoke to the scheme manager as he wasn't sure if this would be for them with only just being 60yrs. They explained their findings and assured him that he would be fine there. The officer liaised with Onwards staff on his behalf.
A viewing was arranged and then the sign up and now the client is settling very well and according to the scheme manger last week 'he fits in great with the whole community and has brightened up the place and brought a new lease of life there"!

Comments from the client were "please do call round for a cuppa when you have chance as I wouldn't have considered moving into sheltered but it's the best thing I could have done, I'm really happy".

Appendix 3 – Stakeholder and customer feedback

Social worker feedback

- *I could not have done this on my own. I could focus on social care and you took care of all the rest. this made it a great experience for the person.*
- *You are the missing link, it's now health, social care and housing – it's all covered*
- *A brilliant and valued service that was the missing link. What did we do before you came. Please don't go away.*

Customer Feedback

- *Brilliant service. I cannot thank you enough you made want seemed an impossible task for me become true. I couldn't have done this on my own.*
- *Couldn't have done this without your support. You came along at a difficult time and just helped and supported me and my son in the most gracious but yet professional way possible.*

Staying Well Team

- *I wanted to tell you that your fast and friendly interventions have made such a difference to the clients that I have referred to you recently. It can be a very difficult and daunting prospect if you are an older person who has housing difficulties, many people think they just have to stay put and make the best of the situation because the online registration and bidding process is something they cannot engage in as they don't have a computer or they are not comfortable using one. You have helped my clients and literally changed their lives for the better.*

Report to:	**Joint Commissioning Committee**		
Date of meeting:	29th January 2020		
Report of:	Kate Smith, Transformation Lead		
Contact officer:	Kate Smith	**Telephone number**	
Report title:	**Joint Commissioning Committee Forward Plan**		
Not confidential This report does not contain information which warrants its consideration in the absence of the press or members of the public			
Purpose:	To update the JCC on future items for consideration and noting		
Recommendations:	To note the Forward Plan		
Decision:			
Background documents:			
Date:	29th January		

Consultation with other CCG/Council officers		
	CCG Officer	LA Officer
Finance	N/A	N/A
Legal	N/A	N/A
HR	N/A	N/A
Equality Impact Assessment required?	N/A- proposals wil be assessed individually.	

Standing Items		
Item	**SRO/Contact**	**Meeting**
Quarterly Financial Updates	Ian Boyle/Sue Johnson	Quarterly

Programmed Items		
Item	**SRO/Contact**	**Meeting**
Budget Forward Planning	Rachel Tanner/Su Long	February
Living Well at Home	Rachel Tanner	February
Future of Prevention and Carers Grants	Rachel Tanner	February
Autism Strategy	Rachel Tanner	March