Public Document Pack

Cabinet

Tuesday, 20th January, 2015
at 4.30 pm

PLEASE NOTE TIME OF MEETING

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Simon Letts, Leader of the Council
Councillor Stephen Barnes-Andrews, Cabinet Member for Resources and Leisure
Councillor Daniel Jeffery, Cabinet Member for Education and Change
Councillor Mark Chaloner, Cabinet Member for Children's Safeguarding
Councillor Satvir Kaur, Cabinet Member for Communities
Councillor Jacqui Rayment, Cabinet Member for Environment and Transport
Councillor Dave Shields, Cabinet Member for Health and Adult Social Care
Councillor Warwick Payne, Cabinet Member for Housing and Sustainability

(QUORUM – 3)

Contacts

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BACKGROUND AND RELEVANT INFORMATION

The Role of the Executive
The Cabinet and individual Cabinet Members make executive decisions relating to services provided by the Council, except for those matters which are reserved for decision by the full Council and planning and licensing matters which are dealt with by specialist regulatory panels.

The Forward Plan
The Forward Plan is published on a monthly basis and provides details of all the key executive decisions to be made in the four month period following its publication. The Forward Plan is available on request or on the Southampton City Council website, www.southampton.gov.uk

Implementation of Decisions
Any Executive Decision may be "called-in" as part of the Council's Overview and Scrutiny function for review and scrutiny. The relevant Overview and Scrutiny Panel may ask the Executive to reconsider a decision, but does not have the power to change the decision themselves.

Mobile Telephones – Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media
The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting

Southampton City Council's Priorities:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

Executive Functions
The specific functions for which the Cabinet and individual Cabinet Members are responsible are contained in Part 3 of the Council's Constitution. Copies of the Constitution are available on request or from the City Council website, www.southampton.gov.uk

Key Decisions
A Key Decision is an Executive Decision that is likely to have a significant:

- financial impact (£500,000 or more)
- impact on two or more wards
- impact on an identifiable community

Procedure / Public Representations
Reports for decision by the Cabinet (Part A of the agenda) or by individual Cabinet Members (Part B of the agenda). Interested members of the public may, with the consent of the Cabinet Chair or the individual Cabinet Member as appropriate, make representations thereon.

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take.

Smoking policy – The Council operates a no-smoking policy in all civic buildings.
Access – Access is available for disabled people. Please contact the Cabinet Administrator who will help to make any necessary arrangements.

Municipal Year Dates (Tuesdays)

2014	2015
17 June	20 January
15 July	10 February*
19 August	17 February
16 September	17 March
21 October	21 April
18 November	
16 December	(* Budget)

CONDUCT OF MEETING

TERMS OF REFERENCE
The terms of reference of the Cabinet, and its Executive Members, are set out in Part 3 of the Council's Constitution.

RULES OF PROCEDURE
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS
Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS
A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:
(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests
A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:
Any body to which they have been appointed or nominated by Southampton City Council
Any public authority or body exercising functions of a public nature
Any body directed to charitable purposes
Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making
All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and

- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

1 APOLOGIES

To receive any apologies.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

EXECUTIVE BUSINESS

3 STATEMENT FROM THE LEADER

4 RECORD OF THE PREVIOUS DECISION MAKING (Pages 1 - 6)

Record of the decision making meetings held on 16th December, 2014 attached.

5 MATTERS REFERRED BY THE COUNCIL OR BY THE OVERVIEW AND SCRUTINY MANAGEMENT COMMITTEE FOR RECONSIDERATION (IF ANY) (Pages 7 - 22)

Report of Chair of Overview and Scrutiny Management Committee, seeking a response to recommendations made by the Committee at the meeting held on 15th January 2015, regarding Decision Numbers:

- CAB 14/15 13741 - Future of the Respite service for adults with learning disabilities; and
- CAB 14/15 13739 - Future of Day Services in Southampton;

attached.

a Future of the respite service for adults with learning disabilities (Pages 23 - 48)

Report of the Cabinet Member for Health and Adult Social Care detailing recommendations for the future of the respite service for adults with learning disabilities, attached.

b Future of Day Services in Southampton (Pages 49 - 74)

Report of the Cabinet Member for Health and Adult Social Care detailing recommendations for the future of Day Services in Southampton, attached.

6 REPORTS FROM OVERVIEW AND SCRUTINY COMMITTEES (IF ANY)

There are no items for consideration

7 EXECUTIVE APPOINTMENTS

To deal with any executive appointments, as required.

8 QUESTIONS FROM MEMBERS TO CABINET MEMBERS

To consider any questions to the Executive from Members of the Council submitted on notice.

ITEMS FOR DECISION BY CABINET

9 RESPONSE TO THE HEALTH OVERVIEW AND SCRUTINY PANEL INQUIRY RECOMMENDATIONS ON THE IMPACT OF HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE ((Pages 75 - 106)

Report of the Cabinet Member for Health and Adult Social Care in consultation with the Cabinet Member for Housing and Sustainability detailing a response to the Health Overview and Scrutiny Panel's inquiry, attached.

10 SOUTHAMPTON LOCAL PLAN FOR THE BETTER CARE FUND (Pages 107 - 234)

Report of the Cabinet Member for Health and Adult Social Care, in association with Cabinet Members for Education and Change, Children's Safeguarding and Housing and Sustainability, seeking approval of the Southampton local plan for the Better Care Fund, attached.

11 EXCLUSION OF THE PRESS AND PUBLIC - CONFIDENTIAL PAPERS INCLUDED IN THE FOLLOWING ITEM

To move that in accordance with the Council's Constitution, specifically the Access to Information Procedure Rules contained within the Constitution, the press and public be excluded from the meeting in respect of any consideration of the confidential appendices to the following Item.

Appendices 2 and 3 of this report are not for publication by virtue of Paragraphs 3 and 7A of the Council's Access to Information Procedure Rules. It is not in the public interest to release this information as it would prejudice the Council's ability to contract with third parties and obtain best value when entering into competitive tenders with the market.

12 DOMICILIARY CARE RECOMMISSIONING ((Pages 235 - 384)

Report of the Cabinet Member for Health and Adult Social Care seeking approval to

award potential providers on the Framework Agreement for Domiciliary Care Services, attached.

Monday, 12 January 2015 Head of Legal and Democratic Services

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SOUTHAMPTON CITY COUNCIL
EXECUTIVE DECISION MAKING

RECORD OF THE DECISION MAKING HELD ON 16 DECEMBER 2014

Present:

Councillor Letts	Leader of the Council
Councillor Barnes-Andrews	Cabinet Member for Resources and Leisure
Councillor Jeffery	Cabinet Member for Education and Change
Councillor Chaloner	Cabinet Member for Children's Safeguarding
Councillor Kaur	Cabinet Member for Communities
Councillor Rayment	Cabinet Member for Environment and Transport
Councillor Payne	Cabinet Member for Housing and Sustainability

Apologies: Councillor Shields

48. FUTURE OF DAY SERVICES IN SOUTHAMPTON
DECISION MADE: (Ref: CAB 14/15 13739)

On consideration of the report of the Cabinet Member for Health and Adult Social Care and having received representations from parent carers, Southampton MENCAP, other interested organisations, Members of the Council and having taken into consideration recommendations from Overview and Scrutiny Management Committee, Cabinet agreed the following modified recommendations:

(i) To consider the responses received during a public consultation into the future of Southampton Day Services conducted between 24 July and 23 October 2014, outlined in Appendix 1.

(ii) To authorise the restructured Southampton Day Services service to cease service delivery out of two centres, (St Denys and Freemantle) and all satellite bases when all of their current service users have been supported to move to suitable alternative care settings and to restructure the remaining service to provide an alternative model of delivery that is fit for the future needs of Southampton residents and users.

(iii) To note that the needs of current service users and their carers will be thoroughly assessed prior to and following their moves to ensure that these needs continue to be met and to reduce any impact on their wellbeing.

(iv) To note that if the proposal is agreed to undertake a 45 day consultation with affected staff with a view to minimising or avoiding compulsory redundancies.

(v) To note that a further review may be required into alternative delivery models following a restructure.

(vi) To delegate authority to the Cabinet Member for Health and Adult Social Care following consultation with the Leader and the Director, People to do anything necessary to give effect to the proposals in this report.

(vii) To approve the establishment of a dedicated team of experienced social work practitioners (from existing resources) to complete a thorough assessment of the

needs of all individuals who currently receive a directly provided day and, or, respite service and that the anticipated outcome of these assessments will be:

(a) The individual will be deemed not to have eligible social care needs and so will be signposted to access universal or other appropriate services or support;

(b) The individual or their representative will choose to receive a Direct Payment and will use this to purchase the care and support needed to meet their eligible social care needs; or

(c) The council will commission the care and support needed to meet an individual's eligible social care needs on their behalf.

(d) The council will then seek to carry out an annual assessment of individuals' and carers' needs.

(viii) To note that it is anticipated that the assessments will be completed by 28 February 2015.

(ix) To note that no service will be closed or withdrawn until all assessments have been completed and individuals with eligible social care needs have been supported to move to suitable alternatives.

(x) To require a progress report at the Cabinet meeting in March 2015.

(xi) To note that the commissioning of any new service will involve engagement with service users and carers.

(xii) To authorise support for those service users and their carers (who need it) wishing to take a Direct Payment, provided either by the council or a contracted third party.

49. FUTURE OF THE RESPITE SERVICE FOR ADULTS WITH LEARNING DISABILITIES

DECISION MADE: (Ref: CAB 14/15 13741)

On consideration of the report of the Cabinet Member for Health and Adult Social Care and having received representations from parent carers, Southampton MENCAP, other interested organisations, Members of the Council and having taken into consideration recommendations from Overview and Scrutiny Management Committee, Cabinet agreed the following modified recommendations:

(i) To consider the responses received during a public consultation into the future of respite services for adults with learning disabilities conducted between 24 July and 23 October 2014, outlined in Appendix 1.

(ii) To note the intention to move the provision of respite care towards individual packages of care that make increased use of direct payments through a range of alternative options including shared lives and short breaks.

(iii) To note that the needs of current service users will be thoroughly reviewed prior to and following their moves to ensure that these needs continue to be met and to reduce any impact on their wellbeing.

(iv) To authorise a phased closure of Kentish Road beginning with supporting clients with lower needs, followed by those with higher needs to access alternative respite options with a clear focus on more personalised support being accessed and resulting in the eventual total closure of the Kentish Road service by April 2015.

(v) If the proposals are agreed to undertake a 45 day consultation with affected staff with a view to minimising or avoiding compulsory redundancies.

(vi) To delegate authority to the Cabinet Member for Health and Adult Social Care following consultation with the Leader and Director, People to do anything necessary to give effect to the proposals in this report.

(vii) To approve the establishment of a dedicated team of experienced social work practitioners (from existing resources) to complete a thorough review of the needs of all individuals who currently receive a directly provided day and, or, respite service and that the anticipated outcome of these reviews will be:

  (a) The individual will be deemed not to have eligible social care needs and so will be signposted to access universal or other appropriate services or support;
  (b) The individual or their representative will choose to receive a Direct Payment and will use this to purchase the care and support needed to meet their eligible social care needs; or
  (c) The council will commission the care and support needed to meet an individual's eligible social care needs on their behalf.

(viii) To note that it is anticipated that the reviews will be completed by 28 February 2015.

(ix) To note that no service will be closed or withdrawn until all reviews have been completed and individuals with eligible social care needs have been supported to move to suitable alternatives.

(x) To require a progress report at the Cabinet meeting in March 2015.

50. FUTURE OF WOODSIDE LODGE RESIDENTIAL CARE HOME

DECISION MADE: (Ref: CAB 14/15 13737)

On consideration of the report of the Cabinet Member for Health and Adult Social Care, and having received representations from residents relatives and an interested organisation, Cabinet agreed the following:

(i) To consider the responses received during a public consultation into the future of Woodside Lodge conducted between 24 July and 23 October 2014, outlined in Appendix 1.

(ii) To close Woodside Lodge when all of its current residents have been supported to move to suitable alternative care settings.

(iii) To note that the needs of current residents will be thoroughly reviewed prior to and following their moves to ensure that these needs continue to be met and to minimise any impact on their wellbeing.

(iv) If the proposals are agreed to undertake a 45 day consultation with affected staff with a view to minimising or avoiding compulsory redundancies.

(v) To note that a full appraisal of the buildings and site will be commissioned to inform options for their future use or disposal.

(vi) To delegate authority to the Director, People following consultation with the Cabinet Member for Health and Adult Social Care to do anything necessary to give effect to the proposals in this report.

SOUTHAMPTON CITY COUNCIL
EXECUTIVE DECISION MAKING

RECORD OF THE DECISION MAKING HELD ON 16 DECEMBER 2014

Present:

Councillor Letts	Leader of the Council
Councillor Barnes-Andrews	Cabinet Member for Resources and Leisure
Councillor Jeffery	Cabinet Member for Education and Change
Councillor Chaloner	Cabinet Member for Children's Safeguarding
Councillor Kaur	Cabinet Member for Communities
Councillor Rayment	Cabinet Member for Environment and Transport
Councillor Payne	Cabinet Member for Housing and Sustainability

Apologies: Councillor Shields

51. CHANGES TO EXISTING REVENUE AND CAPITAL BUDGETS

DECISION MADE: (Ref: CAB 14/15 13646)

On consideration of the report of the Cabinet Member for Resources and Leisure, Cabinet agreed the following:

(i) To note that the Hampshire Chamber of Commerce has requested a contribution of £50,000 to meet the costs of engaging a 3rd party consultant to progress the setting up of a Business Improvement District in Southampton.
(ii) To approve the contribution of £50,000 for this purpose in 2014/15 to be funded from a draw from contingencies. If the BID is successful this contribution will be repaid in full.

52. TOWNHILL PARK REGENERATION- SCHEME APPROVAL TO DEMOLISH PROPERTIES IN PHASE 1 AND OTHER MATTERS

DECISION MADE: (Ref: CAB 14/15 13966)

On consideration of the report of the Cabinet Member for Housing and Sustainability, Cabinet agreed the following:

(i) To delegate authority to the Director, Place, in consultation with the Chief Financial Officer to accept grant funding of £750,000 from the Affordable Housing Programme 2015 – 2018 from the Homes and Communities Agency to part fund phase one of the redevelopment of Townhill Park and enter into the affordable housing grant funding agreement as a member of the Wayfarer Consortium.
(ii) To serve Final Demolition Notices on any secure tenants remaining in occupation of properties on the phase one redevelopment sites.
(iii) To approve (once vacant possession and planning permission has been obtained) the demolition of the buildings and structures on the land hatched in black in Appendix 1.

(iv) To authorise the Estate Regeneration Project Manager responsible for managing the Townhill Park Redevelopment project in consultation with the (Interim) Planning & Development Manager and the Highways Manager to make the necessary applications for highway/ footpath stopping up and/or diversion orders in respect of the Paulet Close / Meggeson Avenue footpath, the Roundhill Close / Townhill Way footpath and Roundhill Close and Townhill Way including footways, verges and carriageway within the site identified in the plan at Appendix 1.

(v) To delegate authority to the Director, Place following consultation with the Head of Housing Services, Head of Development, Economy & Renewal and the Cabinet Member for Housing and Sustainability to submit a planning application for redevelopment of phases one, two and three of the Townhill Park regeneration.

(vi) To authorise the Director, Place, following consultation with the Head of Legal and Democratic Services and the Chief Financial Officer, to take all lawful steps to effect the proposals in the report.

53. SALE OF LONG LEASEHOLD 22 - 28 ABOVE BAR SOUTHAMPTON

DECISION MADE: (Ref: CAB 14/15 14145)

On consideration of the confidential report of the Cabinet Member for Resources and Leisure, Cabinet agreed the recommendations set out in the report.

DECISION-MAKER:		CABINET		
SUBJECT:		CALL IN OF EXECUTIVE DECISIONS: • CAB 14/15 13741 - FUTURE OF THE RESPITE SERVICE FOR ADULTS WITH LEARNING DISABILITIES • CAB 14/15 13739 - FUTURE OF DAY SERVICES IN SOUTHAMPTON		
DATE OF DECISION:		20 JANUARY 2015		
REPORT OF:		CHAIR OF THE OVERVIEW AND SCRUTINY MANAGEMENT COMMITTEE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**mark.pirnie@southampton.gov.uk**		
Director	**Name:**	**Suki Sitaram**	**Tel:**	**023 8083 2060**
	E-mail:	**Suki.sitaram@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The Overview and Scrutiny Management Committee (OSMC) called in the decisions made at the Cabinet meeting on 16th December 2014 relating to the future of the respite service for adults with learning disabilities, and the future of day services in Southampton.

The Call-ins are to be heard at a meeting of the OSMC on 15th January 2015 and the recommendations generated by the OSMC will be circulated to Cabinet at the conclusion of the meeting.

At its meeting on 20th January 2015 the Cabinet is requested to respond to the recommendations generated by the OSMC, following its consideration of these matters.

RECOMMENDATION:

(i) That Cabinet considers its response to the recommendations made by the Overview and Scrutiny Management Committee at its meeting on 15th January 2015.

REASON FOR REPORT RECOMMENDATIONS

1. To comply with the Call-in procedure rules set out in Part 4 of the Council's Constitution.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. A Call-in notice, signed by the Chair of the OSMC, was received in accordance with Paragraph 12 of the Overview and Scrutiny Procedure Rules set out in Part 4 of the Council's Constitution. The Call-in notice relates to the decisions made by the Cabinet on 16th December 2014 relating to the future of the respite service for adults with learning disabilities, and the future of day services in Southampton. The reason cited by the Chair of the OSMC for this Call-in was 'insufficient consideration of consultation feedback'.

4. The OSMC are to discuss the Call-in report at its meeting on 15th January 2015. Details of the Call-in notice are attached as Appendix 1, and recommendations agreed by the OSMC will be circulated to Cabinet for consideration at the 20 January 2015 meeting.

5. The Cabinet is requested to consider the recommendations arising from the consideration of the Call-ins by the OSMC.

RESOURCE IMPLICATIONS

Capital/Revenue

6. As detailed in the Cabinet reports dated 9th December 2014 appended to this report.

Property/Other

7. As detailed in the Cabinet reports dated 9th December 2014 appended to this report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. As detailed in the Cabinet reports dated 9th December 2014 appended to this report.

9. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

10. As detailed in the Cabinet reports dated 9th December 2014 appended to this report.

POLICY FRAMEWORK IMPLICATIONS

11. As detailed in the Cabinet reports dated 9th December 2014 appended to this report.

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Call In Notice
2.	Decision Notice – Future of the Respite service for adults with learning disabilities
3.	Decision Notice – Future of Day services in Southampton
	Agenda Item 5a (20th January 2015 Cabinet Meeting) - Future of the Respite service for adults with learning disabilities
	Agenda Item 5b (20th January 2015 Cabinet Meeting) - Future of Day services in Southampton

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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NOTICE OF CALL-IN

In accordance with rule 12 of the Overview & Scrutiny procedure rules of the Council's Constitution, a request is hereby made that the Head of Legal and Democratic Services exercise the call-in of the decision identified below for consideration by Overview and Scrutiny Management Committee.

Decision Numbers: 1. CAB 14/15 13741 - FUTURE OF THE RESPITE SERVICE FOR ADULTS WITH LEARNING DISABILITIES 2. CAB 14/15 13739 - FUTURE OF DAY SERVICES IN SOUTHAMPTON
Decision Taker: Cabinet
Date of Decision: 16/12/14

Reason(s) for Requisition of Call-In of Decisions:

Insufficient consideration of consultation feedback

Call-In Requested by:

Name	Signature	Date
Councillor Moulton	JMoulton	22/12/14

All Members requesting that a Decision be Called-In must sign this Call-In Notice. A decision may be called in by:

- The Chair of Overview and Scrutiny Management Committee
- Any 2 Members of Overview and Scrutiny Management Committee
- In respect of a Decision relating to Education, any 2 Parent Governor or Church Representatives

Please submit to the Head of Legal and Democratic Services within 5 clear days of the publication of the relevant decision.

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RECORD OF EXECUTIVE DECISION

Tuesday, 16 December 2014

Decision No: (CAB 14/15 13741)

DECISION-MAKER:	CABINET
PORTFOLIO AREA:	CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE
SUBJECT:	FUTURE OF THE RESPITE SERVICE FOR ADULTS WITH LEARNING DISABILITIES
AUTHOR:	Stephanie Ramsey

THE DECISION

MODIFIED RECOMMENDATIONS:

(i) To consider the responses received during a public consultation into the future of respite services for adults with learning disabilities conducted between 24 July and 23 October 2014, outlined in Appendix 1.

(ii) To note the intention to move the provision of respite care towards individual packages of care that make increased use of Direct Payments through a range of alternative options including shared lives and short breaks.

(iii) To note that the needs of current service users and their carers will be thoroughly assessed prior to and following their moves to ensure that these needs continue to be met and to reduce any impact on their wellbeing.

(iv) To authorise a phased closure of Kentish Road beginning with supporting clients with lower needs, followed by those with higher needs to access alternative respite options with a clear focus on more personalised support being accessed and resulting in the eventual total closure of the Kentish Road service by April 2015.

(v) To note that if the proposal is agreed to undertake a 45 day consultation with affected staff with a view to minimising or avoiding compulsory redundancies.

(vi) To delegate authority to the Cabinet Member for Health and Adult Social Care following consultation with the Leader and the Director, People to do anything necessary to give effect to the proposals in this report.

(vii) To approve the establishment of a dedicated team of experienced social work practitioners (from existing resources) to complete a thorough assessment of the needs of all individuals who currently receive a directly provided day and, or, respite service and that the anticipated outcome of

these assessments will be:

(a) The individual will be deemed not to have eligible social care needs and so will be signposted to access universal or other appropriate services or support;

(b) The individual or their representative will choose to receive a Direct Payment and will use this to purchase the care and support needed to meet their eligible social care needs; or

(c) The council will commission the care and support needed to meet an individual's eligible social care needs on their behalf.

(d) The council will then seek to carry out an annual assessment of individuals' and carers' needs.

(viii) To note that it is anticipated that the assessments will be completed by 28 February 2015.

(ix) To note that no service will be closed or withdrawn until all assessments have been completed and individuals with eligible social care needs have been supported to move to suitable alternatives.

(x) To require a progress report at the Cabinet meeting in March 2015. This report will include a list of costed options for respite care.

(xi) To note that the commissioning of any new service will involve engagement with service users and carers.

(xii) To authorise support for those service users and their carers (who need it) wishing to take a Direct Payment, provided either by the council or a contracted third party.

REASONS FOR THE DECISION

1. Traditional respite services have been matched to individuals instead of individual packages of care tailored to meet personal preferences and lifestyle. Kentish Road is a bed based service that offers planned and emergency respite for up to 8 people at a time. Users have limited choice about when to receive their respite and who else will be using the service at the same time. Increasing incidences of users with higher level needs requiring increasing amounts of respite limit the capacity available to other users.
2. The need to move towards more personalised forms of care, where individuals can exercise more choice and control over the support and services they access is a priority both locally and nationally. In concert with this, the requirement to offer direct payments to individuals is national policy. The council currently performs in the bottom three of all councils nationally around this performance indicator, with our take up rate of direct payments currently standing at only 6% compared to a national average of 21.03% (data taken from Ascof outcome (1c(2) 2013/2014). The policy direction and imperative is to offer more personalised forms of care and in particular to offer direct payments and this continues to be a national driver as set out in the Care Act 2014 becoming a legislative requirement from April 2015.
3. There is significant evidence nationally that direct payments support people to

have increased choice, control, flexibility and an improved quality of life. They can provide bespoke solutions for unique needs which then improve outcomes for individuals. Improved outcomes can have a cost benefit by reducing the need for other services. Direct Payments cannot be used to purchase council run services.

4. The longer term viability of Kentish Road may be at threat even if no changes are made. This is due to an expected increase in the uptake of direct payments and evidence of people using their direct payment to purchase less traditional, more creative care solutions such as employing personal assistants, paying for community based activities or supported holidays. In the 14-18 years age group of those with a learning disability, who in the past may have been expected to access Kentish Road when they become an adult, the uptake of direct payments has increased from 12% in 2009/10 to 32% in 2014/15 and this trend is expected to continue over the next few years, particularly in light of the right to request a personal budget and focus on more personalised services brought in by the Children & Families Act 2014 and the Care Act 2014.
5. The statutory requirement to consult with service users, their families and other stakeholders has been fulfilled and although the overwhelming response from families was to keep Kentish Road open (77%), their comments have helped to ensure that all relevant factors have been taken into consideration.
6. Evidence from discussion with service users, their families and carers and with experienced social care practitioners shows that the development of services for individuals with the highest needs and most challenging behaviour will take time. It will also be important that users and their carers are confident in and comfortable with these alternatives. A phased approach supports this period of transition. A full Equality and Safety Impact Assessment has been carried out to identify the potential impact and mitigation of these proposals on servicer users and their carers and is attached as Appendix 2 for consideration.
7. The current provision of respite at Kentish Road is not the most cost effective way of providing respite. The 2014/15 unit cost, based on current occupancy, of an overnight stay at Kentish Road is £219 compared to an average cost of £53 for an overnight stay provided through the Shared Lives scheme.

DETAILS OF ANY ALTERNATIVE OPTIONS

1. The alternative option of keeping Kentish Road open to continue to provide services in the same way was considered and rejected for the reasons set out above. The current service does not meet the requirement to increase choice and control and promote individual approaches, nor does it provide best value which is a significant consideration within the current financial climate.
2. Consideration was given to a redesign of the current service. This option was rejected because it is not likely to support the full development of personalised care and the increased use of direct payments.

OTHER RELEVANT MATTERS CONCERNING THE DECISION

Cabinet took into consideration recommendations from the meeting of the Overview and Scrutiny Management Committee held on 4th December 2014.

CONFLICTS OF INTEREST

None

CONFIRMED AS A TRUE RECORD

We certify that the decision this document records was made in accordance with the Local Authorities (Executive Arrangements) (Access to Information) (England) Regulations 2000 and is a true and accurate record of that decision.

Date:16 December 2014	Decision Maker: The Cabinet
	Proper Officer: Judy Cordell

SCRUTINY

Note: This decision will come in to force at the expiry of 5 working days from the date of publication subject to any review under the Council's Scrutiny "Call-In" provisions.

Call-In Period expires on
Date of Call-in *(if applicable) (this suspends implementation)*
Call-in Procedure completed *(if applicable)*
Call-in heard by *(if applicable)*
Results of Call-in *(if applicable)*

RECORD OF EXECUTIVE DECISION

Tuesday, 16 December 2014

Decision No: (CAB 14/15 13739)

DECISION-MAKER:	CABINET
PORTFOLIO AREA:	CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE
SUBJECT:	FUTURE OF DAY SERVICES IN SOUTHAMPTON
AUTHOR:	Stephanie Ramsey

THE DECISION

MODIFIED RECOMMENDATIONS:

(i) To consider the responses received during a public consultation into the future of Southampton Day Services conducted between 24 July and 23 October 2014, outlined in Appendix 1.

(ii) To authorise the restructured Southampton Day Services service to cease service delivery out of two centres, (St Denys and Freemantle) and all satellite bases when all of their current service users have been supported to move to suitable alternative care settings and to restructure the remaining service to provide an alternative model of delivery that is fit for the future needs of Southampton residents and users.

(iii) To note that the needs of current service users and their carers will be thoroughly assessed prior to and following their moves to ensure that these needs continue to be met and to reduce any impact on their wellbeing.

(iv) To note that if the proposal is agreed to undertake a 45 day consultation with affected staff with a view to minimising or avoiding compulsory redundancies.

(v) To note that a further review may be required into alternative delivery models following a restructure.

(vi) To delegate authority to the Cabinet Member for Health and Adult Social Care following consultation with the Leader and the Director, People to do anything necessary to give effect to the proposals in this report.

(vii) To approve the establishment of a dedicated team of experienced social work practitioners (from existing resources) to complete a thorough assessment of the needs of all individuals who currently receive a directly provided day and, or, respite service and that the anticipated outcome of these assessments will be:

(a) The individual will be deemed not to have eligible social care needs and so will be signposted to access universal or other appropriate services or support;

(b) The individual or their representative will choose to receive a Direct Payment and will use this to purchase the care and support needed to meet their eligible social care needs; or

(c) The council will commission the care and support needed to meet an individual's eligible social care needs on their behalf.

(d) The council will then seek to carry out an annual assessment of individuals' and carers' needs.

(viii) To note that it is anticipated that the assessments will be completed by 28 February 2015.

(ix) To note that no service will be closed or withdrawn until all assessments have been completed and individuals with eligible social care needs have been supported to move to suitable alternatives.

(x) To require a progress report at the Cabinet meeting in March 2015.

(xi) To note that the commissioning of any new service will involve engagement with service users and carers.

(xii) To authorise support for those service users and their carers (who need it) wishing to take a Direct Payment, provided either by the council or a contracted third party.

REASONS FOR THE DECISION

1. The Council would like to develop a wider range of options for individuals who require support to access day opportunities, such as further developing a wider range of commissioned services and supporting service users to access existing community facilities through greater use of direct payments and personal budgets, instead of directly providing care and support.
2. Traditional day services have been matched to individuals instead of individual packages of care tailored to meet personal preferences and lifestyle. Services are currently delivered in 4 community centres (Sembal House, Woolston Community Centre, Freemantle Community Centre and St Deny's Community Centre) and 4 satellite bases (Nutfield, TFSR, Stella Maris and Wooden reflections), with users being exclusively people with assessed and eligible social care needs. While some progress has been made in moving away from traditional building based services, the service currently offered does not make best use of existing available community assets and services, and does not encourage inclusion into the wider community.
3. The need to move towards more personalised forms of care, where individuals can exercise more choice and control over the support and services they access is a priority both locally and nationally. In concert with this, the requirement to offer direct payments to individuals is national policy. The council currently performs in the bottom three of all councils nationally around this performance indicator, with our take up rate of direct payments currently standing at only 6% compared to a national average of 21.03% (data taken from Ascof outcome (1c(2) 2013/2014). The policy direction and imperative to

offer more personalised forms of care and in particular to offer direct payments continues to be a national driver as set out in the Care Act 2014 becoming a legislative requirement from April 2015.

4. There is significant evidence nationally that direct payments support people to have increased choice, control, flexibility and an improved quality of life. They can provide bespoke solutions for unique needs which then improve outcomes for individuals. Improved outcomes can have a cost benefit by reducing the need for other services. Direct Payments cannot be used to purchase council run services.
5. Whilst there is some alternative provision of day services of the required type and quality in Southampton, it is unlikely that this is able to meet all current and forecast demands. Service users currently accessing SDS have a range of differing levels of complexity of need and span a wide age range and it is not possible to tailor the existing service to meet everyone's individual needs and interests.
6. The longer term viability of SDS may be at threat if no changes are made. This is due to an expected increase in the uptake of direct payments and evidence of people using their direct payment to purchase less traditional, more creative care solutions such as employing personal assistants, paying for community based activities or supported holidays. In the 14-18 years age group of those with a learning disability – who in the past may have been expected to access SDS when they become an adult – the uptake of direct payments has increased from 12% in 2009/10 to 32% in 2014/15 and this trend is expected to continue over the next few years, particularly in light of the right to request a personal budget and focus on more personalised services brought in by the Children & Families Act 2014 and the Care Act 2014.
7. The statutory requirement to consult with service users, their families and other stakeholders has been fulfilled and although the overwhelming response was to keep SDS open, their comments have helped to ensure that all relevant factors have been taken into consideration.
8. Evidence from discussion with service users, their families and carers and with experienced social care practitioners shows that the development of services for individuals with the highest needs and most challenging behaviour will take time. It will also be important that users and their carers are confident in and comfortable with these alternatives. A phased approach supports this period of transition. A full Equality and Safety Impact Assessment has been carried out to identify the potential impact and mitigation of these proposals on servicer users and their carers and is attached at appendix 2 for consideration.
9. Consultation undertaken with staff during the formal consultation period suggested a desire to restructure the service. The proposals within this report have been developed in conjunction with SDS staff and reflect their views that the service needs to be restructured to provide a sustainable and desirable delivery model for the future.
10. If the proposals are agreed there will be full consultation with affected staff on the future structure and staffing model. Officers will also ensure that the implementation of agreed proposals will be done in conjunction with the current work on the Community Asset Strategy, as the pilot phase focuses on Council owned community centres.

DETAILS OF ANY ALTERNATIVE OPTIONS

1. The alternative option of keeping all services currently provided by SDS was considered and rejected for the reasons set out above.
2. The option of ceasing activity at all sites used by SDS was considered and rejected because there is recognition that further market development will be necessary to ensure that all service users can access appropriate services. In particular, it was recognised that those service users with the most complex and challenging needs, along with those service users who have been attending SDS services for a significant number of years, will require time and support to transition to alternative services, and that services for those service users with the highest needs are not currently widely available or with sufficient capacity to meet the likely needs of all of our existing service users.
3. The option of developing a social enterprise or other alternative delivery vehicle to provide the full range of services currently provided by SDS was considered and rejected because of the likely time it would take to develop an enterprise of the size and scale necessary. However, it was felt that this is an option that should be revisited in the future.

OTHER RELEVANT MATTERS CONCERNING THE DECISION

Cabinet took into consideration recommendations from the meeting of Overview and Scrutiny Management Committee held on 4th December 2014.

CONFLICTS OF INTEREST

None.

CONFIRMED AS A TRUE RECORD
We certify that the decision this document records was made in accordance with the Local Authorities (Executive Arrangements) (Access to Information) (England) Regulations 2000 and is a true and accurate record of that decision.

Date: 16 December 2015

Decision Maker:
The Cabinet

Proper Officer:
Judy Cordell

SCRUTINY
Note: This decision will come in to force at the expiry of 5 working days from the date

of publication subject to any review under the Council's Scrutiny "Call-In" provisions.
Call-In Period expires on
Date of Call-in *(if applicable) (this suspends implementation)*
Call-in Procedure completed *(if applicable)*
Call-in heard by *(if applicable)*
Results of Call-in *(if applicable)*

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DECISION-MAKER:	CABINET
SUBJECT:	FUTURE OF THE RESPITE SERVICE FOR ADULTS WITH LEARNING DISABILITIES
DATE OF DECISION:	9 DECEMBER 2014
REPORT OF:	CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE

CONTACT DETAILS

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STATEMENT OF CONFIDENTIALITY

NOT APPLICABLE

BRIEF SUMMARY

Cabinet is recommended to approve the phased closure of Kentish Road residential respite service, an 8 bed residential respite service for adults with learning disabilities, after taking into account the consultation findings and all relevant factors.

The report includes information on the current provision, the views expressed during the consultation period and the potential for alternative ways of meeting needs, including the range and capacity of alternative options within the local market.

RECOMMENDATIONS:

(i) To consider the responses received during a public consultation into the future of respite services for adults with learning disabilities conducted between 24 July and 23 October 2014, outlined in Appendix 1.

(ii) To note the intention to move the provision of respite care towards individual packages of care that make increased use of direct payments through a range of alternative options including shared lives and short breaks.

(iii) To note that the needs of current service users will be thoroughly reviewed prior to and following their moves to ensure that these needs continue to be met and to reduce any impact on their wellbeing.

(iv) To authorise a phased closure of Kentish Road beginning with supporting clients with lower needs, followed by those with higher needs to access alternative respite options with a clear focus on more personalised support being accessed and resulting in the eventual total closure of the Kentish Road service by April 2015.

(v) If the proposals are agreed to undertake a 45 day consultation with affected staff with a view to minimising or avoiding compulsory redundancies.

(vi) To delegate authority to the Director, People following consultation with the Cabinet Member for Health and Adult Social Care to do

anything necessary to give effect to the proposals in this report.

REASONS FOR REPORT RECOMMENDATIONS

1. Traditional respite services have been matched to individuals instead of individual packages of care tailored to meet personal preferences and lifestyle. Kentish Road is a bed based service that offers planned and emergency respite for up to 8 people at a time. Users have limited choice about when to receive their respite and who else will be using the service at the same time. Increasing incidences of users with higher level needs requiring increasing amounts of respite limit the capacity available to other users.

2. The need to move towards more personalised forms of care, where individuals can exercise more choice and control over the support and services they access is a priority both locally and nationally. In concert with this, the requirement to offer direct payments to individuals is national policy. The council currently performs in the bottom three of all councils nationally around this performance indicator, with our take up rate of direct payments currently standing at only 6% compared to a national average of 21.03% (data taken from Ascof outcome (1c(2) 2013/2014). The policy direction and imperative is to offer more personalised forms of care and in particular to offer direct payments and this continues to be a national driver as set out in the Care Act 2014 becoming a legislative requirement from April 2015.

3. There is significant evidence nationally that direct payments support people to have increased choice, control, flexibility and an improved quality of life. They can provide bespoke solutions for unique needs which then improve outcomes for individuals. Improved outcomes can have a cost benefit by reducing the need for other services. Direct Payments cannot be used to purchase council run services.

4. The longer term viability of Kentish Road may be at threat even if no changes are made. This is due to an expected increase in the uptake of direct payments and evidence of people using their direct payment to purchase less traditional, more creative care solutions such as employing personal assistants, paying for community based activities or supported holidays.

   In the 14-18 years age group of those with a learning disability, who in the past may have been expected to access Kentish Road when they become an adult, the uptake of direct payments has increased from 12% in 2009/10 to 32% in 2014/15 and this trend is expected to continue over the next few years, particularly in light of the right to request a personal budget and focus on more personalised services brought in by the Children & Families Act 2014 and the Care Act 2014.

5. The statutory requirement to consult with service users, their families and other stakeholders has been fulfilled and although the overwhelming response from families was to keep Kentish Road open (77%), their comments have helped to ensure that all relevant factors have been taken into consideration.

6. Evidence from discussion with service users, their families and carers and with experienced social care practitioners shows that the development of services for individuals with the highest needs and most challenging behaviour will take time. It will also be important that users and their carers

are confident in and comfortable with these alternatives. A phased approach supports this period of transition. A full Equality and Safety Impact Assessment has been carried out to identify the potential impact and mitigation of these proposals on servicer users and their carers and is attached as Appendix 2 for consideration.

7. The current provision of respite at Kentish Road is not the most cost effective way of providing respite. The 2014/15 unit cost, based on current occupancy, of an overnight stay at Kentish Road is £219 compared to an average cost of £53 for an overnight stay provided through the Shared Lives scheme.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

8. The alternative option of keeping Kentish Road open to continue to provide services in the same way was considered and rejected for the reasons set out above. The current service does not meet the requirement to increase choice and control and promote individual approaches, nor does it provide best value which is a significant consideration within the current financial climate.

9. Consideration was given to a redesign of the current service. This option was rejected because it is not likely to support the full development of personalised care and the increased use of direct payments.

DETAIL (Including consultation carried out)

10. Kentish Road is a CQC registered service providing short term respite for up to 8 people. This is to maintain the health and wellbeing of approximately 76 adults with learning disabilities and provide their carers with a break from their caring responsibilities.

11. The service is delivered from a large building at 32 Kentish Road in Shirley and a separate general needs house on the same site called 32b Kentish Road. This has three bedrooms and is used to support individuals with behaviour that severely challenges the service. Only one service user can be accommodated within 32b Kentish Road at any given time due to the building layout. In addition, there is a separate 3 bedroom house at 32a Kentish Road which is currently leased to the Police for £7,500 per annum. The site and properties are owned by the council.

12. A CQC inspection in October 2013 found the service to be compliant in all six standards that were inspected.

13. Access to the service is through a Care Management assessment and is for individuals with a learning disability aged between 18 and 65 years who live in their own home, with family or as part of the council's Shared Lives scheme.

14. Kentish Road is currently operating at around 73% capacity, this equates to around 2,126 nights out of a potential maximum capacity of 2,912 nights per year. The cost of an overnight stay at Kentish Road is £219 per night.

15. An analysis of the current Kentish Road service users was conducted in May 2014, using three broad support bands:

- Band 1 – individuals requiring support on an average 4 clients to 1 staff member basis. 33 clients (43%) were identified as requiring this level of support. This equates to 36% (853 night) of the total number of nights.
- Band 2 – individuals requiring occasional support on a 1 to 1 basis for particular activities. 21 clients (28%) were identified as requiring this

level of support. This equates to 23% (555 nights) of the total number of nights.

- Band 3 – individuals requiring regular 1 to 1 staffing to keep them safe and support them appropriately. 22 clients (29%) were identified as requiring this level of support. Resulting in 41% (983 nights) of the total number of night coming from this banding.

The allocation of overnight stays for individual service users ranges from 12 per year up to 80 per year, with an average of 31 nights each.

16. The decision to consult on the future of Kentish Road was based on the current cost of the service, the predicted future needs of service users and the national policy imperative to offer more personalised forms of care. Consideration was also given to the inflexibility of the current service and requests from service users and their families for increased options for respite services.

17. Cabinet approved a public consultation on the future of Kentish Road on 15 July 2014 and this ran from 24 July 2014 to 23 October 2014. During this time, the families and carers of users of Kentish Road were invited to attend six meetings held at Kentish Road on 7 August, 10 September and the 6 October 2014. These meetings were generally well attended and independent advocates were available to provide support. In addition, there were two public meetings held at the Civic Centre on 8 August 2014 and 22 October 2014. Information about the consultation was published on the council's website and was covered by the Daily Echo and BBC Radio Solent.

18. Copies of the notes taken at these meetings and all of the responses received are available in Members' rooms and these are summarised in Appendix 1.

19. A number of options for Kentish Road were presented during the consultation:

(a) for it to remain open.

(b) for it to be closed with current service users being supported to move to suitable alternative care settings such as Shared Lives.

(c) for users and their families to be offered a direct payment to be able to purchase their own form of respite care, for example, utilising a direct payment for short break provision or for a more suitable and tailored form of respite such as a supported family holiday.

(d) for care to be purchased for individuals requiring respite care in private or voluntary sector homes.

20. Independent advocates worked separately with the users of Kentish Road and were able to record the views of 28 service users. Of the responses gained with the help of advocates 9 individuals (32%) agreed that the council should look at different ways of meeting the needs of people who use respite services at Kentish Road. 3 individuals (10%) gave no reply or said they did not mind. The remaining individuals (16 or 58%) felt that the council should not make any changes the provision of respite services at Kentish Road. The majority of those who worked with advocates were positive about their experiences of Respite Services. A number made reference to the current value they gain from spending time with friends who also receive support from Respite Services.

21. In order to reduce reliance on more traditional building based forms of care, the development of a clear, easily accessible and attractive direct payment process is a key dependency. As previously noted, the council has not been

performing well in the take up of direct payments, and as part of the consultation two specific meetings were arranged to give families and carers a clearer understanding of direct payments, our Shared Lives scheme and the potential benefits of alternative forms of respite care. Alongside this work, a project is being undertaken with users, carers and partners to redesign our direct payment system.

22. Assessments of need will be carried out with all service users of Kentish Road and the options for future care and support will be considered. Analysis of capacity within the Shared Lives Scheme shows that there are currently 42 registered and approved carers with a further 3 carers going through the recruitment process and expected to be approved in December 2014. A recruitment campaign is currently being run, both helping to maximise knowledge and understanding of the Shared Lives scheme and to attract new carers. In addition, the council has agreed that carers living on the borders of Southampton but not technically within the city boundaries may also become registered Shared Lives carers and we have current expressions of interest from 4 carers who wish to be considered. Shared Lives carers undergo a rigorous application and selection process and receive the same training as staff based at Kentish Road.

23. Shared Lives is affiliated with National Shared Lives plus which offers support and guidance to all shared lives services across the UK. Shared lives is CQC regulated and subject to the same level of inspection and quality regulation as Kentish Road. A CQC inspection of Shared Lives in 2013 found the service to be compliant in all six standards that were inspected.

24. Eight existing Shared Lives carers have expressed interest in offering respite care for service users with learning disabilities. Shared Lives carers would be able to offer respite for up to 3 people at any given time, including offering respite to friendship groups. Shared Lives carers are not legally able to take more than three people at any one time. 3 Shared Lives carers offering respite provision would mean that all services users currently using Kentish Road with band 1 and 2 level needs would be able to be accommodated within the Shared Lives scheme at the same level of respite they currently receive. Initial assessments undertaken in May 2014 shows that there are currently 33 service users with band 1 needs and 21 with band 2 needs.

25. Analysis of market capacity for bed based respite provision shows that there is currently limited availability for those service users with the most complex needs (band 3). Some alternative bed based provision is available locally through Rose Road, although this service is usually used for respite provision for children. Initial discussions with Rose Road have shown that the provider is open to providing respite for adults and does currently accommodate some adults with learning disabilities.

26. Through moving all band 1 and 2 level service users to alternative provision, it is anticipated that the remaining 22 band 3 level users would be able to be accommodated within Kentish Road. This would allow time for further market options to be developed and for users to be transitioned in a managed and supported way by April 2015.

27. Within the current HASC Capital Programme the sum of £148,000 has been set aside to cover the costs of capital work and modernisation to Kentish Road. If the recommended option is agreed the funding for this scheme could be returned to Corporate Resources.

28. Closing Kentish Road does not impact on individuals' eligibility for support to meet their social care needs. The current criteria under the Fair Access to Care Services (FACS) scheme or, from 1 April 2015, under the Care and Support (Eligibility Criteria) Regulations 2014 will be applied and individuals with eligible needs that are best met through traditional forms of bed based respite will continue to be supported in Kentish Road whilst alternative market provision is developed.

RESOURCE IMPLICATIONS

Capital/Revenue

29. The budget report presented to Cabinet on 16th July 2014 identified that a review of the Council's provider services would be undertaken. This review and associated consultation has now been completed. It is now anticipated that the proposed closure of Kentish Road will achieve recurring savings of £200,000 from 2015/16.

30. The budget for Kentish Road is £365,000. The closure of the unit by 1st April 2015 will save this sum on a recurring basis excluding any residual costs such as rates and security, (£40,000) which will be incurred until the property is disposed of. In addition, as per the proposal in this report, an element of the saving from closure will be required to fund the cost of reprovision.

31. The cost of reprovision for the Band one and two clients within shared lives settings is anticipated to be £50,000 per year on a recurring basis at current volumes. The cost of reprovision for the band three clients is difficult to quantify with certainty as detailed assessments of clients' needs has not yet taken place. However it is expected that this cost can be met within a funding envelope of £75,000. This will enable the full achievement of the net saving of £200,000 proposed for 2015/16.

32. For 2016/17 it is anticipated that further market development and client reviews, this may further increase the overall saving. The level of this saving will not be known until these reviews are complete. Should it be identified that a further saving has been made this will be subject to another saving proposal.

33. If the proposal is agreed consultation with staff employed at Kentish Road will commence in January 2015 with a view to minimising or avoiding compulsory redundancies. There are currently 11.2fte posts within the funded establishment of which 4fte are vacant. This proposal will affect 8 people who could be subject to compulsory redundancy should alternative suitable employment not be found within the Council. It is anticipated that vacancies within People Directorate will help in the reduction of the number of compulsory redundancies arising from this proposal. The cost of any redundancies will be picked up within a central provision.

34. Funding of £148,000 for the Modernisation of Kentish Road scheme within the Capital Programme will not be required should this proposal be accepted. This sum can be returned to Council Resources to fund the alternative schemes within the Capital Programme.

Property/Other

35. Property Services will be commissioned to carry out a full appraisal of the building and site to inform options for their future use or disposal.

36. Through a phased approach to closure, it may be possible to dispose of 32a and 32b Kentish Road separately to the main Kentish Road site, although this decision will need to be informed by an up to date property appraisal and therefore no potential savings have been included in this report in relation to the disposal of property.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

37. When considering the recommendations and in particular the decision to close Kentish Road residential respite service the Council must take into account a number of factors, including:

The representations made during the consultation and any analysis of the consultation

The equality impact assessment bearing in mind its public sector equality duties as well as all other relevant information.

The effect on individual health, lives and well- being of service users and their carer's in having to use alternative respite services, particularly individuals who regularly use the unit

Consideration of any duty under the Human Rights Act 1998 so as not to act incompatibly with the rights under the European Convention for the Protection of Fundamental Rights and freedoms ("the Convention"). The Council will need to consider whether the proposed closure is likely to breach any of the service users rights e.g. Article 2 the right to life, Article 3 the right not to be subjected to torture or inhuman or degrading treatment and Article 8 the right to respect for a person's family life and their home. If this decision is likely to breach the convention the Council will need to examine any particular facts and determine if such a breach is justified and proportionate. The Council can though take into account general economic and policy factors which have led the Council to conclude that the home should be closed. This though must be balanced against the impact on the service users

38. The Care Act 2014 requires local authorities to prepare for implementation of the Act in April 2015. The recommended option of moving to a more personalised service approach would support greater compliance with the Care Act.

The Act though places various duties and responsibilities on Local Authorities about commissioning appropriate services. In particular all Local Authority should encourage a wide range of service provision to ensure that people have a choice of appropriate services, local authorities must ensure their commissioning practices and the services delivered on their behalf comply with the requirements of the Equality Act 2010 and should encourage services that respond to the fluctuations and

Changes in people's care and support needs.

The Care Act also places duties on Local Authority to carry out an assessment of any carers needs. This can include participation in education, training and recreation which may require the provision of respite for the adult they are caring for.

The Council has a number of statutory duties and powers to individuals under various pieces of legislation to assess individual needs and then to provide appropriate care, support and accommodation for the eligible needs.

The Care Act 2014 provides an updated legal framework for care and support and introduces a number of new rights, responsibilities and processes. All Local Authorities are now in the transition phase with parts of the Act coming into force in April 2015. When carrying out new assessment or when re-assessing individuals, the needs assessment must be carried out in line with the Care Act 2014. It would also be best practice when assessing the impact on carer's to ensure this is done in compliance with the 2014 Act.

Other Legal Implications:

39. The Children & Families Act 2014 which became law in September 2014 sets out how the education, health and social care needs of children and young people aged 0-25 years should be assessed and met. There may be some clients who will be affected by the proposed changes to Kentish Road who have Education, Health & Care Plans and for whom both the Care Act and Children & Families Act will apply.

40. If service users are moved from Kentish Road against their will, this is likely to constitute a prima facie breach of their rights under Article 8(1) the Council need to consider whether this breach can be justified as above.

In addition if any service user is subject to restraints that amount to a deprivation of liberty and no less restrictive options are available to meet that persons needs any planned move from the unit must be lawfully authorised either by the Deprivation of Liberty safeguards or by an order of the Court of Protection, whichever is appropriate.

There is a legal requirement to consult with staff where redundancies are contemplated. The 45 day consultation referred to earlier in this report will meet this requirement.

POLICY FRAMEWORK IMPLICATIONS

41. These proposals are aligned to the following priorities set out in the Council Strategy 2014-2017:

- Prevention and early intervention
- Protecting vulnerable people
- A sustainable council

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED: ALL

SUPPORTING DOCUMENTATION

Appendices

1. Summary of Consultation Responses
2. Equality and Safety Impact Assessment

Documents In Members' Rooms

1. Record of all the Consultation Responses Received

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out? Yes

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1. Adult Social Care Provider Services – Cabinet Report dated 15 July 2014 (Seeking Approval For A Public Consultation on the Future of Respite Services For Adults with Learning Disabilities	

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APPENDIX 1

Consultation on the future of Respite Services

Summary of responses received

Contents

1 Consultation approach

1.1 Relatives and carers of Kentish Road service users were invited to a meeting that took place at Kentish Road on Monday 7 July 2014. At the meeting, they were advised that Cabinet would be considering a proposal to hold a public consultation on the future of respite services, including Kentish Road respite service. A staff briefing was held on the same day at Kentish Road. A copy of the presentation was posted to relatives after the meeting.

1.2 Cabinet considered this proposal and approved a public consultation on the future of Respite Services on 15 July 2014 and this ran from 24 July 2014 to 23 October 2014. The consultation was covered by local media, including the local newspaper (Daily Echo) and local radio (BBC Radio Solent).

1.3 The schedule of meetings was published on the council's website and relatives and carers of Respite Service users were sent this by post with an invitation to attend. Staff were briefed so that they could give information about the proposals and the ways in which to respond. The schedule of meetings is attached at Appendix A.

1.4 A consultation document including a questionnaire was published on the council's website, where it could be downloaded, and was made available at all of the consultation meetings and from staff at Kentish Road. The consultation document is attached at Appendix B.

1.5 Six meetings for relatives and carers were held at Kentish Road on 7 August 2014, 10 September 2014 and 6 October 2014. Meetings were held on these days at 2pm and 6pm, to enable as many people as possible to attend. Representatives from Choices Advocacy and, or, Carers in Southampton attended these meetings and were able to support relatives, as required.

1.6 The format of the group meetings consisted of a presentation given by the Interim Head of Adult Services followed by a question and answer session. Notes of these meetings were taken and these are attached to Appendix A.

1.7 In addition to the six meetings held at Kentish Road, two public meetings were held at the Civic Centre at 6pm on 8 August 2014 and 22 October 2014. These meetings covered the proposals regarding Kentish Road along with separate proposals for the future of day services and the future of a residential home, Woodside Lodge. A verbatim record of these meetings, chaired by the Director of People, was made and this is attached to Appendix A. The Cabinet Member for Health and Adult Social Care also attended these meetings, along with representatives from Choices Advocacy (both meetings) and Carers in Southampton (the second meeting).

1.8 In addition to the above, a meeting for carers was hosted by Southampton Mencap (carers' lunch); two meetings were held with the council's partners and care providers; and meetings in public were held at Consult and Challenge (Spectrum Centre for Independent Living) and Southampton

Healthwatch. These meetings included the proposals for respite services along with those for day services and Woodside Lodge. Notes from these meetings have been placed in Members' rooms and are available on request.

1.9 Several briefings were also held for Members of the council and the consultation and proposals were considered at a meeting of the council's Overview and Scrutiny Management Committee (OSMC) on 11 September 2014. The minutes of this meeting are available online at http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=123&MId=2852&Ver=4

1.10 A dedicated email address was publicised on the council's website and at all of the meetings outlined above. Everyone who attended the meetings was invited to respond to the consultation in the way that best suited them, including a direct invitation to phone or write to the Interim Head of Adult Services or a member of the project team, whose contact details were included in the presentations.

1.11 Independent advocates from Choices Advocacy worked separately with the service users of respite and were able to record the views of 28 of its current service users, where appropriate.

2 Questionnaire responses

2.1 45 questionnaire responses were received related directly to respite services. The majority were received by users of respite services, two responses were from carer's of individuals who uses respite services. 28 of the responses were received from services users with the help and support of independent advocates. Ten responses (22%), from all completed questionnaires agreed that the way the council provide respite services should be reconsidered.

2.2 A small number of questionnaire responses contained questions. These requests have been summarised and the councils response is, as follows:

Comment	Council's response
The council requires more provisions like Kentish Road not fewer of them.	The council agrees that provisions such as Kentish Road are incredibly valuable. However the council believes that the way in which facilities like respite are provided has potential to be improved. This is why we are consulting with you and asking for how we might improve this valuable service, we are not consulting with you about whether or not respite services should be provided.
Individuals want a choice over what respite service is provided.	Changing the way respite is provided will allow all service users and their

	families a choice over how they receive respite. By changing the way we provide respite services we will be increasing the choice service users have not reducing it.
Concern that transport links to services will be lost.	The council believes that choice over services are imperative to ensure everyone is receiving the best care possible. This is why we are promoting choices such as direct payments. This means service users and families can prioritise what's important to them and therefore ensure services of greatest value to them are retained.
A number of responses suggest that people would prefer more time using respite facilities.	Through the take up of different services via direct payments people will be able to receive the service they really want as they will have a higher level of control over their own service.
People who receive services are not always in a position to manage their own finances which direct payments would require.	Direct payments do required a managed approach but this is not required to be the service user themselves. They are able to receive support from relatives and carers in this matter and are also able to, if they wish, use some of their finance to buy help to manage their direct payment.

2.3 From the responses received a number of themes emerged of areas respondents felt were of particular importance. These are summarised as follows:

- Undoubtedly the biggest concern expressed via questionnaire responses was the potential loss of friendship that may come as a result of changes in the way respite care is provided.
- Staff are a valuable resource and their skills cannot be lost. They know individuals and their care requirements very well.
- Transport to and from respite facilities are very important. Without this respite is not a viable service as it becomes inaccessible.
- Locations for respite are required on both sides of the city.
- Service users often struggle with change and this proposed change will have a big impact on them and take them time to settle into a new routine.
- The service is currently overstretched and therefore this provision should have capacity increased.

- A number of individuals also raised concerns that current decoration within the building could be improved.

3 Written responses

3.1 In addition to the questionnaire responses, 13 letters and emails from those who had links to respite services were received. The respondents included relatives of service users, carers of services users, social workers and managers contacting on behalf of service users as well as local voluntary sector groups.

3.2 The majority of responses were strongly in favour of ensuring respite facilities are retained as they are viewed as a valuable service. A number of people expressed concerns about where alternatives may be sourced from should Kentish Road facilities not be provided in their current state.

3.3 One respondent raised concerns with the manner in which the consultation had been conducted. The concern continued to explain finding materials on the council's website had been difficult. The respondent queried whether the consultation has been publicised well enough. The Councils response to this is that the consultation was listed on a dedicated page on the council's website. The consultation was also covered in the Daily Echo and by BBC Radio Solent.

3.4 Another respondent raised concerns that the council had not been clear about the alternatives that the council would provide. They felt that more information was require to allow those who would be effected by any change to make informed decisions. During the consultation process the council explained that earlier consultation exercises had highlighted the importance of working with service users and families to develop a range of alternatives which were co-produced. In order to facilitate this, co-production sessions ran alongside the consultation as a valuable source of information and ideas. Sessions which raised awareness and explained alternative options such as shared lives and direct payments were also organised by the council.

3.5 Concerns were also raised that following the consultation the council should ensure they interact with those effected by the changes to ensure that their needs are being met. The council's response to this is that any service user who is eligible to receive services is entitled to a statutory review of their needs. As a minimum these reviews must be carried out annually, although the frequency of review will depend on the level of need and risk, and will be agreed with the individual and/or their carer.

3.6 A couple of responses made reference to the fact that recent refurbishments had been made to Kentish Road and responses expressed concerns that this money could now be consider to have been 'wasted'.

3.7 A few responses made reference to other alternatives which currently exist such as arrangements like Shared Lives. While generally the use of Shared Lives was considered positive, concerns were raised about maintaining friendship groups and a social network.

3.8 One response raised concerns that respite provisions equal to Kentish Road does not exist within Southampton. In order to help those effected by any potential change understand alternative options that exist, new initiatives such as Southampton Information Directory were explained. The council also explained that social workers and care managers are good sources of information for what is available locally.

3.9 Two responses received suggested that those carers who currently benefit from the provision of respite services at Kentish Road should be required to volunteer. They suggest that this volunteering suggestion would reduce costs of staffing within Kentish Road.

3.10 The majority of responses were clear that respite facilities do not just bring benefits to the service users. They feel that the benefits brought to the carers are just as valuable and if such services were to be removed both carers and service users would suffer as a result.

3.11 Another theme of concern from respondents was that current transport provision surrounding respite services are very good. They feel that this is an element of respite which cannot be ignored as without it respite services do not exist as they are not accessible.

3.12 One respondent raised concerns that should the take up of personalised care options increase, in particular direct payments, that the finance team may not be able to cope with the demand. They suggested that at current levels payments were not always accurate.

3.13 One response was clear that they fully supported the council's consideration to look at alternatives in the way care is provided. They stated "we strongly support the council's decision to modernise the way they provide services. All disable people should be enabled to live their lives more independently with personalised services".

4 Meetings held at Respite Services

4.1 Notes from the meetings are attached to Appendix A.

5 Public meetings held at Civic Centre

5.1 Notes from the meetings are attached to Appendix A

6 Overview and Scrutiny Management Committee

6.1 The minutes of this meeting are available online at: http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=123&MId=2852&Ver=4

SOUTHAMPTON CITY COUNCIL

Equality and Safety Impact Assessment

The **public sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be e efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the council to better understand the potential impact of the budget proposals and consider mitigating action.

Name or Brief Description of Proposal	Future of respite service for adults with learning disabilities (Kentish Road) A consultation recently closed and recommendations are being put forward to Cabinet on 9th December regarding the future of Kentish Road respite service. No decisions have been made at this point.
Brief Service Profile (including number of customers)	Kentish Road is a CQC registered 8 bedded residential unit providing short term respite to meet the needs and maintain the health and wellbeing of approximately 76 adults with learning disabilities and provide their carers with a break from their caring responsibilities. Access to the service is managed through a Care Management assessment and is for individuals with a learning disability aged 18-65 years who live in their own home, with family or as part of the council's Shared Lives scheme. Around 2,100 nights are provided per year, with overnight allocations ranging from 12 up to 80 nights per year per person. A profile of the support band level and age range is set out below.

	<table><tr><th>Band</th><th>Description</th><th>No. service users</th></tr><tr><td>1</td><td>Individuals requiring support on an average 4 clients to 1 staff member basis</td><td>33 (43% of total)</td></tr><tr><td>2</td><td>Individuals requiring occasional support on a 1 to 1 basis for particular activities</td><td>21 (28%)</td></tr><tr><td>3</td><td>Individuals requiring regular 1 to 1 staffing to keep them safe and support them appropriately</td><td>22 (29%)</td></tr></table> <table><tr><th>Age range</th><th>No. service users</th></tr><tr><td>18-24</td><td>14 (18% of total)</td></tr><tr><td>25-34</td><td>22 (29%)</td></tr><tr><td>35-44</td><td>14 (18%)</td></tr><tr><td>45-54</td><td>15 (20%)</td></tr><tr><td>55-64</td><td>7 (9%)</td></tr><tr><td>65+</td><td>4 (5%)</td></tr><tr><td>Total</td><td>76</td></tr></table>
Summary of Impact and Issues	No decisions have been made at this time; however potential impacts to changes in the residential overnight respite provision at Kentish Road have been explored through the consultation. The proposed changes to the Kentish Road provision have the potential to affect services provided to adults with care and support needs including. • Adults with learning disabilities, • Adults with physical disabilities • Adults with sensory support needs • Carers of people in all the above groups. Issues identified so far include • Concerns expressed by service users and carers regarding loss of services resulting in more pressure on them. • Need to improve access to information on available services provided to adults with care and support needs

	and their carers All current service users will be entitled to an assessment and review of their care needs. The Care Act 2014 also promotes carers assessments. This will identify impact and required actions on an individual basis.
Potential Positive Impacts	Potential positive impacts of the review could be that respite provision becomes more flexible in meeting the needs of adults with care and support needs who meet the local authority eligibility criteria. The Care Act 2014, which becomes a legislative requirement in April 2015, emphasises the use of personal budgets to provide care and support to adults assessed as eligible for local authority funding. Personal Budgets have the potential to provide increased choice and control to more service users and their carers' in how they utilise the budget to meet their identified needs and outcomes. This supports people to have more bespoke solutions for their unique needs and this can improve outcomes for individuals.
Responsible Service Manager	Ricky Rossiter (operational Service Manager) Sandra Jerrim (Senior Commissioner)
Date	November 2014

Approved by Senior Manager	Stephanie Ramsey
Signature	
Date	20/11/14

Please note: this ESIA is a work in progress. Any revisions will be tabled at the Cabinet Meeting on 9 December 2014.

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	The greatest impact is likely to be on those older service users who have been using Kentish Road services for many years and for whom any change in provision will be difficult. Some of the younger service users may benefit from the flexibility that a personal budget offers and be able to take part in more personalised support which suits their particular circumstances, likes and dislikes.	Needs assessments and reviews will take place for all service user prior to any changes. Through this process information on alternatives will be made available. Where changes need to be made, a gradual approach will be taken to support those who will be most affected. Advocacy services are in place to help support the individual and ensure that the move is in their best interest.
Disability	All service users have learning disabilities and most also have physical disabilities. The recommendation may have either a positive or negative impact depending on the individual and the extent to which they prefer current models of service and their ability and interest in accessing other options such as direct payments Those with physical disabilities may experience a larger impact due to some of the alternative respite options (such as shared lives) not having the equipment to be able to support appropriately. A positive impact for some will be the freedom and flexibility to use their personal budget to meet their individual need	Needs assessments and reviews will be undertaken with all service users to identify their needs and eligibility for local authority funding. Service users and their carers will be supported to identify the most appropriate respite option which meets their physical needs. Individuals will be able to have a personal budget/take a Direct Payment, and be supported to do so, which will enable people to make arrangements to meet their individual need.
Gender Reassignment	Ni identified negative impacts. In House services can provide a safe environment for people who face multiple discrimination. Accessing mainstream activities may be more challenging due to	This can be mitigated by support to access alternative, appropriate services such as peer support and by working with other agencies to ensure al purchased and community services are accessible to

	stigma.	all communities.
Marriage and Civil Partnership	No identified negative impacts	
Pregnancy and Maternity	No identified negative impacts	
Race	The flexibility that personal budgets offer means that service users and carers will be able to arrange personalised services that are more culturally appropriate.	All service users will have an assessment prior to any service change which will include cultural issues.
Religion or Belief	The flexibility that personal budgets offer means that service users and carers will be able to arrange personalised services that are appropriate to their individual need including religion and belief.	All service users will have an assessment prior to prior to any of service change which will address matters of religion and belief
Sex	The flexibility that personal budgets offer means that service users and carers will be able to arrange personalised services and activities/support that is tailored to their needs including single gender services.	
Sexual Orientation	In House services can provide a safe environment for people who face multiple discrimination. Accessing mainstream activities may be more challenging due to stigma	This can be mitigated by support to access alternative, appropriate services such as peer support and by working with other agencies to ensure all purchased and community services are accessible to all communities.
Community Safety	National research identifies disabled people are more likely to experience crime and anti-social behaviour, than non-disabled people. There could be a negative impact on Individuals who feel safer accessing city council buildings in areas that they know and feel comfortable in. http://www.equalityhumanrights.com/sites/default/files/documents/disabilityfi/briefing_paper_3_new.pdf Local mechanisms for reporting Hate Crime and harassment are not	Assessments will consider community safety issues for individuals including service location. The Community Safety team works with a wide range of partners to address and provide a more resilient response to community safety issues. The Community Trigger gives victims and communities the right to require a multi-agency review and ensure that effective action is taken

	affected.	where an ongoing problem of persistent antisocial behavior has not been addressed.
Poverty	There are potential impacts if people have to travel further at extra cost to access their support. Alternatively people can chose to access more local services. Personal budgets provide flexibility for individuals, regardless of their economic situation. Having control of a personal budget via the mechanism of a direct payment may support some service users and carers to access more community based activities and develop community support networks as well as have control over their support and care.	All services users will have an assessment prior to any service change which will address these issues. Individuals will be given information and support to take up community based activities Costs of transport can be included in a personal budget/direct payment
Other Significant Impacts	Employment prospects for service users and carers may increase through having a personal budget and the flexibility to choose when support is needed most.	Needs assessments and reviews will be undertaken with all service users prior to any service changes. Identifying needs in respect of employment will be part of the re-assessment process.

Cabinet – 9th December 2014

Additional Recommendations to the following reports:

4 - Future of Day Services in Southampton
5 - Future of the Respite Service for Adults with Learning Disabilities

RECOMMENDATIONS

(vii) To approve the establishment of a dedicated team of experienced social work practitioners (from existing resources) to complete a thorough review of the needs of all individuals who currently receive a directly provided day and, or, respite service and that the anticipated outcome of these reviews will be:
  (a) The individual will be deemed not to have eligible social care needs and so will be signposted to access universal or other appropriate services or support;
  (b) The individual or their representative will choose to receive a Direct Payment and will use this to purchase the care and support needed to meet their eligible social care needs; or
  (c) The council will commission the care and support needed to meet an individual's eligible social care needs on their behalf.

(viii) To note that it is anticipated that the reviews will be completed by 28 February 2015.

(ix) To note that no service will be closed or withdrawn until all reviews have been completed and individuals with eligible social care needs have been supported to move to suitable alternatives.

(x) To require a progress report at the Cabinet meeting in March 2015.

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DECISION-MAKER:	CABINET
SUBJECT:	FUTURE OF DAY SERVICES IN SOUTHAMPTON
DATE OF DECISION:	9 DECEMBER 2014
REPORT OF:	CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE

CONTACT DETAILS

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STATEMENT OF CONFIDENTIALITY

NOT APPLICABLE

SUMMARY

Cabinet is recommended to approve the restructure of Southampton Day Services (SDS) including a reduction in the number of bases used for delivery from four centres and four satellite services to two centres, after taking into account the consultation findings and all relevant factors. The current bases are; Sembal House, Freemantle Community Centre, Woolston Community Centre and St Denys Community Centre, with satellite services being; Nutfield (operating 5 days a week), Wooden reflections (operating 3 days a week), Tools for self-reliance(TFSR- operating 2 days a week) and Stella Maris (operating 2 days a week).

RECOMMENDATIONS:

(i) To consider the responses received during a public consultation into the future of SDS conducted between 24 July and 23 October 2014, outlined in Appendix 1.

(ii) To authorise the restructured Southampton Day Services service to cease service delivery out of two centres, (St Deny's and Freemantle) and all satellite bases when all of their current service users have been supported to move to suitable alternative care settings and to restructure the remaining service to provide an alternative model of delivery that is fit for the future needs of Southampton residents and users.

(iii) To note that the needs of current service users will be thoroughly reviewed prior to and following their moves to ensure that these needs continue to be met and to reduce any impact on their wellbeing.

(iv) To note that if the proposal is agreed to undertake a 45 day consultation with affected staff with a view to minimising or avoiding compulsory redundancies.

(v) To note that a further review may be required into alternative delivery models following a restructure.

(vi) To delegate authority to the Director, People following consultation with the Cabinet Member for Health and Adult Social Care to do anything necessary to give effect to the proposals in this report.

REASONS FOR REPORT RECOMMENDATIONS

1. The council would like to develop a wider range of options for individuals who require support to access day opportunities, such as further developing a wider range of commissioned services and supporting service users to access existing community facilities through greater use of direct payments and personal budgets, instead of directly providing care and support.

2. Traditional day services have been matched to individuals instead of individual packages of care tailored to meet personal preferences and lifestyle. Services are currently delivered in 4 community centres (Sembal House, Woolston Community Centre, Freemantle Community Centre and St Deny's Community Centre) and 4 satellite bases (Nutfield, TFSR, Stella Maris and Wooden reflections), with users being exclusively people with assessed and eligible social care needs. While some progress has been made in moving away from traditional building based services, the service currently offered does not make best use of existing available community assets and services, and does not encourage inclusion into the wider community.

3. The need to move towards more personalised forms of care, where individuals can exercise more choice and control over the support and services they access is a priority both locally and nationally. In concert with this, the requirement to offer direct payments to individuals is national policy. The council currently performs in the bottom three of all councils nationally around this performance indicator, with our take up rate of direct payments currently standing at only 6% compared to a national average of 21.03% (data taken from Ascof outcome (1c(2) 2013/2014). The policy direction and imperative to offer more personalised forms of care and in particular to offer direct payments continues to be a national driver as set out in the Care Act 2014 becoming a legislative requirement from April 2015.

4. There is significant evidence nationally that direct payments support people to have increased choice, control, flexibility and an improved quality of life. They can provide bespoke solutions for unique needs which then improve outcomes for individuals. Improved outcomes can have a cost benefit by reducing the need for other services. Direct Payments cannot be used to purchase council run services.

5. Whilst there is some alternative provision of day services of the required type and quality in Southampton, it is unlikely that this is able to meet all current and forecast demands. Service users currently accessing SDS have a range of differing levels of complexity of need and span a wide age range and it is not possible to tailor the existing service to meet everyone's individual needs and interests.

6. The longer term viability of SDS may be at threat if no changes are made. This is due to an expected increase in the uptake of direct payments and evidence of people using their direct payment to purchase less traditional, more creative care solutions such as employing personal assistants, paying for community based activities or supported holidays.

   In the 14-18 years age group of those with a learning disability – who in the past may have been expected to access SDS when they become an adult – the uptake of direct payments has increased from 12% in 2009/10 to 32% in 2014/15 and this trend is expected to continue over the next few years, particularly in light of the right to request a personal budget and focus on more personalised services brought in by the Children & Families Act 2014 and the Care Act 2014.

7. The statutory requirement to consult with service users, their families and other stakeholders has been fulfilled and although the overwhelming response was to keep SDS open, their comments have helped to ensure that all relevant factors have been taken into consideration.

8. Evidence from discussion with service users, their families and carers and with experienced social care practitioners shows that the development of services for individuals with the highest needs and most challenging behaviour will take time. It will also be important that users and their carers are confident in and comfortable with these alternatives. A phased approach supports this period of transition. A full Equality and Safety Impact Assessment has been carried out to identify the potential impact and mitigation of these proposals on servicer users and their carers and is attached at appendix 2 for consideration.

9. Consultation undertaken with staff during the formal consultation period suggested a desire to restructure the service. The proposals within this report have been developed in conjunction with SDS staff and reflect their views that the service needs to be restructured to provide a sustainable and desirable delivery model for the future.

10. If the proposals are agreed there will be full consultation with affected staff on the future structure and staffing model. Officers will also ensure that the implementation of agreed proposals will be done in conjunction with the current work on the Community Asset Strategy, as the pilot phase focuses on Council owned community centres.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

11. The alternative option of keeping all services currently provided by SDS was considered and rejected for the reasons set out above.

12. The option of ceasing activity at all sites used by SDS was considered and rejected because there is recognition that further market development will be necessary to ensure that all service users can access appropriate services. In particular, it was recognised that those service users with the most complex and challenging needs, along with those service users who have been attending SDS services for a significant number of years, will require time and support to transition to alternative services, and that services for those service users with the highest needs are not currently widely available or with sufficient capacity to meet the likely needs of all of our existing service users.

13. The option of developing a social enterprise or other alternative delivery vehicle to provide the full range of services currently provided by SDS was considered and rejected because of the likely time it would take to develop an enterprise of the size and scale necessary. However, it was felt that this is an option that should be revisited in the future.

DETAIL (Including consultation carried out)

14. SDS is a collection of centre-based day services operating from four distinct community centres and four satellite buildings, catering to service users with different types and levels of need and based in four separate locations across the city:
    - Sembal House: a day service for adults with physical disabilities and mental health issues providing 134 sessions per week to 41 service users.
    - St Denys: a day service for adults with learning disabilities providing 257 sessions per week (building and community-based) to 55 service users.
    - Woolston Community Centre: a day service for adults with learning disabilities

and complex needs providing 281 sessions per week (building and community-based) to 55 service users.

- Freemantle: a day service for adults with learning disabilities providing 312 sessions per week (building and community-based) to 69 service users.
- Nutfield operating 5 days a week with 44 clients receiving 140 sessions per week.
- Wooden reflections operating 3 days a week with 13 people accessing 31 sessions per week.
- TFSR (Tools for self-reliance) operating 2 days a week with 15 people accessing 31 sessions per week.
- Stella Maris, operating 2 days a week with 27 people accessing 56 sessions.

15. The majority of SDS services are building based offering a range of activities such as arts and crafts, life skills and educational programmes and in some cases offering specialist therapy and services. All services provide transport and support for trips and activities in the community. The service is used predominantly by individuals with learning disabilities and internally provided day services have a high volume of individuals with more profound and multiple learning disabilities than individuals using external services.

16. In addition to SDS, the council commission a range of external services comprising over 39 different providers, of which 29 are locally based and offer the traditional building based options. Services include horticultural, farm, sport and skills based activities. Some services provide specialist support but few have buildings with the necessary adaptations and facilities to support individuals with higher support needs. This market will require further development to respond to an increasingly personalised purchasing approach.

17. An analysis of current SDS service users was conducted in May 2014, using three broad support bands:

    - Band 1 – individuals requiring support on an average 12 clients to 1 staff member basis. Currently there are 143 clients in this banding.
    - Band 2 – individuals requiring occasional one to one support on a 6 to 1 basis for particular activities. Currently there are 48 clients in this banding.
    - Band 3 – individuals requiring regular 1 to 1 staffing to keep them safe and support them appropriately. Currently there are 23 clients in this banding.

18. The decision to consult on the future of SDS was based on the current cost of the service, the predicted future needs of service users and the national policy imperative to offer more personalised forms of care. Consideration was also given to the inflexibility of the current service model and responses to requests from service users and their families for increased options for day services.

19. Cabinet approved a public consultation on the future of SDS on 15 July 2014 and this ran from 24 July 2014 to 23 October 2014. During this time, the families and carers of SDS service users were invited to attend six meetings held at each SDS base across a 90 day period. This is a total of twenty four meetings across all of the SDS sites Meetings were held at Sembal house on 11 August 2014, 15 September and 13 October September 2014, at Freemantle Community Centre on 14 August, 11 September and 9 October 2014, at St Deny's on August, 22 September and 20 October 2014 and at Woolston Community Centre on 12 and 27 August, 24 September and 14 October 2014. These meetings were generally well attended and independent advocates were available to provide support. In addition, there were two public meetings held at the Civic Centre on 8 August 2014 and 22

October 2014. Information about the consultation was published on the council's website and was covered by the Daily Echo and BBC Radio Solent.

20. Copies of the notes taken at these meetings and all of the responses received are available in Members' rooms and these are summarised in Appendix 1.

21. A number of options for the future of SDS were presented during the consultation, reflecting the desire to move towards a wide range of more personalised services:

(a) for services at all centres to remain and service delivery to remain unchanged;

(b) for services at all centres to be discontinued with current service users being supported to access alternative commissioned provision;

(c) for users and their families to be offered a direct payment to be able to purchase their own form of day activity, for example, utilising a direct payment to purchase a season ticket for the football, or accessing existing leisure facilities; and

(d) for the service to be restructured so that those services users with lower needs could access existing provision (commissioned from external providers or through a direct payment) and those service users with the most complex needs would continue to be supported by SDS at a reduced number of sites.

22. Independent advocates worked separately with the service users of SDS and were able to record the views of 102 service users, where appropriate. These were generally very positive about their experiences of SDS provision. Many made reference to the value of the wide range of activities that SDS offer and the personal value they gain from spending time with friends who also receive support from SDS. Of the responses gained with the help of advocates 15 individuals (15%) agreed that the council should look at different ways of meeting the needs of people who use SDS. 8 individuals (8%) gave no reply or said that they did not mind. The remaining individuals (79 or 77%) felt that the council should not make any changes to the provision of day services in Southampton.

23. Assessments of need will be carried out with all service users of SDS and the options for future care and support will be considered. This will include considering the suitability of utilising direct payments to purchase individually tailored forms of day opportunities, accessing one of the council other commissioned day services providers or continuing to use the restructured SDS service. The assessment will set the expected care needs and it is likely that for users with higher level (band 3) needs, some form of building based service will still be required. The councils current externally commissioned provision would not be able to accommodate those service users with the highest level of need (band 3) and it is likely that due to the severity and complexity of their needs that accessing existing community provision would also not be appropriate.

24. Day service provision is not subject to regulation or inspection by the Care Quality Commission (CQC). Where services are externally commissioned, quality and evidence of how quality will be delivered and measured is a key part of the tendering process. The council's Integrated Commissioning Unit has a dedicated provider quality unit, which carries out separate checks and responds to complaints about poor quality provision in Southampton. The internal team can set expectations for improvements to services and can act to withdraw funding for providers that consistently fail to achieve acceptable standards. A challenge for all councils when increasing the take up of direct payments is that the statutory duty to ensure quality and to safeguard vulnerable adults is retained but control over what services are accessed and particularly what quality safeguards are in place for those services is up to the service user and/or their carer. A facet of a more personalised system is the acceptance that adults with the mental capacity to do so

are allowed to make choices with which the council or their families may not always agree.

25. In order to reduce reliance on more traditional building based forms of care, the development of a clear, easily accessible and attractive direct payment process is a key dependency. As previously noted, the council has not been performing well in the take up of direct payments, and as part of the consultation specific meetings were arranged to give families and carers a clearer understanding of direct payments and the potential benefits of alternative forms of day care. Alongside this work, a project is being undertaken with users, carers and partners to redesign our direct payment system.

26. As a result of central government's policies on deficit reduction, the public sector as a whole is experiencing a continued period of expenditure restraint. Within this environment, as a sector, local government is experiencing a greater proportion of the reduction in funding when compared with Health, Education and Police. This national picture is reflected locally, as the council continues to experience a significant decrease in government grant funding. It is against this background and the need for a further reduction in expenditure that this decision is being made. At the time of writing, the council has a budget gap of £4.3m for 2015/16, which is forecast to increase to £54.2m for the three years from 2015/16 to 2017/18. The Health and Adult Social Care Portfolio currently represents 33% of the council's Net Portfolio General Fund budget.

27. Spending in this area is subject to demand-led pressures associated with the provision of social care, which stem largely from demographic trends, including an ageing population and people having increasingly complex care needs.

28. Overall expenditure on internal day provision is £1.8M per annum, this equates to a weekly expenditure of £35,500, based on a 52 week schedule, although some services close over key holiday periods (summer and Christmas). Over 70% of expenditure is directed towards clients with learning disability, who form over 50% of the client population.

29. The remaining budget for SDS services will be used to fund the structure and costs required to maintain two building based services at Sembal House and Woolston. The changes required to the establishment will be subject to full consultation with staff and unions. A budget will also remain to fund the cost of reprovision for eligible clients that no longer attend SDS. It is envisaged that the cost of reprovision will be in the range of £140,000 to £450,000 per annum. This range is subject to full reviews of client needs being undertaken. In the short term this figure would reduce if applied predominantly to clients with learning disabilities, where the re-provision cost are currently higher. It is anticipated that the cost of re-provisioning for these clients will decrease as market development work begins to impact on developing wider alternatives and improving quality and price.

30. There are 57 staff (49.09 fte) across all SDS sites with a further 27 staff (15.3 fte) working on zero hour contracts. Staff on zero hour contracts may have employment rights due to length of service. The staffing structure in SDS is currently top heavy, with 4 layers of management across the service. The funded establishment includes a budget for staff working on zero hour contracts. Whilst there has been additional use of additional support workers within the centres this has previously been managed within the existing budgets. SDS regularly spend an average of £25K per month on zero hours contract workers.

31. Analysis of the market place shows that in addition to SDS there are currently 112

people (adults) accessing day services commissioned from external providers.

32. A wider review of day services, including those commissioned from external providers had commenced at the time the decision to consult on the future of internal day services was made and this has continued. The review sought to address:

- approaches that enable individuals to be active participants in their local communities, seek employment and education opportunities;
- services that are cost effective and efficient; and
- support to carers.

33. Further work is required to inform the design and development of services for the emerging populations over the next 5-10 years who are choosing different options.

34. Retaining 2 SDS bases and restructuring the service does not impact on individuals' eligibility for support to meet their social care needs. The current criteria under the Fair Access to Care Services (FACS) scheme or, from 1 April 2015, under the Care and Support (Eligibility Criteria) Regulations 2014 will be applied and individuals with eligible needs that are best met through accessing a day service will be supported in the council's remaining restructured service or through a private or independent provider.

RESOURCE IMPLICATIONS

Capital/Revenue

35. The budget report presented to Cabinet on 16th July 2014 identified that a review of the Council's provider services would be undertaken. This review and associated consultation has now been completed. It is now anticipated that the proposed restructure of Southampton Day Services will achieve a minimum and maximum saving of £540,000 and £850,000 respectively for 2015/16 and minimum and maximum savings of £700,000 and £1,010,000 for 2016/17.

36. The budget for Southampton Day Services including the four Day Centres, (Sembal, Woolston, Freemantle and St Denys) and the four satellites, (Wooden Reflections, Tools for Self-Reliance, Stella Maris and Nutfield Nursery) is £1,840,000. The proposed reduction in bases by 1st April 2015 will save £990,000 on a recurring basis. In addition, as per the proposal in this report, an element of the saving from the reduction in bases will be required to fund the cost of reprovision for those eligible clients no longer attending SDS.

37. The cost of reprovision for the clients no longer attending SDS is difficult to quantify with certainty as detailed assessments of clients' needs has not yet taken place. However, the cost of reprovision can be expected to be within the range of £140,000 and £450,000 dependant on the outcome of the reviews. The level of likely saving in 2014/15 therefore could span across the range; £850,000 to £540,000.

38. For 2016/17 it is anticipated that further work in respect of market development and client reviews will be required. It is expected that this work, undertaken during 2015/16 will achieve a minimum of £160,000 additional saving in 2016/17. The current level of saving proposed in both 2015/16 and 2016/17 are realistic estimates. However should, after the client reviews are completed, it be identified that a further saving has been made this will be subject to another saving proposal.

39. Consultation with staff employed at SDS will commence in January 2015 with a view to minimising or avoiding compulsory redundancies and restructuring the

existing service. There are currently 49.09fte posts within the funded establishment of which 5.64fte are vacant. This proposal could affect 57 people that could be subject to compulsory redundancy should alternative suitable employment not be found within the Council. In addition there are 27 staff currently working on zero hours contracts. It is anticipated that vacancies within People Directorate will help in the reduction of the number of compulsory redundancies arising from this proposal. The cost of any redundancies will be picked up within a central provision.

Property/Other

40.

Adult day services are provided from 4 main sites, with 4 additional locations used to offer specific elements of the service. Of the 4 main sites, 3 are cost neutral and available through a lease agreement with the relevant Community Association. The fourth site is owned by SCC and provides accommodation to the City Care First team and one voluntary sector agency.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

41. When considering the recommendations and in particular the decision to cease delivery of SDS services at two existing centres and to restructure the remaining service the Council must take into account a number of factors, including:

The representations made during the consultation and any analysis of the consultation

The equality impact assessment bearing in mind its public sector equality duties as well as all other relevant information.

The effect on individual health, lives and well- being of service users and their carer's in having to use alternative day services or other models of delivery , particularly individuals who regularly use the day services

Consideration of any duty under the Human Rights Act 1998 so as not to act incompatibly with the rights under the European Convention for the Protection of Fundamental Rights and freedoms ("the Convention"). The Council will need to consider whether the proposed closure is likely to breach any of the service users rights e.g. Article 2 the right to life, Article 3 the right not to be subjected to torture or inhuman or degrading treatment and Article 8 the right to respect for a person's family life and their home. If this decision is likely to breach the convention the Council will need to examine any particular facts and determine if such a breach is justified and proportionate. The Council can though take into account general economic and policy factors which have led the Council to conclude that the home should be closed. This though must be balanced against the impact on the service users.

The Care Act 2014 requires local authorities to prepare for implementation of the Act in April 2015 and April 2016.The recommended option of moving to a more personalised service approach would support greater compliance with the Care Act.

The Act though places various duties and responsibilities on Local Authorities about commissioning appropriate services. In particular all Local Authority should encourage a wide range of service provision to ensure that people have a choice of appropriate services, local authorities must ensure their commissioning practices and the services delivered on their behalf comply with the requirements of the Equality Act 2010 and should encourage services that respond to the fluctuations and Changes in people's care and support needs.

The Care Act also places duties on Local Authority to carry out an assessment of any carers needs. This can include participation in education, training and recreation.

The Council has a number of statutory duties and powers to individuals under various pieces of legislation to assess individual needs and then to provide appropriate care, support and accommodation for the eligible needs.

The Care Act 2014 provides an updated legal framework for care and support and introduces a number of new rights, responsibilities and processes. All Local Authorities are now in the transition phase with parts of the Act coming into force in April 2015. When carrying out new assessment or when re-assessing individuals, the needs assessment must be carried out in line with the Care Act 2014. It would also be best practice when assessing the impact on carer's to ensure this is done in compliance with the 2014 Act.

Other Legal Implications:

42. If service users are moved from SDS services against their will, this is likely to constitute a prima facie breach of their rights under Article 8(1) the Council need to consider whether this breach can be justified as above.

In addition if any service user is subject to restraints that amount to a deprivation of liberty and no less restrictive options are available to meet that persons needs any planned move from the unit must be lawfully authorised either by the Deprivation of Liberty safeguards or by an order of the Court of Protection, whichever would be most appropriate.

There is a legal requirement to consult with staff where redundancies are contemplated. The 45 day consultation referred to earlier in this report will meet this requirement.

POLICY FRAMEWORK IMPLICATIONS

43. These proposals are aligned to the Communuity Asset Strategy and following priorities set out in the Council Strategy 2014 -2017:

- Prevention and early intervention.
- Protecting vulnerable people.
- A sustainable Council.
- Officers will also ensure that the implementation of agreed proposals will be done in conjunction with the current work on the Community Asset Strategy, as the pilot phase focuses on Council owned community centres

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED: ALL

SUPPORTING DOCUMENTATION

Appendices

1. Summary of Consultation Responses
2. Equality and Safety Impact Assessment

Documents In Members' Rooms

1. Record of all the Consultation Responses Received

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out? Yes

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1. ADULT SOCIAL CARE PROVIDER SERVICES CABINET REPORT DATED 15TH JULY 2014 (SEEKING APPROVAL FOR A PUBLIC CONSULTATION ON THE FUTURE OF WOODSIDE LODGE)	

APPENDIX 1

Consultation on the future of Day Services

Summary of responses received

Contents

1 Consultation approach

1.1 Relatives and carers of day service users were invited to a meeting that took place at day centres on Monday 7 July 2014. At the meeting, they were advised that Cabinet would be considering a proposal to hold a public consultation on the future of day services. A staff briefing was held on the same day. A copy of the presentation was posted to relatives after the meeting.

1.2 Cabinet considered this proposal and approved a public consultation on the future of Day Services on 15 July 2014 and this ran from 24 July 2014 to 23 October 2014. The consultation was covered by local media, including the local newspaper (Daily Echo) and local radio (BBC Radio Solent).

1.3 The schedule of meetings was published on the council's website and relatives and carers of Day Service users were sent this by post with an invitation to attend. Staff were briefed so that they could give information about the proposals and the ways in which to respond. The schedule of meetings is attached at Appendix A.

1.4 A consultation document including a questionnaire was published on the council's website, where it could be downloaded, and was made available at all of the consultation meetings and from Day Service Staff. The consultation document is attached at Appendix B.

1.5 A total of 13 meetings were arranged as part of the Day Services Consultation. 3 meetings were arranged for service users, families and carers and were held at Sembal House. 10 meetings were arranged for relatives and carers and these were all held at a variety of Day Centre buildings. Representatives from Choices Advocacy and, or, Carers in Southampton attended meetings and were able to support relatives, as required. The Cabinet Member for Health and Adult Social Care attended some of the meetings.

1.6 The format of the group meetings consisted of a presentation given by the Interim Head of Adult Services followed by a question and answer session. Notes of these meetings were taken and these are attached to Appendix A.

1.7 In addition to the 13 meetings held at Day Centres, two public meetings were held at the Civic Centre at 6pm on 8 August 2014 and 22 October 2014. These meetings covered the proposals regarding Day Services along with separate proposals for the future of respite services and the future of a residential home, Woodside Lodge. A verbatim record of these meetings, chaired by the Director of People, was made and this is attached to Appendix A. The Cabinet Member for Health and Adult Social Care also attended these meetings, along with representatives from Choices Advocacy (both meetings) and Carers in Southampton (the second meeting).

1.8 In addition to the above, a meeting for carers was hosted by Southampton Mencap (carers' lunch); two meetings were held with the council's partners and care providers; and meetings in public were held at Consult and Challenge (Spectrum Centre for Independent Living) and Southampton Healthwatch. These meetings included the proposals for day services along with those for respite services and Woodside Lodge. Notes from these meetings have been placed in Members' rooms and are available on request.

1.9 Several briefings were also held for Members of the council and the consultation and proposals were considered at a meeting of the council's Overview and Scrutiny Management Committee (OSMC) on 11 September 2014. The minutes of this meeting are available online at http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=123&MId=2852&Ver=4

1.10 A dedicated email address was publicised on the council's website and at all of the meetings outlined above. Everyone who attended the meetings was invited to respond to the consultation in the way that best suited them, including a direct invitation to phone or write to the Interim Head of Adult Services or a member of the project team, whose contact details were included in the presentations.

1.11 Independent advocates from Choices Advocacy worked separately with the service users of day services and were able to record the views of 102 of its current service users, where appropriate.

2 Questionnaire responses

2.1 163 questionnaire responses were received related directly to day services. The majority were received by users of day services, however other respondents included members of day services staff (7), other staff member (4), carer of person using day services (2) and those interested in the ways adult services are provided in Southampton (3). 102 of the responses were received from services users with the help and support of independent advocates.

2.2 27 responses (16.5%), from all completed questionnaires agreed that the way the council provide day services should be reconsidered. 15 respondents did not mind or felt unable to answer the questions. The remaining 121 (74%) respondents felt that the council should not change the way day services are provided.

2.3 A number of questionnaire responses contained questions. These requests have been summarised and the councils response is, as follows:

Comment	Council's response
One response suggested that reasons for consultation had not been clear.	At all meetings time was taken to explain why the decision to consult has been made. These reasons include: a need to ensure that services fit with current lifestyles, promotion of independent living where individuals are empowered to make their own decisions, services need to be more flexible to ensure all needs of people are fully met, with life expectancy ever increasing a growing demand is highly likely and current provision may not be providing the best value so we want to ensure individuals, who are eligible, are supported to achieve the best outcomes for the money available.
Concerns were raised that it was not suitable to consult with service users.	Different approaches were taken on how to consult with individuals based on their needs and understanding. Individuals were supported by their families, carers, social workers and care managers and independent advocates were also used to gain the views of service users where appropriate.
It is not always suitable for serviced users to manage their own budgets.	Direct payments do required a managed approach but this is not required to be the service user themselves. They are able to receive support from relatives and carers in this matter and are also able to, if they wish, use some of their finance to buy help to manage their direct payment.

2.4 From the responses received a number of themes emerged of areas respondents felt were of particular importance. These are summarised as follows:

- The potential loss of friendship is of major concern to service users. Many service users explained that the day centres have led them to create their friendship circles and fear how they will recover this if the day centres are lost.
- Service users, relatives and carers alike explained that the activities provided by day services have both social and educational benefits to

them. They fear that alternatives will not combine both important aspects.

- The wide range of activities provided by all day centres was also discussed. Many praised the wide range and the benefits these brought. On the other hand other responses also suggested that day services need to be more flexible in the activities they provide. Further suggestions made also noted that other services in addition to day services should be provided however no detail about what these services should be was given.
- Staff are clearly seen as a valuable resource within day services. Concern was raised that staff who know service users and their needs will be lost. Furthermore some individuals expressed that these links can take a long time to be built up making them very important.
- Concerns were raised as to how service users often struggle with change and that that settling into new services can sometimes be a slow transition.
- A couple of responses suggested that the way services are already provided are innovative and "forward thinking" and suggested that the council do not provide services in a "traditional" way.
- One respondent stated "the fees are not fair and do not represent the service that clients receive". The council's response is that if services are changed then service users would be able to choose the services of most value to them.
- A number of respondents explained how safe the environment the day service provides makes them feel very safe – this is something they really value.
- A few respondents explained that they already use services provided by both private and public sector organisations. They explained that both had real value to them and that they enjoyed both aspects.
- A fairly large number of responses made reference to the Café provision at day centres. Many explained that the skills running the café bring are incredibly important.
- A few respondents explained that having teams based in some of the building in which day services are provided is valuable as it mean that "there is always someone around".

3 Written responses

3.1 In addition to the questionnaire responses, 25 letters from a number of sources were received. The respondents included relatives of service users, carers of services users, social workers and managers contacting on behalf of service users as well as local voluntary sector groups.

3.2 The majority of responses were strongly in favour of ensuring day services are retained in their current state as they are viewed as a valuable service. A number of people expressed concerns about where alternatives may be sourced from should day services not be provided in their current state.

3.3 One respondent raised concerns with the manner in which the consultation had been conducted. The concern continued to explain finding materials on the council's website had been difficult. The respondent queried whether the consultation has been publicised well enough. The Councils response to this is that the consultation was listed on a dedicated page on the council's website. The consultation was also covered in the Daily Echo and by BBC Radio Solent.

3.4 Concerns were also raised that following the consultation the council should ensure they interact with those effected by the changes to ensure that their needs are being met. The council's response to this is that any service user who is eligible to receive services is entitled to a statutory review of their needs. As a minimum these reviews must be carried out annually, although the frequency of review will depend on the level of need and risk, and will be agreed with the individual and/or their carer.

3.5 A number of responses stated that current provisions are not flexible enough. One response stated the "flexibility is the key". Another response stated that "the current service does little to empower service users". The council acknowledges that the current service has areas for improvement and flexibility is one of those areas for development. This is one of the reasons that this consultation is being undertaken, to explore how personalised care can be better implemented within the service.

3.6 One response raised that the consultation process appeared to have failed to have consulted with future service users.

3.7 In addition to the above points raised a number of consultation responses received contained questions. These questions have been summarised and the councils response is as follows:

Comment	**Council's response**
Is it suitable for service users to be consulted with? Are they in a position to make informed decisions?	Different approaches were taken on how to consult with individuals based on their needs and understanding. Individuals were supported by their families, carers, social workers and care managers and independent advocates were also used to gain the views of service users where appropriate.
How will the implementation of the Care Act impact on service user and carers assessments? Do they have to be provided jointly?	The Care Act will bring changes in the way that the assessments for carers are conducted. The act does not make it a requirement for the assessment of carers and those they care for to be carried out jointly. However should both parties consent,

	in certain situation, the council may decide to combine the assessments.
One response stated that “one size fits all questionnaire” was not suitable for everyone.	The council made clear that throughout the consultation a number of methods for providing feedback were provided. The questionnaire provided was just one of these methods. Other have been detailed through part one of this report.

4 Meetings held at Day Services

5.1 Notes from the meetings are attached to Appendix A.

5 Public meetings held at Civic Centre

5.1 Notes from the meetings are attached to Appendix A.

6 Overview and Scrutiny Management Committee

6.1 The minutes of this meeting are available online at http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=123&MId=2852&Ver=4

SOUTHAMPTON CITY COUNCIL

Equality and Safety Impact Assessment

The **public sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be e efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the council to better understand the potential impact of the budget proposals and consider mitigating action.

Name or Brief Description of Proposal	Future of day services The recommendation is for Cabinet to approve the phased closure of two of the four Southampton Day Services (SDS) centres provided directly by Southampton City Council, and the restructure of the remaining two after taking into account the consultation findings and all relevant factors.
Brief Service Profile (including number of customers)	SDS is a collection of four distinct day services, catering to service users with different types and levels of need and based in four separate locations across the city: •Sembal House: a day service for adults with physical disabilities and mental health issues providing 134 sessions per week to 41 service users. •St Denys: a day service for adults with learning disabilities providing 257 sessions per week (building and community-based) to 55 service users. •Woolston Community Centre: a day service for adults with learning disabilities and complex needs providing 281 sessions per week (building and community-based) to 55 service users. •Freemantle: a day service for adults with learning disabilities providing 312 sessions per week (building and community-based) to 69 service users. The majority of SDS services are building based offering a range of activities such as arts and crafts, life skills and educational programmes and in some cases offering specialist therapy and services. All services provide transport and support for trips and activities in the community. The service is used predominantly by individuals with learning disabilities and internally provided day services have a high volume of individuals with more profound and multiple learning disabilities than individuals using externally commissioned services.

Summary of Impact and Issues	The recommended option to undertake a phased closure of Council run services forms the basis of this impact assessment. The recommendation has been informed by a series of consultations and coproduction groups. Co-production groups were made up of service users, carers and provider staff. Any proposed changes to the day services have the potential to affect services provided to adults with care and support needs including: • Adults with learning disabilities, • Adults with physical disabilities • Adults with sensory support needs • Adults with mental health related needs There is also the potential to affect: • Carers of people in all the above groups. Issues identified via the co-production work includes: • Concerns expressed by service users and carers regarding potential loss of services resulting in more pressure on them. • The need to improve information on available services provided to adults with care and support needs and their carers • Ensuring transport is available to access services • Ensuring services meet the needs of people with a wide range of needs and disabilities All current service users will be entitled to an assessment and review of their care needs. The Care Act 2014 also promotes carers assessments.
Potential Positive Impacts	Potential positive impacts of the review would be that day service provision becomes more flexible in meeting the needs of adults with care and support needs who meet the local authority eligibility criteria. The Care Act 2014, which becomes a legislative requirement from April 2015, emphasises the use of personal budgets to provide care and support to adults assessed as eligible for local authority or health funding. Personal Budgets have the potential to provide increased choice and control to more service users and their carers' in how they utilise the budget to meet their identified needs and outcomes. This supports people to have more bespoke solutions for their unique needs and this can improve outcomes for individuals. Improved outcomes can have a cost benefit by reducing the need for other services.
Responsible Service Manager	Ricky Rossiter (Operational Service manager) Sandra Jerrim (Senior Commissioner)
Date	November 2014

Approved by Senior Manager	Stephanie Ramsey
Signature	
Date	20/11/14

Please note: this ESIA is a work in progress. Any revisions will be tabled at the Cabinet Meeting on 9 December 2014.

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	The recommendation may have either a positive or negative impact depending on the individual. SDS provides services for a wide group, mainly adults but including older adults with multiple needs. People with learning disabilities experience a range of health problems earlier than the general population which needs to be factored into the design of alternative services. Some service users have older carers who have their own support needs or who may develop needs in the future.	All service users will have an assessment prior to any consideration of service changes. This will address individual needs including age, complexity and access issues. In addition to individual assessments the phased closure of SDS will consider which buildings should be retained in the initial phase in order to address any potential impact. This will also provide the time to seek suitable alternatives for people. Carers are entitled to assessments in their own right and would be able to access this where necessary. This will identify specific needs for older people with caring responsibilities. Carers including those with protected characteristics, will be supported through this approach.
Disability	The recommendation will impact on people with learning disabilities, physical disabilities, sensory impairment and mental health needs. The recommendation may have either a positive or negative impact depending on the individual and the extent to which they prefer current models of service and their ability and interest in accessing other options such as direct payments to purchase	All service users will have an assessment prior to any consideration of service changes. This will address individual needs including age, complexity and access issues. In addition to individual assessments the phased closure of SDS will consider

	more solutions. A negative impact for some will be the change in service location This could be particularly impact on people with physical disabilities who need to use services and buildings which are accessible. Some of the buildings currently providing SDS have good access arrangements but other community resources may not be as suitable. A positive impact for some will be the freedom and flexibility to use their personal budget to meet their individual need The current services impact on a disability group who are known to experience prejudice and stigma and so some people using the current services may feel particularly vulnerable in generic community settings as the	which buildings should be retained in the initial phase in order to address any potential impact. This will also provide the time to seek suitable alternatives for people Alongside the changes individuals will be able to have a personal budget/take a Direct Payment, and be supported to do so, which will enable people to make arrangements to meet their individual need. Good transition arrangements and support to access other services safely will help increase confidence to accessing different services.
Gender Reassignment	In House services can provide a safe environment for people who face multiple discrimination. Accessing mainstream activities may be more challenging due to stigma.	This can be mitigated by support to access alternative, appropriate services such as peer support and by working with other agencies to ensure al purchased and community services are accessible to all communities.
Marriage and Civil Partnership	No identified negative impacts.	
Pregnancy and Maternity	No identified negative impacts.	
Race	The recommendation may have either a positive or negative impact depending on the individual, although increased use of personal budgets is usually experienced as a positive impact, allowing individuals with different requirements to be addressed individually.	All service users will have an assessment prior to any service change which will include cultural issues.
Religion or Belief	The recommendation may have either a positive or negative impact	All service users will have an assessment prior to prior to

	depending on the individual, although increased use of personal budgets is usually experienced as a positive impact, allowing individuals with different requirements to be addressed individually.	any of service change which will address matters of religion and belief.
Sex	No identified negative impacts	The flexibility that personal budgets offer means that service users and carers will be able to arrange personalised services and activities/support that is tailored to their needs including single gender services.
Sexual Orientation	In House services can provide a safe environment for people who face multiple discrimination. Accessing mainstream activities may be more challenging due to stigma	This can be mitigated by support to access alternative, appropriate services such as peer support and by working with other agencies to ensure all purchased and community services are accessible to all communities.
Community Safety	National research identifies disabled people are more likely to experience crime and anti-social behaviour, than non-disabled people. There could be a negative impact on Individuals who feel safer accessing city council buildings in areas that they know and feel comfortable in. http://www.equalityhumanrights.com/sites/default/files/documents/disabilityfi/briefing_paper_3_new.pdf Local mechanisms for reporting Hate Crime and harassment are not affected.	Assessments will consider community safety issues for individuals including service location. The Community Safety team works with a wide range of partners to address and provide a more resilient response to community safety issues. The Community Trigger gives victims and communities the right to require a multi-agency review and ensure that effective action is taken where an ongoing problem of persistent antisocial behavior has not been addressed.
Poverty	There are potential impacts if people have to travel further at extra cost to access their support. Alternatively people can choose to access more local services. Personal budgets provide flexibility for individuals, regardless of their economic situation.	All services users will have an assessment prior to any service change which will address these issues. Costs of transport can be included in a personal budget/direct payment
Other Significant	Although transport is outside the scope of this review, the use of	Assessments will be undertaken with all service

Impacts	personal budgets will have a positive impact as individuals can choose transport arrangements most suited to their individual needs.	users prior to any service changes. Identifying needs in respect of employment and transport will be part of the assessment process.

Cabinet – 9th December 2014

Additional Recommendations to the following reports:

4 - Future of Day Services in Southampton
5 - Future of the Respite Service for Adults with Learning Disabilities

RECOMMENDATIONS

(vii) To approve the establishment of a dedicated team of experienced social work practitioners (from existing resources) to complete a thorough review of the needs of all individuals who currently receive a directly provided day and, or, respite service and that the anticipated outcome of these reviews will be:
  (a) The individual will be deemed not to have eligible social care needs and so will be signposted to access universal or other appropriate services or support;
  (b) The individual or their representative will choose to receive a Direct Payment and will use this to purchase the care and support needed to meet their eligible social care needs; or
  (c) The council will commission the care and support needed to meet an individual's eligible social care needs on their behalf.

(viii) To note that it is anticipated that the reviews will be completed by 28 February 2015.

(ix) To note that no service will be closed or withdrawn until all reviews have been completed and individuals with eligible social care needs have been supported to move to suitable alternatives.

(x) To require a progress report at the Cabinet meeting in March 2015.

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DECISION-MAKER:		CABINET		
SUBJECT:		RESPONSE TO THE HEALTH AND OVERVIEW AND SCRUTINY PANEL INQUIRY RECOMMENDATIONS ON THE IMPACT OF HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE		
DATE OF DECISION:		20 JANUARY 2015		
REPORT OF:		CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Liz Slater** **Matthew Waters**	**Tel:**	**023 8083 2582** **023 8083 4849**
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The Health Overview and Scrutiny Panel (HOSP) undertook an Inquiry into the Impact of Homelessness on the Health of Single People between February and July 2014. Its purpose was to consider the impact of housing and homelessness on the health of single people, a significant number of whom have complex needs, live unsettled and transient lifestyles and to examine the difficulties that their everyday life presents to deliver a preventative and planned approach to improve their health and wellbeing and access to a settled decent home.
During the review period the Panel heard from a wide range of witnesses and visited a number of the homelessness housing and advice services in the City.
25 recommendations for future actions were included in the final report.

RECOMMENDATION:

(i) To receive and approve the proposed responses to the recommendations of the Health Overview and Scrutiny Panel, as detailed in the attached Appendix 1.

REASON FOR REPORT RECOMMENDATIONS

1. Cabinet received the Health Overview and Scrutiny Panel's Inquiry report on the Impact of Homelessness on the Health of Single People on 21st October 2014 and is required to make a formal response within 3 months. This report details Cabinet's response to the recommendations from the Inquiry.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. The Health Overview and Scrutiny Panel (HOSP) undertook a review of the impact of homelessness on the health of single people in the city from February to July 2014. The final report contains a total of 25 recommendations for future action.

4. The report was positive about the current range of options available within the city for single homeless people, and recognised the role of commissioners and agencies in improving outcomes for this group over many years. The Panel heard from a range of agencies during the Inquiry, including local service providers, Homeless Health Care Team and visited a number of the projects in the city. In addition, Homeless Link - a national agency concerned with promoting services to homeless people - provided evidence and were positive about the model and range of services to homeless people in Southampton.

5. The final report provided a total of 25 recommendations on how HOSP viewed improving future services and support for homelessness in the City.

6. Prior to completing the response and action plan, agencies who had taken part in the original report - either by providing formal evidence or through site visits - were consulted. Three formal responses were received from agencies. The responses are included within Appendix 2 to this report. In addition, the Homelessness Strategy Steering Group has been formally presented with the recommendations.

7. In responding to the HOSP report, no recommendations have been rejected. 17 of the recommendations have been accepted, and 8 recommendations have been accepted in part. In the majority of cases those only partly accepted were due to resource implications, which are difficult to quantify or to manage, given the long-term financial issues facing the City Council and other agencies. Other responses are reliant upon outside agencies delivering a greater level of involvement.

8. Since the report was published there have been a number of changes and developments to commissioning intentions and to services. These are reflected in the response, but the City Council has responded to financial pressures by renegotiating prices with providers receiving monies through Supporting People. Significant savings have been achieved, with providers receiving contract extensions in return. The savings have been designed to ensure that existing levels of support are not reduced and to protect services for longer.

9. The response and action plan show a clear and continued commitment on behalf of the City Council to tackle homelessness in the City, within available resources. This includes ensuring services work together appropriately and provide comprehensive responses to identified homelessness needs. The Homelessness Strategy Steering Group will continue to monitor and direct the overarching responses to homelessness in the City, with key agencies represented as appropriate. The Action Plan will form a part of future Homelessness Strategy Steering Group meeting agendas to ensure actions identified are carried out. There is also a further opportunity presented by the next iteration of the Joint Health & Wellbeing Strategy to raise the profile of

housing, homelessness, mental health and wider inequality and the impact these have as determinants of health.

RESOURCE IMPLICATIONS

Capital/Revenue

10. There are no additional financial commitments entered into within the response. Existing commitments are subject to the long-term financial position of the local authority.

Property/Other

11. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

12. Local Government Act 2000.

Other Legal Implications:

13. None.

POLICY FRAMEWORK IMPLICATIONS

14. None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	None

SUPPORTING DOCUMENTATION

Appendices

1.	Response to HOSP inquiry report and action plan
2.	Consultation responses received prior to completing the response to HOSP inquiry report and action plan.

Documents In Members' Rooms

1.	None.

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None.	

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*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
A: <u>A strategic city-wide approach to homelessness</u>				
i. The Homelessness Prevention Strategy continues to support city-wide commitment for continued funding of the existing flexible and innovative partnership model of homelessness in the city.	Accepted in part	The current Homelessness prevention strategy 2013/18 commits to a city-wide collaborative approach to resolving and preventing homelessness in Southampton. This includes agreed commitments around single homeless people. This commitment remains, but is also subject to the long-term financial position of the local authority.	Homelessness Strategy Steering Group	Commissioned supported housing providers , in-house homeless services and floating support and homeless agencies
ii. Commissioners undertake a feasibility study including a cost/benefit analysis, with providers, to consider whether a more intensive 'Housing First' model could provide the relatively small number but high cost entrenched homeless clients a potential route into sustainable and settled accommodation.*	Accepted in part	The commissioning of new services will commence in 2015, with the start of new services from 2016. Southampton already has a Housing First focus, with services provided around the individual – hence, the availability of self-contained accommodation for very vulnerable and chaotic individuals. This has been developed over several years in response to needs. The ICU will however, review the model in other areas to test the value of this to Southampton. The Housing First model is one that will also be considered along with other evidence based models. However, with the resources available the city would need to make decisions on whether to focus on this group potentially at the expense of others, which would be a departure from current provision.	Southampton Integrated Commissioning Group (ICU)	
iii. The Housing Strategy	Accepted	The new Strategy is being led by the new corporate	Policy unit/	Housing providers

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continues to prioritise an increase in affordable single person accommodation across the City, including new developments.		Policy unit and is likely to be completed ready for adoption in late 2015. Development, Economy and Housing Renewal will be responsible for ensuring the delivery actions within the new strategy working with the housing providers operating in the city. It is anticipated that the strategy will continue to prioritise the provision of affordable single person accommodation across the City, including as part of new housing developments**.**	Development, Economy and Housing Renewal	working in Southampton
iv. Links are maintained and strengthened between homelessness prevention and employment projects such as City Limits and the new City Deal to increase the skills and employment opportunities for homeless and vulnerably housed individuals.	Accepted	City Limits Employment (CLE) has been commissioned through Supporting People (SP) to deliver an Employment Project to achieve the following: Support to over 100 SP funded homeless and vulnerably housed individuals with employment & training support. Targets to assist: - 35 into sustainable paid employment; -40 into accredited training; -15 into non-accredited training; -13 work trials/ experience; -13 into volunteering. CLE will continue to manage the SP resource which eligible individuals can access to further their employment, training and education goals. It should be noted, however, that demand for these services is greater than can currently be provided through the level of funding. However, from April, this funding will be combined with other funding from	Housing Needs / Skills and Regeneration/ ICU	Southampton Employment, Skills and Learning Partnership and wider private, public and third sector agencies

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		the ICU providing employment opportunities for people with mental health problems - there is a cross-over between the groups - which will provide efficiencies. In addition, there remains a resource from SP to pay for courses and equipment for individuals returning to work. Also need to ensure that other city council schemes and budgets are aligned. CLE is also funded through HRA to support c100 vulnerable housing tenants pa into employment, but similarly there is potential to provide larger scale/more targeted transformational change in areas of deprivation given greater resource allocation. The City Deal employment programmes have eligibility criteria relating to young people/adults, unemployed status and health conditions. Homeless/vulnerably housed people may fall into these criteria, and links will be made to ensure there are referral pathways (whilst these programmes are not specific to homeless clients)		
B: <u>Raising awareness and recognition of homelessness issues and protecting valued services</u>				
v. Continue to build relationships with landlords to raise awareness and common understanding of the	Accepted	Regular landlord forums are facilitated by Housing Needs as part of the Homelessness strategy commitment. The forum brings together landlord association representatives, Housing Benefit and Regulatory services with third sector and in house	Homelessness Strategy Steering Group	Landlord associations, supported housing providers and third sector homeless

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issues and barriers of homeless tenancies and increase social letting with relevant support agencies. This includes bringing together the current range of city approaches for social lettings to the private sector housing rental market.*		homeless services with a view to encouraging landlords to assist access to private rented housing for homeless clients and those needing to move on from supported housing. Longer term homes are provided currently through leasing schemes that operate in the city for adult and young people provided by partners RSLs in conjunction with landlords (e.g. No Limits/Chapter one and Real Lettings South).		agencies
vi. Raise awareness of good practice and successful outcomes in homelessness prevention services as a means of reducing the stigma for homeless clients and encourage wider partnership involvement of other agencies including the Police and National Health Services including GPs and the University Hospital Southampton Trust.*	Accepted	The Homelessness strategy steering group meets quarterly to monitor trends in homelessness in the city and to monitor progress against the strategy action plan including sharing good practice. Representation is from a range on internal and external agencies but will be reconsidered in the light of this recommendation with a view to widening the presentation in particular from health and Police.	Homelessness Strategy Steering Group	
vii. Expand the partnership to wider health services to reduce	Accepted	The development of the ICU provides an initial route to this - bringing together health and social care.	Homelessness Strategy	

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inequalities for homeless people services through delivering a comprehensive framework of preventative and integrated services.*		However, including UHS, Solent (although the Homeless Health Care Team are already a part of the Steering Group) and Southern formally will increase understanding and participation.	Steering Group	
viii. Raise the awareness of healthcare professionals of the role of homeless healthcare provider case workers and the value of their support of the single homeless, particularly through advocacy.*	Accepted	The launch of the Homelessness Prevention strategy in early 2014 was well attended and included agency service stalls which gave the opportunity for all contributors to understand how their service could better link to others. Feedback from the event indicates that similar opportunities would be beneficial to providing insight to wider health services to improve understanding . Extending membership of HSSG to more health partners will enable greater insight and understanding amongst healthcare professionals.	Homelessness Strategy Steering Group	SCC Housing Services/ Homelessness healthcare
ix. Maintain an overview of the cost benefit of key valued services within the City's Homelessness model, including the Homeless Health Care Team and dedicated specialist services supporting substance misuse and mental health problems.	Accepted	These are kept under review. New substance misuse services have commenced in the city under a long-term contract. This will continue to provide support to homeless people in the city, and the positive links already made with services will be built upon. Mental health services are currently being reviewed, and the impact of changes on homelessness will be considered as part of this - however, the key focus is on move-on and better support within the community, which will. The key consideration is the provision of appropriate long-	Southampton ICU / Clinical Commissioning Group	

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		term accommodation for this group. ICU will work towards maintaining tenancies or increasing % of people in settled accommodation being included as part of all contracts .		
x. Consider outcomes from the Southampton Healthwatch review of GP registration and continue to work with GPs to improve access and integration to support homeless clients to move on from homeless health care to primary care services.	Accepted	HealthWatch have been working with Wessex LMC to formalise the process for registering patients who do not have valid photo identification. Wessex LMC have published guidance to all practices which explains the requirements of the registration process. This clarifies that there is no obligation on practices to check identity on registration which has been seen as a barrier for homeless clients. The guidance outlines and suggests actions if fraud is suspected. Practices may request identification to minimise the potential for fraud however a lack of ID is not a reason to refuse registration. HealthWatch have a focus group with practice manager representation to develop this further and oversee impact of the guidance.	HealthWatch	GPs
C: Improving service delivery				
xi. The Homelessness Strategy Steering Group continue to support commissioners as they progress towards an	Accepted	The model of homelessness services within the city is based upon outcomes for users, both moving through the model and being diverted to other, more appropriate solutions. The Strategic Review process followed prior to future	Homelessness Strategy Steering Group/ ICU	Homelessness Services and providers

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evidence-based and outcome-focussed commissioning model so that the case for changes in policy and practice can be evidenced.		commissioning proposals being agreed enables all parties to be involved in discussions on future service structures. This enables the current performance and future requirements to be considered, so that evidence can be used to determine future structures within the available resources.		
xii. **Children and Family Services continue to prioritise the Multi-Agency Safeguarding Hub (MASH) and Early Help Team to ensure children in need are not falling through the gaps.***	Accepted	An effective MASH has been established in Southampton which is enabling good inter-agency information sharing and decision making at the first point of contact with statutory social care services. Early evidence from Southampton's MASH is very promising showing there has been a more accurate assessment of risk and need, as safeguarding decisions are based on coordinated, sufficient, accurate and timely information. Within MASH information is gathered from a wider range of sources which helps to build a more complete picture. Improved identification of risk allows for earlier intervention, taking preventative action before risk has escalated though the Early Help Team. These arrangements ensure that there is consistent management oversight of cases which avoids cases getting 'lost' in the system. Commitment to prioritising these services has been given and plans to extend the remit are progressing.	Children and Families	
xiii. **Children in Care**		Children's services have identified a number of	Children and	

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continue to be a priority, particularly in preparing those in care to lead an independent life and that care leavers have access to suitable accommodation and maximise opportunities for employment, education and training.*	Accepted	priorities for looked after children which include actions to achieve outcomes in relation to education, training, work and accommodation. These are included in the Ofsted action plan and are monitored by the Children's services Transformation Board. The recruitment of 5 additional Personal Advisors in the Pathways service will strengthen the offer to this group of young people and will provide some practical capacity in respect of reducing NEET and finding suitable accommodation in particular.	Families	
xiv. Homelessness Services work with National Probation Trust and the Hampshire Community Rehabilitation to support more pre-release planning to ensure emergency bed spaces are being used appropriately and to include looking at possibility of avoiding Friday prison releases.	Accepted in part	A Hampshire Community Rehabilitation representative is now part of the Homelessness Strategy Steering Group to progress better pre-release planning . Day of prison release is governed by sentence end dates which are outside of the remit of local agencies	Homelessness Strategy Steering Group	Housing providers, National Probation Service and Community Rehabilitation companies
xv. **Commissioners of Homelessness services should consider the option of providing a 'dry' environment within**	Accepted	The new contract for Alcohol services was implemented in June 2014. This includes a number of bedspaces (5) within a 'dry' house. There are further discussions with another agency to provide a supportive environment for users, which may include 'dry' areas.	Southampton ICU	

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Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
the homelessness prevention model in the City to support those who want to become or stay sober.*				
xvi. **Homelessness providers and commissioners should work towards developing 'psychologically informed environments' in hostels and develop a staff training programme as appropriate. Partnerships between the psychological support from the University of Southampton and local housing providers are essential to achieving this.***	Accepted in part	Proposals have already been received from a number of providers of homelessness services regarding psychologically informed environments. These are being taken forward as part of a programmed approach by landlords, where appropriate.This is best practice that providers should be incorporating within the training they are responsible for . It is important to use evidence based approaches	Southampton ICU	Homelessness Services and providers, Landlords
xvii. **Undertake a fundamental review of Mental Health services for the City, specifically including improving**	Accepted in part	Mental health services are currently being reviewed, and the impact of changes on homelessness is considered as part of this. The key consideration is the provision of appropriate long-	Southampton ICU	

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access to behaviour therapies for homeless clients and considering raising the age for transition for young people into adult services to 24 years in line with the thresholds for the Integrated Substance Misuse Service. Early intervention should be prioritised alongside improving access to services from primary to acute care to ultimately reduce and better manage demand.*		term accommodation for this group. In the meantime, there is an added focus being given to supporting employment opportunities with a joining of resources for homeless people and those with mental health problems into a single approach. This will rationalise the approach and provide benefits for users. However many people who are homeless would not meet specialist mental health services threshold and as there is a significant prevalence of lower level mental health issues in homeless community there is a need to train homelessness services to be able to address needs as part of core work, ensuring access to primary care services including IAPT. Commissioning post for young people/CAMHS will be looking at age issue as part of that project		
xviii. **Investigate opportunities to reduce barriers and provide incentives for Houses in Multiple Occupation (HMOs) to be used for homeless clients.***	Accepted	This recommendation will be raised at local landlord forums to determine what the barriers are and generate ideas about how these can be overcome.	Regulatory Services	
xix. Expand training on homelessness services / welfare services to community first	Accepted in part	This will be taken forward as part of the engagement with health services within the Homelessness Strategy Steering Group work. There	Public Health	

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Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
responders and primary care services e.g. Hampshire Police, Ambulance Services, GPs and community nurses		will need to be an analysis of impact from undertaking such training.		
D: <u>Monitoring and reviewing critical services and issues</u>				
xx. **Regulatory Services undertake an evidence based review of the effectiveness of the HMO licensing scheme to ensure that standards of quality are maintained for all private sector tenants in the City and to support the decision making process for whether to expand the scheme to other wards in the city. It should be recognised that those who have been homeless will be moving on into the lower cost / quality end of the market where risks to their**	Accept	A review has been undertaken to inform a Cabinet approved 12 week public consultation to support a proposal to designate Freemantle, Shirley, Millbrook and Bassett wards as an area for the licensing of houses in multiple occupation (HMOs).	Regulatory Services	

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Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
health remain high.*				
xxi. **Regulatory Services consider options to undertake a new stock condition survey to gain a better understanding of the quality of the City's private housing stock and establish mechanisms and resources to secure an up to date survey at least every 6 years.***	Accept in part	Agree with the recommendation and the principles behind this. At present no City Council resources have been identified to facilitate this, however, efforts will continue to identify the necessary budget.	Regulatory Services	
xxii. Integrated Drug and Alcohol Substance misuse service to report to the Health Overview and Scrutiny Panel on how changes to service delivery will support homeless people more effectively, particularly in relation to raising the age of transition into adult services.	Accepted	New substance misuse services commenced in December 2014 in the city under a long-term contract. This will continue to provide support to homeless people in the city, and the positive links already made with services will be built upon. Data will be collated to assess the impact	Southampton ICU	Drug service providers
xxiii. Continue to monitor homelessness trends	Accepted	The impact of welfare reforms locally will be monitored quarterly and reviewed/revised annually.	Skills and Regeneration,	Local Welfare Reforms Monitoring

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and impacts of Welfare Reforms on homeless people to enable an evidence based response to adapt the Local Welfare Provision where necessary and report the impacts of Welfare Reforms to commissioners, the Jobcentre Plus and the Department of Work and Pensions.		The outcome of government's consultation and funding decision for beyond March 2015 will influence the future of Local Welfare Provision, and will have a significant impact on support for homeless people.	Local Welfare Provision	Group
xxiv. The Homelessness Strategy Steering Group review the number, use and awareness of emergency weekend bed schedule for adults and especially for young homeless referrals and discharge from hospital or custody.	Accepted	The provision of emergency beds at both adult and young people supported housing services are monitored through contract meetings and the opportunity to raise additional issues is provided by the SP homeless supported housing group. This will then be fed into the HSSG via their representative.	Homelessness Strategy Steering Group	Homelessness service providers, hospitals, prison services
xxv. Homelessness commissioners undertake a city-wide review of valued services which may	Accepted in part	A review of the full range of homeless services will be required to identify what does or doesn't achieve best , cost-effective outcomes and how services fit into wider pathways. Breathing Space was developed as a pilot and funded	ICU/ Housing Service	

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Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
come under threat due to lack of funding. Immediate consideration should be given to determine their value to the city's Homelessness Model and health outcomes for individuals for The Two Saints Day Centre and 'Breathing Space' project and the Vulnerable Adult Support Team in the University Hospital Southampton NHS Trust's Emergency Department.		through a grant from the Department of Health. The city was approached recently by Two Saints as the original funding is due to end. Financial information shows the rates required to sustain the service are significantly higher than would be expected to be paid for a support service in the city. In addition, there have been significant void rates in the property. The service is in discussion with other agencies. There is a positive impact by providing a service for end of life care and for clients whose chaotic behaviour makes sustaining accommodation elsewhere problematic. Two Saints are now considering other options for continuing the service. Approval of grant funding for the provision of services for rough sleepers next year has recently be given to support services delivered by Two Saints at the Cranbury Avenue Day Centre from where health care provision for single homeless clients is delivered. Funding for VAST services has been extended and the function is being considered as part of wider pathway work to support rehabilitation and reablement		

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Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
A: A strategic city-wide approach to homelessness				
i. The Homelessness Prevention Strategy continues to support city-wide commitment for continued funding of the existing flexible and innovative partnership model of homelessness in the city.		Southampton' Homelessness Prevention Strategy and partnership model has been successful in keeping on top of homelessness in difficult circumstances – it is vital to retain the city wide commitment to the partnership model. Comments in Italics from No Limits a third sector provider service*:* *There will be a very significant drop in funding to SP projects effective immediately.*	Homelessness Strategy Steering Group	
ii. Commissioners undertake a feasibility study including a cost/benefit analysis, with providers, to consider whether a more intensive 'Housing First' model could provide the relatively small number but high cost entrenched homeless clients a potential route into sustainable and settled accommodation.*		A report from university of York will be published in February evaluating a number of Housing First models operating in UK. This will look at : Whether Housing First is an effective alternative to supported accommodation for chronically homeless people with support needs; and if this is the case determine key features of an efficient, effective, sustainable Housing First model for England -the scalability and replication of Housing First in England, can it work as effectively with 400 as it may with 14? -what does Housing First need in terms of	Southampton Integrated Commissioning Group (ICU)	

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		surrounding context, services in order to function well? -what are the barriers to successful implementation of Housing First? links to personalisation agenda -Suggesting a comparison with "treatment as usual", so that is a matter of comparing existing *system* costs against costs of Housing First This should be useful in feeding into your decision about developing this as a model. I have been on steering group for Housing First pilot in Brighton and am happy to share experiences from that. In Brighton the pilot has worked with the most complex individuals who have been in and out of services for years , and it has achieved some really good results.		
iii. The Housing Strategy continues to prioritise an increase in affordable single person accommodation across the City, including new		This should continue to be a priority	Development, Economy and Housing Renewal	

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Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
developments.				
iv. Links are maintained and strengthened between homelessness prevention and employment projects such as City Limits and the new City Deal to increase the skills and employment opportunities for homeless and vulnerably housed individuals.		It is increasingly the case that helping people into the labour market is the most sustainable way out of homelessness and so the strengthening of links between employment projects and homeless providers is an important focus	Housing Needs / Skills and Regeneration	
B: Raising awareness and recognition of homelessness issues and protecting valued services				
v. Continue to build relationships with landlords to raise awareness and common understanding of the issues and barriers of homeless tenancies and increase social letting with relevant support agencies. This includes bringing together the current range of city approaches for social lettings to the private sector housing rental		Comments in italics from No Limits a third sector provider service: *No Limits (national) funding for providing a PRAS (Private rented access scheme) for 18-25 year olds is due to end in April 2015. There is some local investment in the Day Centre and Real Lettings for private rented accommodation for 25 plus but this service is not available to 18-25 year olds. Building relationships with landlords is time consuming and they also need maintaining, there don't seem to be any resources identified to address this (with the exception of Real Lettings).The PRS is sighted as the*	Homelessness Strategy Steering Group	

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Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
market.*		*housing solution for single homeless but the city doesn't seem to be investing in the development and provision of affordable opportunities for those at risk of homelessness. If landlords are to get involved there need to be some clear incentives and benefits, this could include direct payment of rent post universal credit, checking the immigration status of potential tenants etc.*		
vi. Raise awareness of good practice and successful outcomes in homelessness prevention services as a means of reducing the stigma for homeless clients and encourage wider partnership involvement of other agencies including the Police and National Health Services including GPs and the University Hospital Southampton Trust.*		Encouraging wider partnership involvement from police, NHS, ASC, probation etc is vital to achieve more understanding of where services need to join together to jointly meet homeless people's needs.	Homelessness Strategy Steering Group	
vii. Expand the partnership to wider health services to reduce inequalities for homeless		There is quite a bit in the guidance to the new Care Act which supports and promotes integrated services. I haven't looked in detail but apparently these sections in particular worth looking at:	Homelessness Strategy Steering Group	

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KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
people services through delivering a comprehensive framework of preventative and integrated services.*		2.23 – "Prevention" explained in the context of the Care Act 2.34 / 2.36 – on the requirement to develop prevention work through integration of services inc. social care, health and housing Chapter 15 in its entirety on –"Duty to Cooperate" but specifically: 15.5 – CCG duty to integrate services / 15.6 details a housing integration case study within Better Care Fund 15.7 (b) – talks about having housing and Housing Related Support represented at Health & Wellbeing Boards 15.7 (c) – talks about potential to integrate information, advice and assessment services across social care and housing 15.12 / 13 – talks about joint commissioning and joint provision of integrated services 15.24 – Duty to Cooperate – housing colleagues working together with social care 15.29 – working with the NHS –		

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
viii. Raise the awareness of healthcare professionals of the role of homeless healthcare provider case workers and the value of their support of the single homeless, particularly through advocacy.*			Homelessness Strategy Steering Group	
ix. Maintain an overview of the cost benefit of key valued services within the City's Homelessness model, including the Homeless Health Care Team and dedicated specialist services supporting substance misuse and mental health problems.		Homeless health care team and dedicated specialist around substance misuse are a model of good practice in providing health care to this very vulnerable group. The evidence on health inequalities experienced by homeless people makes it vital to retain these specialist services	Southampton ICU / Clinical Commissioning Group	
x. Consider outcomes from the Southampton Healthwatch review of GP registration and continue to work with GPs to improve access and integration to support homeless clients to		It is important that people move on from homeless health care services to mainstream services as part of their integration into wider society and to free up capacity of Homeless health care to work with most vulnerable	Healthwatch	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
move on from homeless health care to primary care services.				
C: <u>Improving service delivery</u>				
xi. The Homelessness Strategy Steering Group continue to support commissioners as they progress towards an evidence-based and outcome-focussed commissioning model so that the case for changes in policy and practice can be evidenced.		Evidence based and outcome focussed commissioning is needing to become the operating mode for commissioning while resources everywhere are getting tighter	Southampton ICU	
xii. Children and Family Services continue to prioritise the Multi-Agency Safeguarding Hub (MASH) and Early Help Team to ensure children in need are not falling through the gaps.*			Children and Families	
xiii. Children in Care continue to be a priority,		According to latest Homeless Link report on young homeless 11 % of young homeless	Children and Families	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
particularly in preparing those in care to lead an independent life and that care leavers have access to suitable accommodation and maximise opportunities for employment, education and training.*		people are care leavers. This shows that more needs to be done to ensure care leavers are not failed and let fall into homelessness		
xiv. Homelessness Services work with National Probation Trust and the Hampshire Community Rehabilitation to support more pre-release planning to ensure emergency bed spaces are being used appropriately and to include looking at possibility of avoiding Friday prison releases.		The new CRC and duties around housing offers an opportunity to put in place some new structures. Simple no resource system changes such as avoiding Friday prison releases are exactly the kind of issues that need to be identified and acted on across services to ensure they work in the interests of the client group	Homelessness Strategy Steering Group	
xv. **Commissioners of Homelessness services should consider the option of providing a 'dry' environment within the homelessness prevention model in the City to support those**		Southampton is unusual in allowing the consumption of alcohol in all it's hostels. I cite this as a model of good practice as so many hostels work with people that are alcohol/substance dependent but don't allow consumption of alcohol or substances on premises. However there is also a case that	Southampton ICU	

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Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
who want to become or stay sober.*		some people trying to break drinking habits or people who don't drink would be better off in a dry environment		
xvi. Homelessness providers and commissioners should work towards developing 'psychologically informed environments' in hostels and develop a staff training programme as appropriate. Partnerships between the psychological support from the University of Southampton and local housing providers are essential to achieving this.*		PIE standards are being commissioned to in some areas and there is a good evidence base for 'Psychologically informed environments 'achieving good outcomes. Pap available from South London and Maudsley Mental health trust. Oxford providers offered staff training programme on PIE	Southampton ICU	
xvii. Undertake a fundamental review of Mental Health services for the City, specifically including improving access to behaviour therapies for homeless		Access to mental health services for people experiencing homelessness seems to be one of the biggest problems in every area. A fundamental review of how access works for this client group could prove to be an exciting model for other areas.	Southampton ICU	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
clients and considering raising the age for transition for young people into adult services to 24 years in line with the thresholds for the Integrated Substance Misuse Service. Early intervention should be prioritised alongside improving access to services from primary to acute care to ultimately reduce and better manage demand.*		The Making Every Adult Matter pilots have some examples of areas that are tackling the multiple needs issue and having some success. http://www.themeamapproach.org.uk		
xviii. Investigate opportunities to reduce barriers and provide incentives for Houses in Multiple Occupation (HMOs) to be used for homeless clients.*			Regulatory Services	
xix. Expand training on homelessness services / welfare services to community first responders and primary care services e.g.			Public Health	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
Hampshire Police, Ambulance Services, GPs and community nurses				
D: <u>Monitoring and reviewing critical services and issues</u>				
xx. Regulatory Services undertake an evidence based review of the effectiveness of the HMO licensing scheme to ensure that standards of quality are maintained for all private sector tenants in the City and to support the decision making process for whether to expand the scheme to other wards in the city. It should be recognised that those who have been homeless will be moving on into the lower cost / quality end of the market where risks to their health remain high.*		People who are moving on from homeless re main vulnerable and need protection from going into the poorest quality housing with unscrupulous landlords.	Regulatory Services	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
xxi. Regulatory Services consider options to undertake a new stock condition survey to gain a better understanding of the quality of the City's private housing stock and establish mechanisms and resources to secure an up to date survey at least every 6 years.*			Regulatory Services	
xxii. Integrated Drug and Alcohol Substance misuse service to report to the Health Overview and Scrutiny Panel on how changes to service delivery will support homeless people more effectively, particularly in relation to raising the age of transition into adult services.		Transition into adult services is an area that often causes difficulty. Keeping young people out of adult services for as long as possible seems like appositive step.	Southampton ICU	
xxiii. Continue to monitor homelessness trends and impacts of Welfare			Skills and Regeneration, Local Welfare Provision	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
Reforms on homeless people to enable an evidence based response to adapt the Local Welfare Provision where necessary and report the impacts of Welfare Reforms to commissioners, the Jobcentre Plus and the Department of Work and Pensions.				
xxiv. The Homelessness Strategy Steering Group review the number, use and awareness of emergency weekend bed schedule for adults and especially for young homeless referrals and discharge from hospital or custody.			Homelessness Strategy Steering Group	
xxv. Homelessness commissioners undertake a city-wide review of valued services which may come under threat due		These are models of good practice some developed on short term funding, much would be lost to homeless services if they cannot be retained.		

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of activity or reason for rejection	Lead	Key Partners
to lack of funding. Immediate consideration should be given to determine their value to the city's Homelessness Model and health outcomes for individuals for The Two Saints Day Centre and 'Breathing Space' project and the Vulnerable Adult Support Team in the University Hospital Southampton NHS Trust's Emergency Department.				

Submitted by: Sarah Gorton

Name (on behalf of) :

Organisation: Homeless Link

DECISION-MAKER:		CABINET		
SUBJECT:		SOUTHAMPTON LOCAL PLAN FOR THE BETTER CARE FUND		
DATE OF DECISION:		20 JANUARY 2015		
REPORT OF:		CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman**	**Tel:**	**023 80296004**
	E-mail:	**Donna.chapman@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Alison Elliott** **John Richards**	**Tel:**	**023 80 832602** **023 80 296923**
	E-mail:	**alison.elliott@southampton.gov.uk** **john.richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

In the statement on the next comprehensive spending review made in summer of 2013 the Chancellor of the Exchequer announced that nationally a sum of £3.8 billion would be set aside for 2015/16 to ensure closer integration between health and social care. This funding was described as “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities”. Local Authorities and the Clinical Commissioning Groups (CCGs) operating in their area were required to submit a plan setting out how the pooled funding will be used to improve outcomes for patients, drive closer integration and identify the ways in which the national and local targets will be met.

Over the last 12 months extensive work has been undertaken by the City Council working in partnership with Southampton City CCG and other stakeholders to develop Southampton's Better Care Plan, under the auspices of the Health and Wellbeing Board. The final plan was signed off by the Health and Wellbeing Board, Chief Executive of the City Council and Chief Operating Officer of the CCG on 19 September 2014 and submitted to Ministers. This has been recently approved following the Nationally Consistent Assurance Review which identified no areas of high risk within the plan and means that Southampton can now progress its plan with establishment of a Better Care pooled fund by 1 April 2015.

Southampton is one of ten authorities nationally with the ambition to integrate and pool resources at scale to significantly transform its health and care services. The Better Care Fund (BCF) requires a minimum contribution of £15.325m revenue funds plus £1.526m capital to a pooled fund. Southampton City's plan is to go far beyond this and pool over £132m, nearly 9 times more than the minimum requirement. The split between the forecast contributions is currently 57% CCG and 43% City Council.

RECOMMENDATIONS :

(i) To recommend that Council approve entering into a S75 of the National Health Service Act 2006 Partnership Agreement pooled fund, noting the minimum statutory requirement to pool £15.325m revenue and £1.526m capital.

(ii) To recommend that Council approve exceeding the minimum requirement to pool up to the total value of the first 3 schemes identified in Section 13 of this report (Cluster development, Supporting carers and Integrated discharge, reablement and rehabilitation) from 1 April 2015, noting Southampton's ambition to achieve integration at scale at a total cost of approximately £61m.

(iii) To recommend that Council approve the addition of the remaining budgets included within Section 13 of this report into the pooled fund as and when appropriate, bringing the total value to approximately £132m.

(iv) To recommend that Council delegate authority to the Director, People, following consultation with the lead Cabinet Member for Health and Adult Social Care, the Chair of the Health and Wellbeing Board and the Head of Legal and Democratic Services, to (a) agree the terms and conditions of the pooled fund agreement under Section 75 (S75) of the National Health Service Act 2006 and (b) to carry out any ancillary actions needed to give effect to this recommendation

REASONS FOR REPORT RECOMMENDATIONS

1. From 1 April 2015 Local Authorities and CCGs are required to establish a pooled fund under Section 75 of the NHS Act 2006 for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authority. For Southampton City the minimum value of the pooled fund is £15.325m revenue and £1.526m capital.

2. Southampton City Council has taken a more holistic approach to health and social care and proposes to fund and commission it in that way. The ambition is to encompass all services that fit within the scope of the Better Care model, bringing together approximately £132m into the pooled fund.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. Not to establish a pooled fund - this is not an option as Local Authorities and CCGs are required to establish a pooled fund for the minimum £15.325m revenue and £1.526m capital by 1 April 2015

4. To pool only the minimum - this has been rejected on the basis that Southampton's Better Care Plan, which has been signed off by the Health and Wellbeing Board, seeks to achieve a fully integrated model of health and social care. In order to achieve this ambitious transformation, it is considered necessary to bring together all of those health and social care resources associated with this vision and commission services in a fully integrated way, which is focussed on people's outcomes and needs in their entirety, as opposed to their health or social care in isolation.

5. To pool all of the health and social care resources for those services within the scope of the Better Care model from 1 April 2015 - this has been rejected in favour of a more gradual progression towards this aim which allows each scheme to be fully scoped and tested before adding it to the pooled fund. Three of the five schemes have been worked up in significant detail and are ready for inclusion from 1 April 2015.

DETAIL (Including consultation carried out)

6. The Southampton Better Care Plan is attached at **Appendix 1**. The details of the plan are not re-iterated in this covering report, as the plan is a detailed stand-alone document.

7. **Summary of Plan**

Southampton's vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.

The overall aims are:

- Putting people at the centre of their care, meeting needs in a holistic way.
- Providing the right care, in the right place at the right time, and enabling people to stay in their own homes for as long as possible.
- Making optimum use of the health and care resources available in the community, reducing duplication and closing gaps, doing things once wherever appropriate.
- Intervening earlier in order to secure better outcomes by providing more coordinated, proactive services.

Underpinning these aims are the following national conditions:

- Protecting social care services.
- Seven day services to support discharge from hospital.
- Data sharing.
- Joint assessment and accountable lead professional for high risk populations.

8. Southampton's plan has the following main schemes:

1. Local person centred coordinated care (clusters) - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working.
2. Integrated discharge, reablement and rehabilitation service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deterioration, as well as supporting people's recovery and reablement following a period of illness
3. Community solutions and prevention - this scheme is aimed at building on and developing local community assets and supporting people and families to find their own solutions.

4. Supporting carers – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care.
5. Developing the market for placements and packages and further integrating approaches – this includes work to develop the market to provide greater opportunity and choice, encourage a recovery/ reablement focus and support people to remain as independent as they can be in their own homes.

9. Southampton's Better Care Plan has been designed to achieve the following key targets:

- To reduce unplanned hospital admissions - by 2% year on year over the next 5 years (2014 – 2019).
- To reduce permanent admissions to residential and nursing homes - by 12.3% in per capita terms over 2014/15 and sustain and improve on this in subsequent years, bringing Southampton in line first with its statistical neighbours and then the national average.
- To reduce readmissions by increasing the percentage of older people still at home 91 days post discharge into reablement services - to achieve 90% in 2015/16.
- To reduce delayed transfers of care and therefore excess bed days - by 3 per day in 15/16 which equates to an approximate 10% reduction.
- To reduce injuries due to falls - by 12.5% by the end of 2014/15 and sustain and improve on this in subsequent years.

10. **Consultation**

Engagement with local providers has been an important aspect of the Local plan development. Providers, along with community, voluntary sector and public representatives have contributed to the shared view of the future shape of services.

Three large stakeholder workshops were held on 16 November 2013, 12 December 2013 and 17 January 2014 and involved a wide range of stakeholders from all of the local health providers, primary care, voluntary sector groups, local councillors and City Council housing and social care. Since then the Integrated Care Board which brings together senior operational and clinical leaders from the CCG, City Council, provider NHS Trusts and voluntary sector has been overseeing the development of the plan, with regular updates to the Health and Wellbeing Board. There has been ongoing engagement and consultation in cluster areas.

Extensive engagement with patients/service users and the public has also taken place and included:

- A range of service user focus groups including the CCG Patients Forum, Older Persons Forum focus group, Pensioners Forum
- Equality Reference group
- Healthwatch
- Carers Strategic group

11. **Development of the pooled fund - core principles**
What is a pooled fund?

Section 75 of the NHS Act (2006) allows the pooling of funds where payments may be made towards expenditure incurred in the exercise of any NHS or 'health-related' local authority functions. Section 75 also allows for one partner to take the lead in commissioning services on behalf of the other (lead commissioning) and for partners to combine resources, staff and management structures to help integrate service provision (integrated management or provision), commonly known as 'Health Act flexibilities'.

A pooled budget (or fund) is an arrangement where two or more partners make financial contributions to a single fund to achieve specified and mutually agreed aims. It is a single budget, managed by a single host organisation with a formal partnership or joint funding agreement that sets out aims, accountabilities, responsibilities, governance and technical aspects including financial reporting, management of risks, exit strategy, and treatment of overspends. Detailed guidance is attached at **Appendix 2.**

Benefits of a pooled fund

Southampton City's Better Care Fund Plan seeks to pool all budgets associated with health and social care services for older people and those with long term conditions to deliver a fully integrated provision centred around the needs of individuals. Pooling these budgets at scale will:

- Minimise overlap/gaps in service delivery, increase efficiency, improve value for money and ensure that services are designed to meet the needs of service users.
- Enable faster shared decision making, effective use of resources and economies scale.
- Enable radical redesign of services around the user regardless of whether their needs are mainly social or health.
- Enable greater transparency of spend – governance of a pooled fund requires all budgets to be clearly identified and monitored by both partners.
- Provide greater flexibility to move resources quickly to where they are required to meet need.

The Integrated Commissioning Board (ICB) of the City Council and CCG which oversees all integrated commissioning arrangements between the two organisations has been overseeing the development of the pooled fund, in consultation with City Council and CCG legal representatives and finance. The Board comprises the Cabinet Member for Adult Health and Social Care/Chair of the HWB Board, the Clinical Chair of the CCG, the Chief Executive of the City Council, the Chief Operating Officer of the CCG, the Director of Public Health, the Director of People, Chief Finance Officer of the CCG, Chief Finance Officer of the City Council and the Director of Integrated Commissioning and Quality. The Board have established the following core principles for the pooled fund:

1. To break the total pooled fund down into a number of smaller pooled funds each with their own hosting arrangements and specifications, but sitting under the overall Section 75 Partnership Agreement.
2. The host organisation which holds the budget for each pooled fund /

scheme will be the partner who contributes the majority of the funding to that pool, unless there are stronger reasons for this not to be the case. The main exception will be where the statutory functions associated with the specific scheme sit primarily with the other partner.

3. A phased approach will be adopted, whereby pooled funds are established within the S75 Partnership Agreement as and when schemes have been fully worked up. A gateway process will ensure sign off by both CCG and City Council through the ICB of each pooled fund scheme prior to it being placed within the Partnership Agreement.
4. It is proposed that the overarching Partnership Agreement has duration of 3 years with a 3 month notice period for variation, unless otherwise agreed by the ICB.
5. There will be an annual review of the whole agreement and each of the schemes within it.

12. **Governance**

It is proposed that the ICB will oversee the effective management and performance of the overall Partnership Agreement and each of the individual Schemes within it on behalf of the CCG and City Council. The Integrated Commissioning Unit (ICU) will support the ICB in this function, managing each of the Schemes and their associated contracts. A lead commissioner from the ICU will be identified to manage each Scheme and will ensure that quarterly monitoring reports are produced for each of the Schemes and contracts, detailing financial performance and performance against key outcomes and indicators.

13. Based on the above principles, the following is recommended:

Scheme	**Approximate Value**	**Host**	**Rationale**
From 1 April 2015			
Clusters (Local person centred coordinated care	£30m (CCG £29.8m; SCC £0.2m)	CCG	CCG contributing greatest share; enables alignment of primary care funding under co-commissioning arrangements.
Supporting carers	£1.4m (CCG £1.2m; SCC £0.2m)	SCC	Although CCG contributing greater share, statutory functions sit with SCC
Integrated discharge, reablement and rehabilitation	£29m (CCG £24m; SCC £5m)	CCG, (within this scheme there will be 2 subpools that will be hosted by SCC – Joint Equipment Store and both Capital schemes)	CCG contributing greatest share
TOTAL	£61m		

Funds to be varied into the Partnership Agreement at a later date			
Placements and packages	£60m (CCG £25m SCC £35m)	TBA	Clarification needed around which budgets to include and the benefits
Community solutions and prevention	£11.7m (CCG £200k SCC £11.5m)	SCC	Clarification needed around which budgets to include and the benefits
Total	£72m		
GRAND TOTAL	**£132m**		

It should be noted that all figures in this report are based on 2014/15 budgeted levels for both the Council and CCG. The equivalent budgets for 2015/16, except for the minimum BCF provision, may vary subject to the relevant budget approvals for each organisation.

RESOURCE IMPLICATIONS

Capital/Revenue

14 The minimum requirement for the Better Care Fund in 2015/16 is £15.325M Revenue and £1.526M Capital. The table below outlines the funding sources for the minimum required level for the Southampton Better Care Fund in 2015/16.

Funding Source	**£000**
Existing NHS Resource	
Care Act Implementation	600
Other	7,828
Re-ablement	1,212
Social Care Transfer	5,085
Carers	600
Total Revenue	**15,325**
Capital	
Disabled Facilities Grant	908
Personal Social Services Capital Grant	618
Total Capital	**1,526**
Total Minimum BCF	**16,851**

15. All of the above are existing funding sources included within either the Council or CCG 2014/15 budget. This funding is not new to the Health and Social Care system. However, under the conditions of the Better Care Fund, additional funding of £600,000 from within the pool will be provided to help meet the new responsibilities of the Council required by the Care Act 2014. This funding will

come from the existing NHS resource and will therefore be a pressure to the CCG.

16. The Council currently receive the Social Care Transfer funding of £5.085m from the NHS Commissioning Board and £1.2m from the CCG in respect of re-ablement. Although this funding will form part of the Better Care Fund from 2015/16 this will still be utilised to support Social Care. There will not be a negative impact on the Council's budget.

17. As outlined in the report it is planned to place three of the five schemes into the pool from 1st April 2015. These schemes will incorporate approximately a further £45m of funding from the Council and the CCG bringing the total planned pool for 2015/16 to £61m. Currently £3.4m of the additional £45m is within an existing joint funding arrangement between SCC and SCCCG under a S75, S76 or S256 agreement. The funding for the first three schemes entering into a pooled fund arrangement will be Council £5.3m, (9%) and CCG £55.5m (91%).

18. It is proposed that beyond April 2015 the remaining two schemes, (Placement and Packages and Community Solutions and Prevention) at the point they have been fully developed, will be varied into the pooled fund achieving a pool total of approximately £132m. These schemes total funding of approximately £71m, split Council £46.4m, (65%) and CCG £24.9m (35%). This proposed expansion beyond the minimum required BCF includes other CCG and Council budgets associated with the services within the Better Care model. These will be primarily services for older people and adults with long term conditions.

19. Children's Services are currently not within the scope of the pooled fund but could be considered for inclusion in future to reflect the development of more integrated services in this area also.

20. All financial totals included within this report are based on 2014/15 budgeted levels for both the Council and CCG. The equivalent budgets for 2015/16, except for the minimum BCF provision, may vary subject to the relevant budget approvals for each organisation. In respect of the Council there may be reductions in funding should the proposed savings be accepted at Full Council in February. All figures are indicative only at this stage.

21. As outlined in this report there are significant risks and opportunities associated with a proposed pooled budget of this magnitude. The work to mitigate these risks and maximise the opportunities within the contractual arrangement is currently under the consideration of the Legal Services team and the ICB.

22. It should be noted that it is the commissioning budgets for services that are being pooled and that the services themselves and the associated staff will remain managed and employed as they are currently. Therefore the recommendations in this report have no TUPE implications.

23. **Financial Risks**

The following risks will be mitigated as far as possible through the terms and conditions of the Section 75 Partnership Agreement which is being developed by City Council and CCG legal teams.

1. Overspends - As a general rule, it is proposed that overspends are handled at an individual pool level and are shared proportionately on the

basis of each partner's contribution.

2. Potential loss of each organisation's budget flexibility - careful consideration has been given to the budgets for inclusion in the pooled fund and the terms and conditions of the Agreement will include arrangements for either organisation to vary its contributions or achieve savings, without adversely affecting the other partner.
3. Equally there are risks that the Better Care fund programme does not achieve the targets outlined in Section 9 or indeed activity increases in these areas in spite of the Better Care fund and there is an increase in expenditure outside of the pooled fund. A risk mitigation plan has been developed to address this and is overseen by the Integrated Care Board.

Property/Other

24. The proposal should not have any property implications as it relates to commissioning functions. Any changes made to any service funded through the pooled fund which may have property implications will be subject to a separate report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

25. Section 75 of the National Health Service Act 2006.

    The pooled fund agreement will cover governance and technical aspects including accountability, financial reporting and the handling of overspends, underspends and savings requirements.

Other Legal Implications:

26. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to encourage and support integrated working.

POLICY FRAMEWORK IMPLICATIONS

27. The decision sought is wholly consistent with the Council's Health and Wellbeing Strategy and other policy framework strategies and plans.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton City Better Care Plan

Documents In Members' Rooms

1.	Pooled budgets and the Better Care Fund Guidance, October 2014 (The Chartered Institute of Public Finance and Accountancy)

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**SOUTHAMPTON CITY COUNCIL**
Clinical Commissioning Groups	**SOUTHAMPTON CITY CCG**
Boundary Differences	**Southampton City Council and Southampton City CCG boundaries are coterminous. The only difference will be where non Southampton residents have chosen to register with a GP in Southampton or residents have opted to register with a GP outside of Southampton city. 99.6% of Southampton residents are registered with a Southampton City CCG GP, whilst 5.7% of patients registered with Southampton City CCG live outside of Southampton City.**
Date agreed at Health and Well-Being Board:	**29 January 2014** **Progress report presented 26 March 2014 outlining feedback received on first cut submission and changes being**

	made to the final version of the plan following this and other feedback. **Joint HWBB with provider session to discuss plans and impact on providers held 23 April 2014.** **Meeting with the chair of the HWBB took place on 15 September to sign off the revised submission for 19 September.**
Date submitted:	**19 September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£924,000**
2015/16	**£15,325,000**
Total agreed value of pooled budget: 2014/15	**£2,210,000 (although not pooled until 2015/16)**
2015/16	**£132,718,000** **(Southampton intends to take a holistic approach to out of hospital health and social care and fund and commission it in that way. Our ambition is to encompass all services that fit within the scope of the Better Care model)**

b) Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	Southampton City CCG
By	John Richards
Position	Chief Officer
Date	19 September 2014

Signed on behalf of the Council	Southampton City Council
By	Dawn Baxendale
Position	Chief Executive
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	Southampton City Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor David Shields
Date	19 September 2014

c) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Summary presentation of Southampton's Better Care Fund local plan	Provides a user friendly summary of our plan.
Original Project Initiation Document and Engagement Plan	Sets out the governance arrangements and processes we used to develop our Better Care Fund local plan, along with the plan we used for communication and engagement.
"Healthier Lives in a Healthier City" - Southampton's Health and Wellbeing Strategy	Southampton City's Health and Wellbeing Strategy which is based around 3 key priorities: to build resilience and use preventative measures to achieve better health and wellbeing; ensure a best start in life and support people living and ageing well.
Integrated Reablement/Rehabilitation Service – concept paper	Outlines the model for developing our integrated reablement and rehabilitation service.
Strategic Context for Telecare and Telehealth in Southampton 2013	Sets out our vision, aims and key principles for developing telecare and telehealth in Southampton and the model we propose to adopt. A business case is in development.
Southampton City self management framework, 2013	Sets out how we will encourage, support and assist the wider development of self management with individuals and professionals in a wide range of care settings.
Southampton City personalisation –strategic intent, 2013	Our strategy for personalisation in Southampton.
Integrated progress framework, 2014	Southampton City CCG and Southampton City Council have signed up to Think Local Act Personal (TLAP) and 'Making it Real' (MiR). This document explores, identifies and sets out the key features to deliver Personal Health Budgets; 'Making it Real' and 'Integrated Person Centred Care' as well as presenting our self assessment.
Better Care Project Assurance Report	This provides assurance to the Integrated Care Board that our plans are progressing to timescale and we are delivering against our targets. The report is updated monthly.
Southampton Better Care Joint Communication Strategy	This sets out Southampton's joint Better Care communication strategy going forward.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Over the next 5 years, our vision is to completely transform the delivery of care in Southampton through our jointly led CCG and City Council Better Care programme so that it is fully integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.

Southampton's Health and Wellbeing Board has made strong progress in agreeing the Joint Health and Wellbeing Strategy: ".Healthier Lives in a Healthier City" with priorities to build resilience and use preventative measures to achieve better health and wellbeing, ensure a best start in life and support living and ageing well. Our aim is to deliver better health outcomes for the people of Southampton by ensuring we have the very best health and social care services possible. We believe that by working together in a seamless and integrated way we can achieve this. That is why we have an established Integrated Person Centred Care Programme which is jointly led by Southampton City CCG and Southampton City Council. We have adopted a 'one city' approach with active partnership between health, housing, community and social care and have established an Integrated Commissioning Unit to take forward our plans for stronger integration and aim of moving investment from a traditional organisation-focussed model of service provision to personalised, people-focussed solutions which are based on prevention and early intervention.

Our stated vision is for:

Health and social care working together with you and your community for a healthy Southampton

We are communicating this vision through adoption of the National Voices ambition **"I can plan my care with people who work together to understand me and my carer(s), [empower me to take] control, and bring together services to achieve the outcomes important to me"** (with some adaptation to reflect feedback we have received from community and voluntary sector partners).

Having good partnership working is different to developing the power of a strong inclusive community to boost health and wellbeing. We recognise the need to work with and learn from current and new partners to enable the development of strong, resilient and inclusive communities and to widen mutual understanding of interpretations, concepts or collective ideas around community development, encompassing social models, neighbourhood approaches, expert patient groups, mutual, cooperatives and peer support systems that transcend community, social and health environments.

Person centred care will be at the heart of everything we do. It changes and challenges personal, professional and organisational power - for community services and also fundamentally the way primary care is delivered. We are working with primary care to understand and overcome these challenges, and are working as a pilot site with the national organisation TLAP (Think Local, Act Personal) to develop this approach within the city (see our personalisation strategic intent document and integrated progress framework).

Our overall aims for integrated care in Southampton are:

- Putting **people at the centre of their care**, meeting needs in a holistic way
- Providing **the right care, in the right place at the right time**, and enabling people to stay in their own homes for as long as possible
- Making **optimum use of the health and care resources** available in the community, reducing duplication and closing gaps, doing things once wherever appropriate
- **Intervening earlier** in order to secure better outcomes by providing more coordinated, proactive services

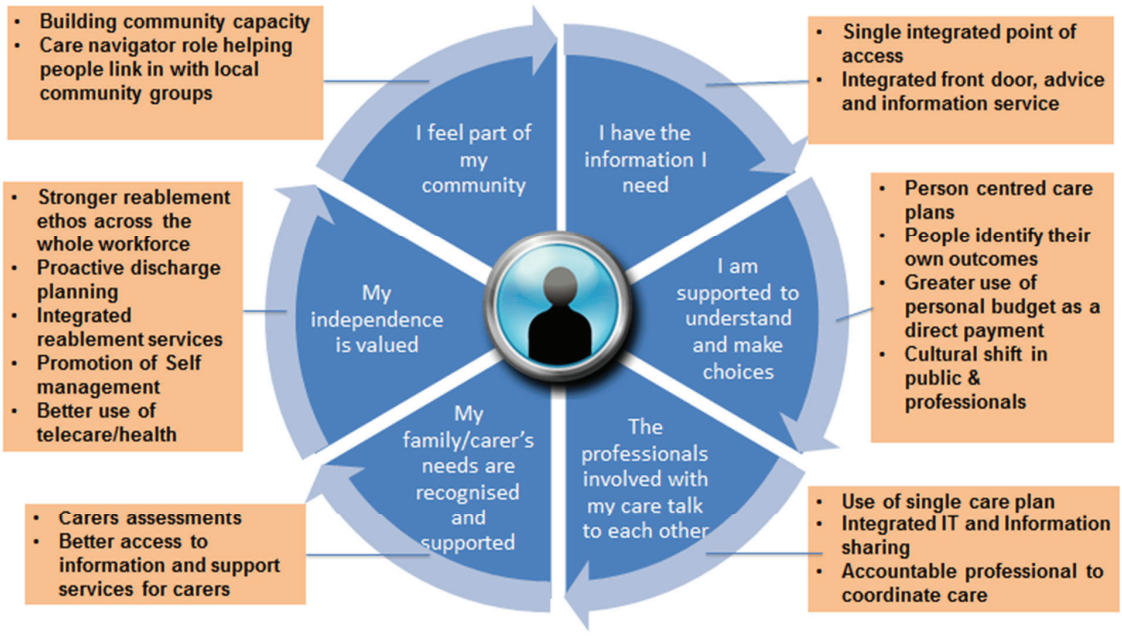
These aims, along with our objectives, outcomes and measures for success are set out below:

Aims	Objectives	Outcomes	Measures
To put people at the centre of their care	People are well informed and supported to manage their own conditions	Needs are met Outcomes for people are improved Health inequalities are reduced A sustainable health and social care system.	• Increased uptake of direct payments/ personal health budgets • Increase in self management • Increase in number of integrated person centred care plans • Positive feedback from service users and their carers
	Physical health, mental health and social care needs are addressed in a joined up way		
	Uptake of joint health and social care personal budgets is increased to maximise choice, flexibility and control.		
	Plans include resources from community, carers, family, alongside health and social care elements to provide holistic person centred working		
To provide the right care, in the right place at the right time	There will be easy access to high quality responsive primary care.		• Fewer people in acute care for less time – reduction in admissions, shorter lengths of stay, fewer delayed transfers of care • Fewer people in residential care • Fewer people dying in hospital • Increased engagement in community services
	Services will be provided in a timely way, when they are needed. This includes rapid response to urgent needs.		
	People will only be in hospital for the time when they need care that can only be provided in the acute hospital setting.		
	Reactive, unscheduled care will reduce and planned care will increase.		
	Direct payments and personal health budgets will be used to secure right services for the individual		
	Communities will provide increasing elements of local community services as an integral part of the care plan.		
To make optimum use of the health and care resources available in the community	Carers are supported to help maintain them in the effective role they play		• Increase in carers assessments • Increased use of telecare/telehealth
	Use of new technologies is maximised, including telecare and telehealth		

	People will be appropriately signposted to local voluntary sector and community support.		• Increased community capacity and utilisation
To intervene earlier in order to secure better outcomes	People's health and wellbeing are maintained for longer People remain as independent as possible Integrated risk stratification and proactive care planning will be rolled out and there will be a much stronger focus on prevention		• Greater number of anticipatory care plans developed following risk stratification • Earlier identification and support for people with dementia • Fewer falls

b) What difference will this make to patient and service user outcomes?

The diagram below illustrates what the future system will look like from the perspective of patients and service users.



From the perspective of patients and service users, the changes we are making will mean:

- **I have the information I need.** People will have easier access to information about the help available to them in their local communities through their local team or a community navigator. Better information and advice will be provided about the services

available and people will be able to telephone or visit the single integrated point of access to health and social care to assess their own needs or be directed to the most appropriate service.

- **I am supported to understand my choices and to set and achieve my goals.** People will be in control and will choose when to invite others to act on their behalf. They will draw up their care plan, in partnership with professionals and others where they choose, and be able to make choices about the support they use, including drawing on their own family and wider community assets. If they choose to do so, more people will be able to receive their personal budget as a direct payment and source their own support. They will have better access to information and resources such as telecare/telehealth that help them manage their own condition at home.
- **The professionals involved with my care talk to each other. We all work as a team.** People will have a single integrated care plan which they can access and control and is used by professionals from health and social care so that they do not have to keep repeating their story. A named lead will coordinate their care and ensure continuity.
- **My carer/family have their needs recognised and are given support to care for me.** Carers will be identified and be given information about their rights and the support they can access to help them cope and live their lives to the full, whilst caring for their loved one.
- **I feel part of my community.** People will have the opportunity to be linked into local voluntary sector schemes and community groups by their care coordinator or community navigator, which enable them to develop a network of support and share experiences. For example, people might choose to access a local time bank which will enable them to make a contribution to their local community and develop wider friendships.
- **My independence is valued.** Care coordinators will play a key role in proactively identifying when people need additional help or support to manage a crisis. When people are admitted to hospital, the care coordinator will coordinate everything that is needed to get that person back home as quickly as possible; planning for discharge will start as soon as someone is admitted. Reablement services will be more proactive in supporting people's recovery, available 7 days a week.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

To deliver its vision, Southampton City had already embarked on a system wide change programme (the Integrated Person Centred Care programme) before the announcement of the Better Care Fund. Success requires substantial change in the way services are provided and staff work with people, local communities and each other.

The Better Care Fund provides a timely opportunity to go further, faster. It will bring together a wider range of existing resources from across the CCG and City Council to commission in a more joined up way, coordinating care, driving out duplication and increasing efficiencies. We will be exploring how different contractual and funding models can support this. Efficiencies from improved utilisation of resources and reductions in activity in the acute hospital sector will release money to be reinvested in the integrated out of hospital model.

<u>Current State</u>

There is a need to move from a reactive system where there is duplication and gaps, characterised by high numbers of delayed discharges, to a more proactive system where care

is delivered with and around the person in a joined up way, focussed on meeting need at the earliest opportunity and connected to local communities.

In Southampton primary care services are delivered to 268,200 registered patients by 33 GP practices, the average list size being around 7,000. Out of hours primary care is provided by Care UK who also now provide the city's Minor Injuries Unit (MIU). There is one main acute NHS Trust provider, University Hospital Southampton (UHS), delivering secondary care to the majority of Southampton's residents with small amounts of activity at neighbouring Trusts, e.g. Salisbury, Winchester and Bournemouth hospitals. UHS is the main provider of accident and emergency care in Southampton. There is an acute ISTC, provided by Care UK, which accounts for approximately 35% of the CCG's elective activity. The CCG commissions adult Mental Health and Learning Disability services from Southern Health NHSFT, IAPT from Dorset and the majority of its remaining community provision from Solent NHS Trust. There is an increasing amount of independent sector activity. Over the last two years other providers have come into this landscape, such as Millbrook Healthcare who delivers the Wheelchair service and jointly commissioned Joint Equipment Service and a series of AQP contracts for ENT/Audiology and Back and Neck pain.

Southampton City Council currently provides the majority of adult social care itself but is part way through a significant transformation that will improve the customer pathway with a focus on personalised approaches and increased choice. The council also owns a lot of housing stock in comparison to other authorities and therefore opportunities for Extra Care and other alternative housing options have been created.

The CCG is coterminous with Southampton City Council and has a strong history of partnership working which has led to the establishment of an Integrated Commissioning Unit (ICU) in January 2014 which also incorporates Public health. There are already a number of joint commissioning arrangements including S75 agreements for Learning Disabilities, Mental Health, the Joint Equipment Service, and Substance Misuse as well as jointly funded provision such as the JIGSAW joint disability service for children, the Behaviour Resource Service for young people, Sexual Health services and reablement provision.

We have a good basis to work from but recognise we still have a long way to go.

Primary care is key to delivering our vision. All 33 GP practices in Southampton have signed up to the Avoiding Unplanned Admissions Avoidance DES (Proactive Care Programme) and are using the risk stratification tool (ACG tool). We have reconfigured Community nursing into 13 teams around groups of GP practices and are building on this for the cluster arrangements described in Better Care Scheme One. Case management is firmly embedded for all elderly patients at risk of admission, care being coordinated by community matrons with a care plan and support in primary care to proactively manage their needs. We are exploring different organisational models with GP practices, such as federations, and have applied to become a co-commissioning pilot (see Section 6c). Some practices are beginning to work differently. Several GP practices have been piloting self management approaches and one neighbourhood (comprising two GP practices, social care, community nursing, older people's mental health services, as well as local voluntary and community groups) has been piloting an advanced model of integrated care to identify early and support people at risk of hospital admission. The pilot has a strong evaluation basis which is being led by Southampton University.

However levels of engagement and capacity within primary care generally are a long way from where they need to be. A key priority in 2014/15 is therefore primary care communication and engagement (see our Communication and Engagement Plan attached).

In addition we are investing £1.287m under the Everyone Counts £5 per head initiative into the provision of elderly care nurses to work in practices supporting them in discharging their responsibilities in caring for people over 75 years under the GMS contract. This has been based on evidence from a pilot in a local practice (Old Fire Station surgery) that has been well reviewed and audits have shown a reduction in admissions. The scheme has been developed with strong practice engagement and different models of employment are being piloted across the city. This will be linked into the Better Care clusters described in Scheme One.

Another key area of focus for Better Care in Southampton is discharge, rehabilitation and reablement. Discharge processes need to become much more proactive. Southampton has an Integrated Discharge Bureau (IDB) which coordinates complex discharge and manages around 23 patients discharged from Section 2/5 a day (split roughly equally between Southampton City and West Hampshire). On a daily basis there are around 140-170 active Section 5s. Approximately 40% are discharged within 3 days, 50% within 5 days. We have set a target to increase this to 60% discharged within 3 days. We are in the process of recruiting a jointly funded IDB manager to strengthen leadership across the system in the discharge process and are working towards a much more proactive model which commences the discharge process at the earliest point within the patient's journey. The agreed direction of travel across all partners is that people are not expected to make life changing decisions in hospital, and that home should be the default position for discharge destination. To facilitate this, it has been agreed that there should only be two discharge pathways out of hospital – simple, covering an anticipated 80% of discharges and complex for the remaining patients. It is anticipated that 80% of discharges will be simple and a model of trusted assessor is being rolled out for this group whereby Southampton City Council are training health staff to undertake simple assessments and restart/initiate simple packages. For the 20% complex discharges we have sourced 12 additional nursing placements to allow for speedy discharge and assessment outside the hospital. Ward staff will be commencing the discharge process at the point of admission.

Our Better Care Scheme Two takes this one step further by integrating health and social care rehabilitation and reablement services. Southampton has two health based rehabilitation wards (Royal South Hants (RSH) with 43 beds across two wards) and a Local Authority Unit (Brownhill House with 25 rehab beds) that is partially health funded to provide rehabilitation for people who are medically fit. Both sets of provision offer "step up" from the community and "step down" from an acute setting. Clinical support to the Local authority unit is provided by the health team at the RSH. Collectively these units are operating under capacity. The intention is therefore to consolidate community bed-based provision with a strengthened rehabilitation/reablement offer both in the community hospital and community. This is described in more detail in Scheme Two.

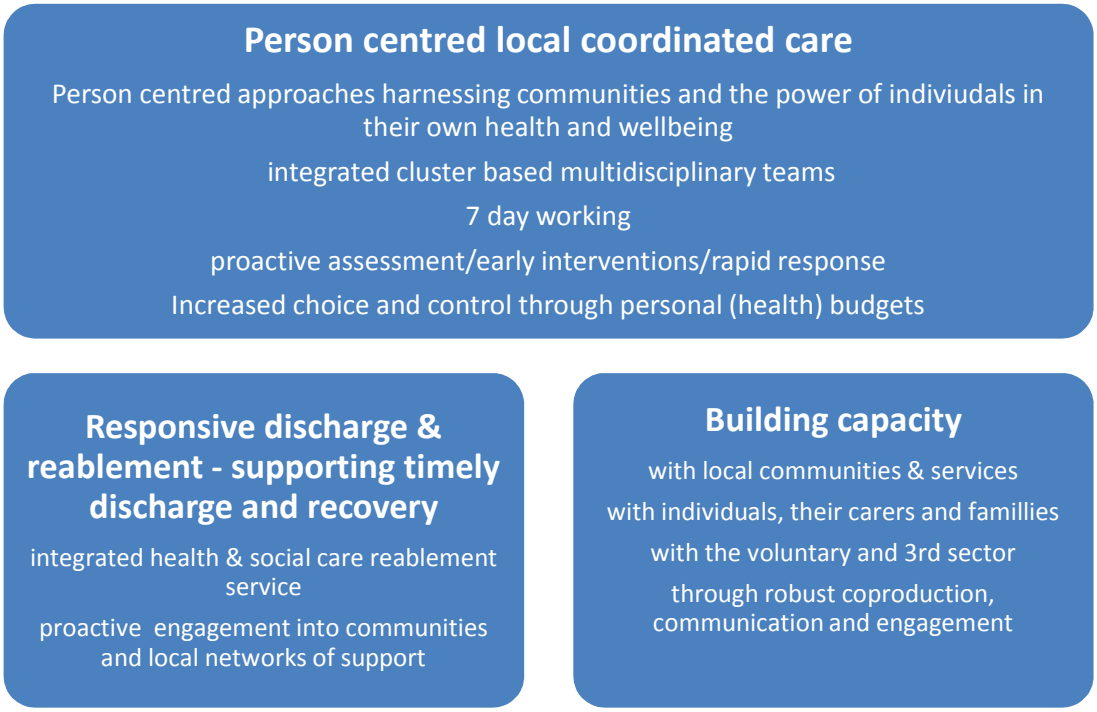
To support the above model, the ICU is also retendering domiciliary care provision. The domiciliary care market currently within Southampton provides care for approximately 1,810 people in any given week (1,750 SCC and 60 SCCCG). There are currently 10 framework providers but up to 65 spot purchased providers) in the city delivering care packages on behalf of SCC and the CCG. The provision includes domiciliary care, supported living and extra care. Whereas usage has reduced over the last 3 years, investment in domiciliary care has

increased, showing the intensity of the services is increasing. Responsiveness of domiciliary care is an issue. Adult domiciliary care is allocated on geographic areas, reflecting the need to reduce travel times and work in smaller areas of the city. However, with only one provider in each area whenever capacity, quality and or safeguarding concerns occur there has been no directly commissioned market provision to provide cover. This has resulted in significant use of spot purchase arrangements (over 45%). Domiciliary care agencies have historically worked in silos, without fully understanding the part they play in contributing towards Southampton's strategic position.

The intention of the new Framework which is being tendered for commencement February 2015 is therefore to increase flexibility, capacity, better support personalisation and Individual Service Fund (ISF) approaches, thereby creating more choice and control for users, ensuring services are able to respond to changing needs and demands and offer better value for money. There will be a focus on the importance of ongoing reablement within the new specification.

Changes to Service Delivery

Our approach to system redesign has 3 basic components:



The core principles underpinning our model are set out below:

- **Person Centred** - individuals will have maximum choice and control through person centred care planning and supported self management of their health and wellbeing.
- **Personal control** – patients and service users can decide how the money allocated for their care should be spent.
- **You, not your illness** - the approach to care will be holistic and not focussed around diseases or conditions.

- **Being the best we can be** – we will make the most of the skills and resources available to us, building on the strengths of people, their families, carers and local communities.

- **Integrated and seamless** - services will be delivered in an integrated way at all levels wherever possible with a focus on local care.

- **Round the clock** - out of hospital care will be a 7-days-a-week service and will be consistent both in and out of hours.

- **Community-led** – the vast majority of people's needs will be managed in the community by the local cluster teams and wider community support. Community services will be the first port of call for people seeking help for themselves or others.

- **Efficient and consistent** - care planning and assessment may be undertaken by any agency using a common trusted tool.

The following sections describe the changes to the pattern and configuration of services in more detail.

Person centred local coordinated care

This includes:

- **Formation of multidisciplinary cluster teams -** Building on our principle of care being as local as possible, we will further develop our integrated nursing clusters and virtual ward model to create a number of fully integrated teams around clusters of practices. These teams will be multidisciplinary including health staff (community nursing, therapists, geriatrician, MH nurses, primary care staff), housing workers, voluntary sector, reablement with strong links to social care and will in-reach into acute settings to facilitate timely discharge. The teams will be co-located in each cluster area. It is expected that each team will cover a population of approximately 30,000 - 50,000. Work has already commenced to align staff and older people's mental health staff have just integrated within the community nursing teams.

  2014/15 is a period of transition. This will include identification of need in each area through the pooling of intelligence and beginning to jointly identify those people most at risk who may benefit from early preventative planning or intensive case management. The link to our Joint Strategic Needs Assessment (JSNA) data compendium below shows how we have already begun to collate demographic and need data about each of the clusters:

  http://www.publichealth.southampton.gov.uk/HealthIntelligence/profiles-local.aspx

  Throughout the transition stage there will be a focus on opportunities for joint training, shadowing and staff rotations.

  This new model of local cluster teams will be underpinned by:

- **Implementation of the new GMS contract** which brings a significant shift of focus, through QOF requirements, into supporting older people. This includes the introduction of a named accountable GP for patients over 75, a contractual duty to monitor the quality of the Out of Hours service and support integrated care by record sharing and a new enhanced service for patients with complex needs. The enhanced service requires practices to improve access, ensure other clinicians can contact the GP for advice, carry

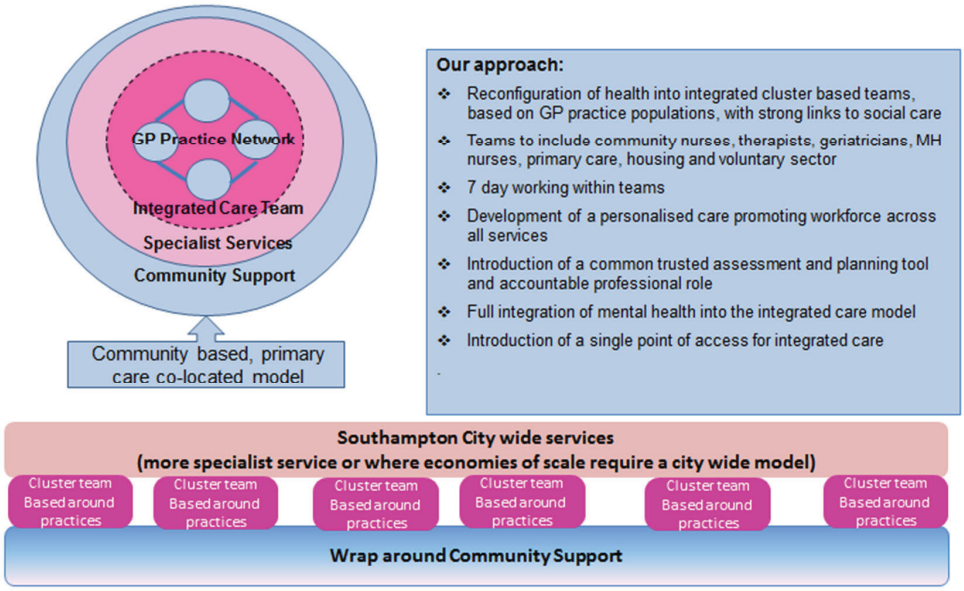
out regular risk profiling to identify at least 2% of patients a year, provide proactive care and support for at risk patients with personalised care plans with a named accountable GP and care coordinator and work with hospitals to review and improve discharge processes. This is progressing well within the city.

- **Introduction of a common trusted assessment and planning tool across health and social care** (building on the comprehensive geriatric assessment but adaptable for all client groups covering medical, mental health, functional capacity and social needs) together with proactive risk profiling to identify high risk patients using predictive tools and combined intelligence. As stated above, we are currently rolling out the "trusted assessor" role amongst our hospital discharge and in-reach coordinator teams to enable them to restart or make small changes to social care packages to facilitate the discharge process.
- **Joint workforce development / development of core generic skills,** e.g. person centred planning, risk profiling, self management, care coordination, brief intervention skills, working with those with dementia and leadership in a multiagency context. This will require working closely with the Local Education and Training Board.
- **Implementation of the care coordinator/accountable professional role** for every person identified as at risk to oversee the person's integrated care plan, coordinate their care and act as a single point of contact for them and their family/carers, building on the existing case coordinator role for older people. During 2014/15 we are developing a common skill set for this role and rolling out a programme of workforce development.

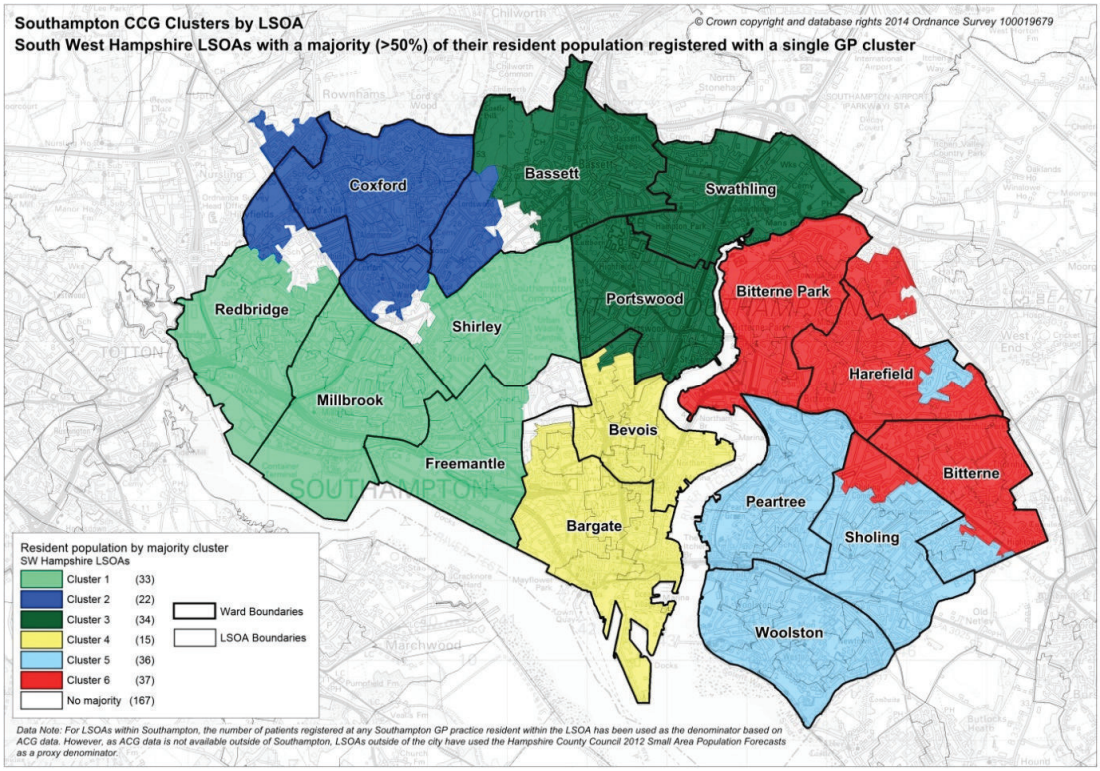
- **Full integration of mental health into the integrated care model.** People with long term conditions, e.g. diabetes are more likely to have mental health problems. Where mental health co-morbidities exist, care can be 45-75% more expensive and patients are less likely to be discharged in a timely way. Therefore it is crucial that the model considers mental health needs. This will include assessment of mental health needs as part of the common assessment tool as well as tailored psychological therapy when necessary. This will be delivered through skilling up the local primary care and community workforce to manage non complex mental health problems, improved psychiatric liaison and further roll out of IAPT, building on the training already provided to some community staff on the use of psychological approaches which is proving to be effective

- **Integration of specialist services for people with Long Term Conditions into the model.** Specialist services will also reconfigure to actively work within the clusters and some outpatient clinics currently located in the hospital will be delivered locally. This will include work with acute and community geriatricians with a focus on frailty.

The diagram below illustrates the role and function of the cluster teams.



The proposed 6 clusters are illustrated below.



The configuration of the clusters has been based on the following principles:

- To be developed through co-production, involving public, patients, services, voluntary sector

- To be built on a geography which is understandable, e.g. that people see as a community, that takes account of transport routes
- To be based on practice populations
- To provide a balance between economies of scale, local responsiveness and cost effectiveness
- To reflect the use of local resources (e.g. schools, churches and faith communities, libraries, housing offices, voluntary groups) and knowledge of the community

The integration that Better Care Southampton provides will enable us to achieve the following:

- 7 day working within teams
- Increased use of technology for delivery of services and support.
- Development of a personalised care promoting workforce across all services
- Greater adoption of Personal Health Budgets ,Personal Budgets and uptake of direct payments as the method of arranging care and support to meet individual need, underpinned by implementation of support planning services and changes to finance systems to support delivery of a personalised health and social care environment
- Introduction of a common trusted assessment and planning tool across health and social care plus proactive risk profiling using combined intelligence
- Implementation of accountable professional role for every person identified as at risk to oversee the person's integrated care plan
- Full integration of mental health into the integrated care model
- Introduction of a single point of access for integrated health and social care providing user friendly information that allows people to assess their own needs and onward referral for intervention
- Increased use of self management approaches

Responsive discharge and reablement

This includes:

- **Redesign of an integrated health and social care rehabilitation/reablement service for the city** bringing together the following individually managed services:
  - Brownhill House (City Council reablement residential provision) and the RSH wards (managed by Solent NHS Trust)
  - Telecare and telehealth
  - City Care First Support (CCFS and CCFS 24) which is a City Council "reablement team", the function being to offer practical support and encouragement to clients in their own home focussing on goal orientated plans that promote independence. The team works with160 Clients (day time) and 15 Clients (overnight).
  - City Council Reablement Team which is a new SCC team developed to act as the practitioner support to CCFS introducing a multidisciplinary team (MDT) approach to reablement goal planning. The team is made up of care managers, OT's and OTA's.
  - Health Community Rehab Teams provided by Solent NHS Trust which are locality based and multi-professional, comprising of Occupational Therapists, Physiotherapists, Associate Practitioners, Community Support Workers, OPMH Support Workers and Consultants in Integrated Medicine for Older People. The teams support people with complex rehab needs in the community, and specialise in the assessment and treatment of falls.

- Rapid Response and Out of Hours service provided by Solent NHS Trust which is a multidisciplinary health and social care team working in Southampton City caring for vulnerable adults who have a medical, nursing or social crisis and can be cared for safely at home for up to seven days. The service also provides nursing care out of hours and on occasions earlier hospital discharges for clients awaiting Care Package start dates for up to seven days.

- Reablement and rehabilitation services help people maintain or regain their ability and confidence to live at home following a period of instability. Key aims of the integrated service will be to:
  - sustain recovery momentum and build confidence
  - focus collective resources to improve potential for successful reablement
  - develop a culture that promotes independence and self management as the default position
  - reduce demand for nursing/residential care or long term social care input
  - reduce, delay or negate the need for people to access acute services through proactive management of care and risk in the community
  - support effective and timely discharge and reduce risk of readmission

- The integrated service will be available 7 days a week and enhanced to provide more people with reablement opportunities. Discharge planning will start at the point of admission or as soon as possible after stabilisation of a crisis and there will be a focus on reablement earlier in the patient's pathway to support speedier recovery. Service users will get tailored and practical support. Straightforward needs will be met early without the need first for extensive assessment. Reviewing processes will be developed to identify people who may not have been ready for reablement initially but following a period of care, reablement may become an option. Explicit methodology will be developed along with consistent, clear routes into reablement.

- There will be much stronger emphasis on embedding a reablement culture across wider community provision and supporting people to engage with existing support in the community, recognising that reablement is wider than the activity associated with a distinct team. This will include enhancing the reablement focus within the locality/cluster teams and with domiciliary care, nursing and residential home providers. In developing the model consideration will also be given to which functions should remain central city wide functions (e.g. community beds, out of hours cover) and which would be better integrated into the locality/cluster teams.

- A key element of the service will be falls prevention. This will include development of a liaison function between the fracture clinic and rehabilitation/reablement team to ensure that all fallers are followed up and an appropriate management/rehabilitation plan is devised, including use of medication. Discussions are also underway with the voluntary and community sector, housing and leisure providers to develop a programme of exercise that patients can be referred into to improve core strength and balance.

We will use the Better Care Fund to:

- Ensure 7 day availability across service
- Ensure more proactive response to meeting straight forward needs
- Increase use of technology for delivery of services and support.

Other key aspects of the model (not solely dependent on the Better Care fund) include:

- Building a reablement culture into wider community provision, e.g. domiciliary care, nursing and residential providers
- Increasing use of self management approaches
- Improving focus on helping people plan to return to employment

Building capacity

This includes:

- **Increased support for carers -** The Council and CCG have pooled available resources to re-commission direct support services during 2014/15. These services will streamline current provision while expanding the identification, advice, information and support provided to the increasing number of unpaid carers. This work is ambitious in its remit and will work with young, adult and older carers in appropriate ways. Services are required to meet the critical areas set out nationally and locally, in particular supporting those with caring responsibilities to identify themselves at an early stage, providing accessible and meaningful information through website, literature, face to face contact and wider technical communication channels, recognizing carers in their own right, maximising the education, employment, income and benefits of carers and building community capacity to improve the wellbeing of carers (and those cared for). This will support the new eligibility framework within the Care Act where, for the first time, councils will be under a duty to provide support for carers who have eligible needs. Initial modelling work suggests that between 5% (249) and 25% (1243) carers providing 50 or more hours of unpaid care per week will request an assessment of need in 2015. As awareness increases over 2015, it is anticipated that a further 5-10% of carers will request an assessment of need in 2016. It is planned to substantially increase the number of carers identified from April 2014, rising from under 3,000 to over 5,000 by March 2015. This will be supported by the creation of a single contact point for advice and information for all adult carers in Southampton.

- **Development of more person centred approaches.** The philosophy of personalisation is relevant to all residents, of all ages, in Southampton to ensure they have the greatest level of choice and control over the care and support needs relevant to them. This includes individuals being able to access good clear and accurate information to support them in making well informed and relevant decisions, through to personal budgets offered and taken by the individual in a way that they feel they have as much choice and control as they would like. Person centred care sits at the heart of personalisation and requires the workforce to work with the individual, once they need care and support, in partnership, so that the individual's expertise and skills about their own situation is combined with the expert knowledge of the professional. Over the next 5 years, we will be improving uptake of Direct payments for residents accessing adult social care. The council currently has a low take up of direct payments in comparison to other authorities. The focus will also be on increasing access to personal health budgets for those eligible for continuing health care (during 14/15) and those with long term conditions (from 2015). We will be developing our workforce to promote the philosophy of personalisation, supported by a CQUIN scheme as part of all our NHS provider 14/15 contracts that requires organisations to self assess where they are in terms of staff awareness, systems and practice and set their own action plans for improvement. Through commissioning we are ensuring a variety of Support Planning approaches that empower and enable individuals to plan their care and support, drawing on strength based approaches, maximizing individual assets and local communities.

- **Development of community assets -** This will include maximising use of local facilities and gathering and making available information about activities and support networks that promote good health and wellbeing such as access to public transport, housing advice and leisure options. Gathering of local community intelligence and building partnerships with

the community, and other stakeholders such as police and fire services, will be a key priority for each of the cluster teams working in shadow form during 2014/15. Community development will be further supported by the **introduction of a community/support navigator role to act as a single point of contact in each cluster.** This role will also include building a knowledge base of local resources/facilities, signposting staff and service users to services/community assets and stimulating community development. We have been further defining this role in partnership with Healthwatch and the voluntary sector with a view to appointing the first care/support navigators later this year. It is envisaged that this role could be undertaken by any discipline or agency and would not require a formal health or social care qualification.

- **Placements and packages –** our commissioning strategy will take into account profiling of future needs and changing demographic factors. It is expected that demand for long term residential and day services will change over time as many older people will want to stay at home for as long as possible. This will require changes in the market to maintain more people at home, remaining healthy and with a sense of wellbeing for longer. This will include reviewing and adapting City Council owned housing stock and development of extra care provision. There are already examples of this underway within the City. The Integrated Commissioning Unit will have a key part to play in shaping the market, for both commissioned provision and provision purchased directly by people through personal health budgets/direct payments or self funders. For this reason, the City Council and CCG have invested specifically in a market development team which forms part of the Integrated Commissioning Unit and in the development of a capacity planning tool
- In the shorter term, the Integrated Commissioning Unit has embarked on a programme of quality and capacity development within nursing homes in order to reduce delayed transfers from hospital. This includes strengthening nurse leadership, improving nurse recruitment and development and negotiation with nursing homes who have voids to take social care clients.

The integration of resources under the Better Care Fund enables us to:

- Develop markets and communities to maximise local capacity to support health and well being of community, including local action to reduce loneliness and social isolation, achieved through robust communication and engagement work
- Develop proactive support through voluntary sector partners to attract and maximise alternative funding opportunities (e.g. Big Lottery, Trust funds) into local communities of identity (e.g. ethnicity, diagnosis, neighbourhoods)
- Provide an integrated health and social care information, advice and guidance service, linked to single point of access
- Develop markets and communities to provide an active and vibrant environment for social enterprise, micro enterprises and self help mechanisms to flourish
- Increase support for carers through new jointly commissioned support services, underpinned through better information for carers, greater identification within community services and increasing assessments
- Implement support planning services to empower and enable individuals to plan their own care and support to those with single diagnosis or low to moderate FACS eligibility.
- Provide greater encouragement and support for self management and person centred care planning through community and early contact points
- Refresh demand and capacity plan for community support (nursing homes, residential homes, day care)
- Quality and capacity development programme with local nursing homes

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

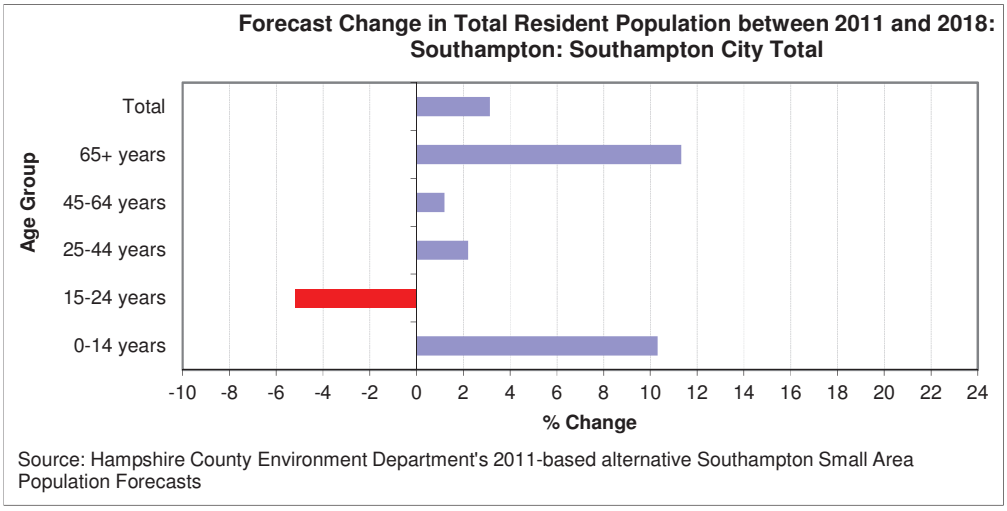
There is a strong case for change. CCG spend on acute activity is 54% and growing, rates of unplanned admissions and delayed transfers are above the national average, pressure on beds is unsustainable and unsafe and there are high rates of admission to residential and nursing homes. A higher proportion of older people in Southampton rely on input from social services than is the case nationally (5.2% compared with 3.8%). This is against a backdrop of rising need.

There are health and social care challenges associated with key population changes that we need to plan for and address. Specific challenges highlighted in the JSNA include:

- The increasing proportion of older people and accompanying increase in dementia
- The increase in unhealthy lifestyles leading to preventable diseases
- Work stresses and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (education, poor housing, transport and economic regeneration)

In 2011 the Census recorded the resident population of Southampton to be 236,900 with 268,200 people registered with GP practices in January 2013. In Southampton 17.6% of residents were born outside UK which is a greater proportion than in any of the city's comparator authorities. Southampton has a higher proportion of households where no-one has English as their main language (7.7% compared to 4.4% nationally).

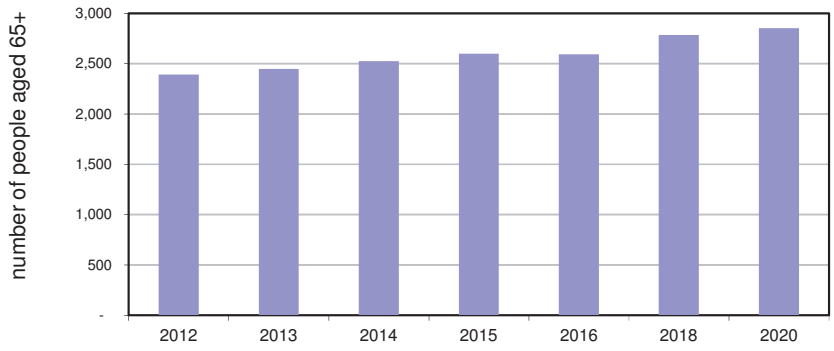
The overall population is forecast to rise by 3% between 2011 and 2018. The over 65s population is set to increase by 11% (see below) and the number of people over 85 years from 5400 to 6100 between 2012 and 2019.



Source: Hampshire County Environment Department's 2011-based alternative Southampton Small Area Population Forecasts

Accompanying this rise in the older population, Southampton is seeing an increasing number of older people living with dementia.

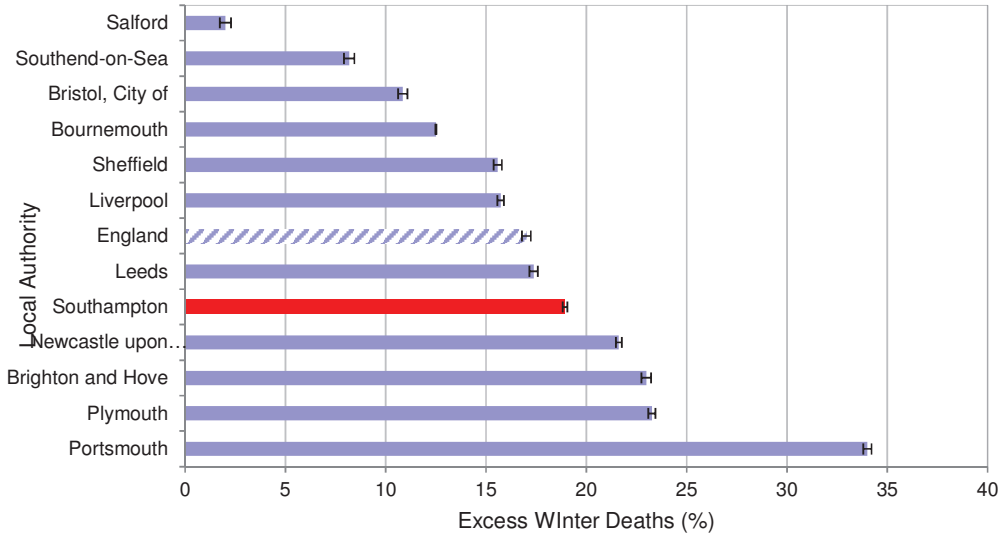
Southampton: Estimated Prevalence of Dementia: Number of People Age 65+



Data Source: Projecting Older People Population Information System (POPPI)

Social circumstances are also changing. There are far more people living alone - 11,283 households in the city consist of older people living alone with increased risk of loneliness and associated poor physical and mental health. More people also own their own homes. There are a significant number of people who die prematurely during winter months in Southampton (see below).

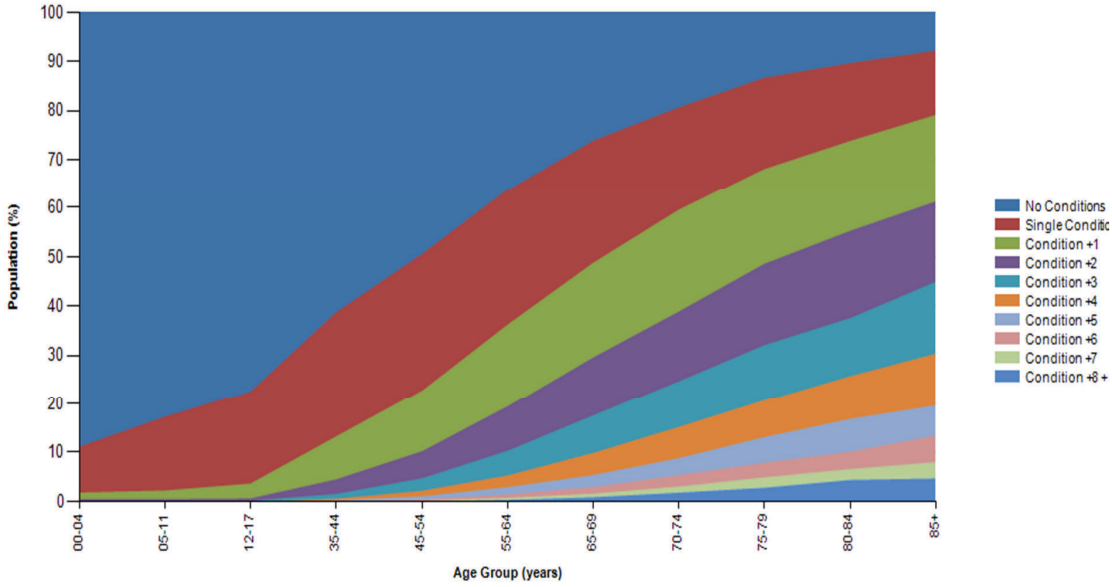
Excess winter deaths: Southampton and ONS Comparators: 2010/11



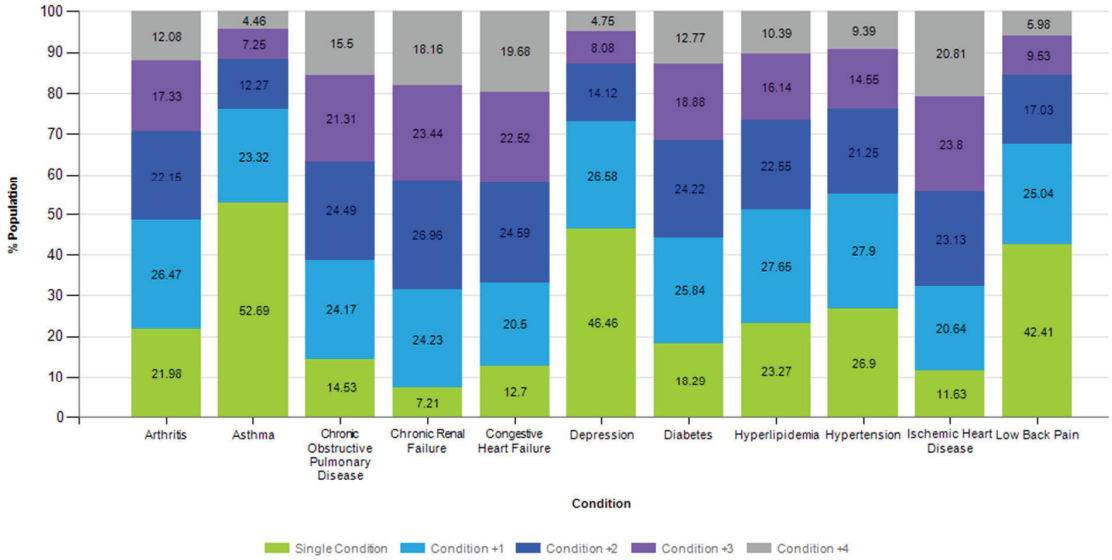
Source: Public Health Outcomes Framework

The number of people with long term conditions is also increasing. There are around 86,000 people in Southampton estimated to be living with long term health conditions, such as asthma, diabetes, heart disease, hypertension, epilepsy and severe mental illness. The table below

illustrates the number of people diagnosed with one or more long term conditions by age in the City, demonstrating that as people get older they are likely to have more long term conditions.



Data from 12 GP practices in Southampton was analysed showing that 85% of people aged 65+ have at least one chronic condition and 30% of them have more than four (amongst the over 85's the equivalent figures are 93% and 47%). The diagram below further illustrates this co-morbidity:



The changing needs of the population are putting increased pressure on health and social care at a time when resources are reducing. Legislative changes, for example the duties posed by the new Care Act, are also requiring services to identify need earlier and respond to a national minimum eligibility threshold.

Attitudes and expectations are also changing. The expectations of people who will reach older age in the next 10 to 20 years will be different to older people now. People are used to expressing far greater choice and control over their needs and aspirations. Currently, people are much more socially mobile than before and have generally experienced a wider exposure to different goods and services. People now and in the future will expect more from their local authority, NHS and care providers in terms of the range and quality of services on offer.

The importance of prevention and early intervention are well evidenced to help people stay well, live independently and remain healthy for longer. It is important to ensure that a wide range of good quality preventative services are available to support people across the spectrum of need, including those who do not approach the Council for support or meet its eligibility criteria. This will ensure that people do not go without the support which could prevent critical needs developing in the future.

All this means that historical models of care are no longer appropriate or affordable. There is a need for more planned care, provided earlier in settings outside of hospital, greater integration between health and social care to improve service user experience and achieve efficiencies, better use of community resources, better service user information about what is available and a much more personalised approach to the way care is accessed and delivered, responsive to both clients eligible for social care and those who are self-funders. This requires a radical transformation of primary, community and social care as well as the surrounding environment including individuals, family, carers and voluntary sector services.

Areas of focus

We have chosen older people (over 65s) and those with long term conditions as the initial focus of our integrated care model as this is where we have identified the greatest need, both in terms of population forecasts and vulnerability to poor health and poor social outcomes as well as the greatest opportunity to make a difference from a more integrated health and social care model.

A review of unplanned hospital admissions for 2013/14 (27,620) showed that 38% (10,260) were over the age of 65. A breakdown of all these admissions (all ages) by HRG chapter showed that the 5 most common types were:

- Respiratory – 10% (2735)
- Cardiac – 12% (3194)
- Digestive – 13% (3615)
- musculoskeletal – 10% (2884)
- childhood diseases and neonates – 15% (4090)

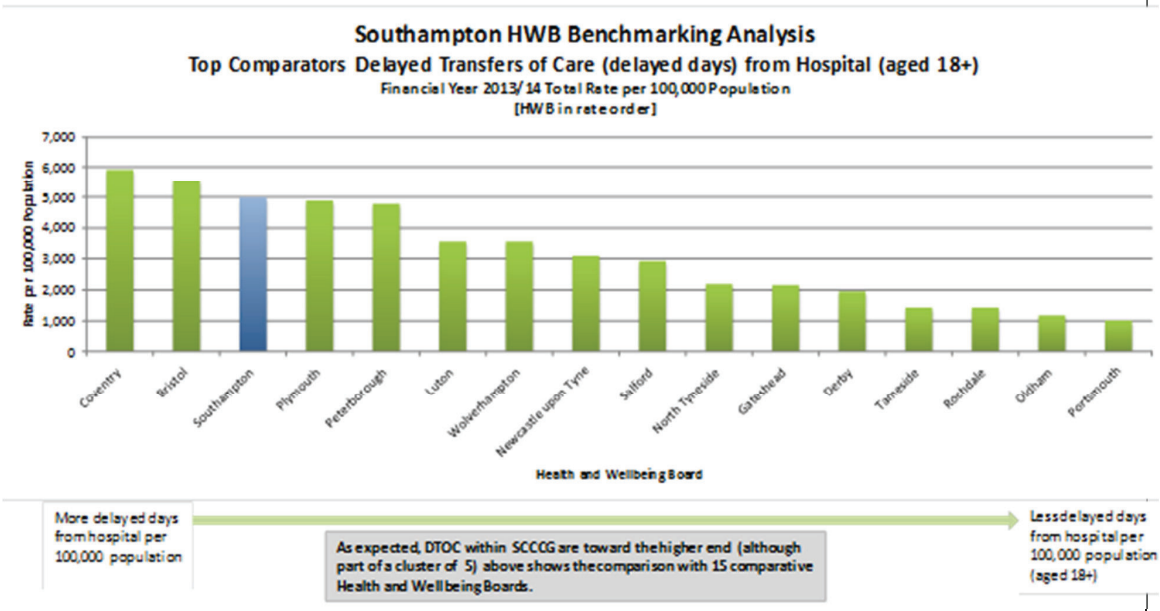
The CCG's QIPP programme is already focussing on a number of these areas, in particular:

- chest pain and abdominal pain pathway
- high volume paediatric admission pathways

Whilst reducing avoidable unplanned hospital admissions is a key priority, our focus for Better Care in Southampton is on reducing pressures in the whole of the health and social care system, the key focus being on supporting people to stay safe and healthy in their own homes and communities. This is supported by recent reviews of our health and social care system. In 2012, for example, following sustained difficulty in maintaining the national A&E waiting time standard (of 95% of people being admitted or discharged within four-hours), the Emergency

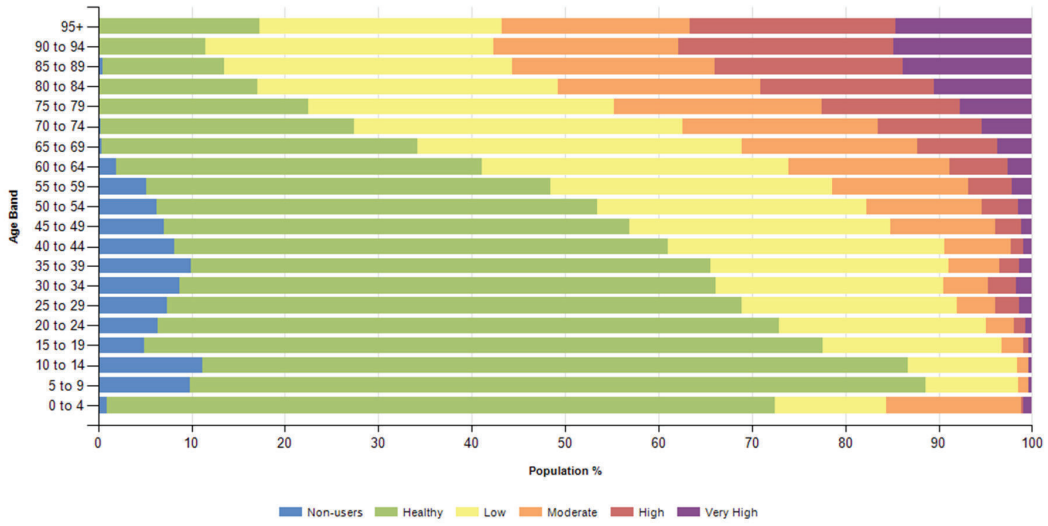
Care Intensive Support Team (ECIST) carried out a review of provision both within UHS and across the wider health and social care system. They concluded that, despite some successes, there had been an over-reliance on schemes to avoid admission and insufficient emphasis on improving discharge planning and onward care. In essence they concluded the whole health and care system needed to change from a culture of trying to 'push' people out of hospital to release capacity, to one where community services intervened to help maintain people in their own homes and 'pull' patients through hospital by means of pre-planning effective community or home-based support.

This is supported by the chart below which shows that the numbers of delayed transfers of care (DTOC) in Southampton are high compared to other areas.



In terms of demographics, Southampton is most comparable to Portsmouth, Salford, North Tyneside and Plymouth.

Looking more widely at the use of health resources by age, the ACG risk stratification tool is able to break down the population into Resource Utilisation Bands (RUB) to show that as people get older they use a greater amount of health resource. The average cost to the NHS of a very high Resource Utilisation Band (RUB) patient is £19,100 per annum, the cost of a high RUB patient is £10,631 per annum, the cost of a moderate patient is £4343 per annum, compared to the cost of an average healthy patient £694 per year.



In Southampton, the population breaks down roughly as follows:

RUB Group	Number Patients
Very High	4,997
High	8,978
Moderate	21,977
Low	60,539
Healthy	137,576
Non users	15,022
TOTAL	249,089

Approximately 5% of Southampton's population are in the very high and high groups. Considering this alongside the Kaiser Permanente Triangle and rates of emergency hospital admissions by different risk groups (based on Wennberg et al 1996), it is possible to make a judgement as to how many hospital admissions might be attributable to this group – ie. 34.1% or a total of 9418 using 13/14 data. Those patients in the moderate risk category who would benefit from supported self care account for roughly 25.5% of total admissions, so approximately 7043.

Roland M BMJ 2012. Preventing Emergency Admissions – excessive focus on "frequent flyers"?

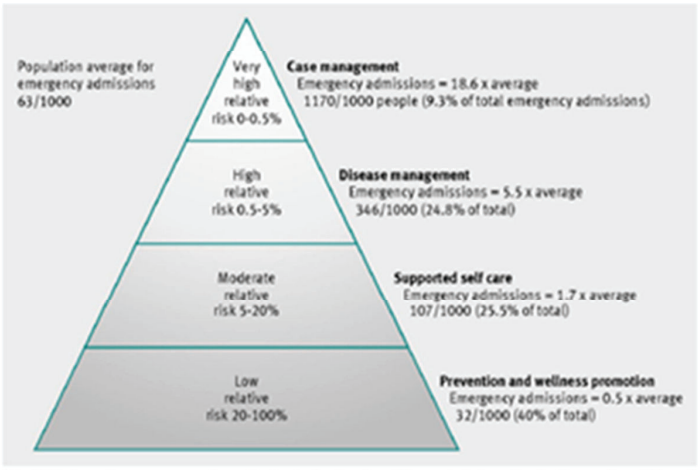


Fig 2 Rates of emergency hospital admission by different risk patients (based on Wennberg et al 1996).[9] Percentage of all emergency admissions is equal to the relative rate multiplied by the size of the population group

Our Better Care programme is therefore focussing on older people and those with multiple long term conditions and seeking to intervene early and proactively in an integrated way to help them to keep themselves healthy and well in their own homes and communities. We have identified the following key schemes:

1. Local person centred coordinated care - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, promoting self management, 7 day working – this will impact on those people in the highest risk groups identified above who will benefit from case management and disease management, roughly 5% of our population (around 12,000 people), but also support those in the moderate group (35,500 people) who would benefit from supported self care. The majority of this target group, as it has been shown, will be older people (65+) and those with multiple long term conditions. This is the group who are also most reliant on social care resources. It is estimated that the high risk groups account for around 9,400 unplanned admissions and we are aiming to prevent approximately 200 (approx. 2%) of these over the next 12 months through a combination of this scheme and the more responsive proactive discharge, rehabilitation and reablement model described below. This scheme also focuses on the medium risk group who would benefit from supportive self care and it is estimated that this group accounts for approximately 7,000 unplanned admissions of which we are aiming to prevent 400 (5-6%) through this scheme. This scheme also contributes significantly to our targets for reducing permanent admissions.

2. Long Term Conditions pathways – supporting local person centred coordinated care – key areas of focus are COPD, given the high proportion of respiratory admissions, and diabetes. We are expecting the COPD element of this scheme to reduce respiratory unplanned admissions by a further 5% in 2015/16 from the 2012/13 baseline. This equates to approximately 135 fewer unplanned admissions. With regard to diabetes and the other long term conditions pathways, we are reviewing how these can better support the model of local person centred coordinated care and are attributing around a further 120 fewer unplanned admissions to this scheme.

3. Integrated discharge, reablement and rehabilitation service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deteoriation, as well as supporting people's recovery and reablement following a period of illness. The scheme will particularly focus on reducing long term admissions to residential and nursing homes and preventing delayed transfers of care (DTOC). Our plan is to reduce DTOC in 15/16 by around 3 per day from the 14/15 position. This scheme will contribute to this reduction, alongside the work we are doing to develop the market for packages and placements. Our target reduction for reducing permanent admissions is 6.1% for 14/15 and 9.7% for 15/16 compared to the previous year.

4. Community development – this scheme is aimed at developing local community assets and supporting people and families to find their own solutions. This is key to the overall development of our local person centred coordinated care model.

5. Supporting carers – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care.

6. Developing the market for placements and packages – this includes work we will be doing to develop the market to provide greater opportunity and choice, encourage a recovery/reablement focus and support people to remain as independent as they can be in their own homes. It is key to reducing delayed transfers of care (we estimate that it will account for a third of our target reduction) and will make a significant contribution to our target for reducing permanent admissions.

Please note that the figures quoted in relation to reduction in unplanned admissions include growth at 1% per annum.

Our analysis of the impact that these schemes will have on the drivers covered in our Case for Change can be found in Annex 1.

The identification of these schemes to meet the needs of older people and those with multiple long term conditions has been based on:

- Views of a wide range of clinicians and practitioners based on evidence and experience. A series of workshop events reviewed national evidence and local best practice, considered potential impact and effectiveness, along with ability of the system to implement the changes, to identify key priority areas for focus. Part of this work was facilitated by Peter Colclough who had been closely involved in the successful implementation in Torbay (Kings Fund 2011 Integrating health and social care in Torbay Peter Thistlethwaite)
- User feedback as outlined in Section 8a and the outcomes from the work with TLAP. This enabled us to identify "Joan" who is central to the work in Southampton. She is a fictitious user of health and social care services in the City but has been used to focus thinking about how care could be improved for her.
- Review of evidence from elsewhere undertaken by CCG Integrated Care Clinical Lead. This was used as a basis for the work, especially the review of learning from Department of Health pilot sites which evidenced the importance of single point of access, integration of health and social care assessment, development of a shared care list identifying the most vulnerable, collaboration (GPs, community health workers, allied health services, social services, voluntary sector, housing, secondary care), provision of key worker as primary contact point, integrated information systems, virtual ward rounds involving all professionals not only health, individual care planning for patients with an emphasis on self-management and joint working across GP practices.

- Review of evidence related to priority areas, as outlined in detailed scheme descriptions in Annex1.
- Work with other areas, especially NE Lincolnshire, Leeds and Torbay. This provided information on outcomes and effective approaches.

This has been further substantiated by evidence shared as part of the current Better Care submission which provides a synthesis of the integrated care evidence base. This supports the local prioritisation of local person centred coordinated care with multi-disciplinary teams developing individualised care plans and effective care co-ordination and case management. Other local priorities of intermediate care, reablement and rehabilitation, falls prevention and a focus on self-care are also identified as effective.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The timelines below map out the key milestones associated with delivery of each of the 3 components of our model. Each section also outlines the key interdependencies.

1. Person centred local coordinated Care

Scheme	14/15 Milestones	15/16 Milestones	16-18 Milestones	18-20 Milestones
Development of person centred local coordinated care	Implementation Unplanned admissions DES (May – Sept) Extensive stakeholder engagement around function and requirements of clusters (May – Oct) Implementation of Everyone Counts practice based nurses for over 75s scheme in primary care to increase capacity (from Oct) Cluster teams established and beginning to work together (Oct – Mar) Develop key components of integrated working: risk profiling & proactive case management, care coordination & key worker role, single	Embed key components of integrated working focussing on over 75s and people with LTC: risk profiling & proactive case management, care coordination & key worker role, single assessment (Apr – Sept) Enhance psychological support for people with LTC – roll out of IAPT training amongst cluster teams (Apr – June) Implement single point of access for integrated health and social care (Apr – Sept)	Roll out of key components of integrated working to adults with LD and MH problems and children & young people	Continue to embed, evaluate and develop

		assessment - focussing on over 75 population (Oct – Mar) Interoperable IT solution in place using Hampshire Health Care Record, accessible to health & social care staff and receiving health & social care feeds (by Nov) Clusters operating each with development plan in place (Jan – Mar) Scope single point of access for integrated health and social care (Jan – Mar)			
	Review Long term conditions pathways	Embed and evaluate integrated pathway for adults with COPD (by Mar 15) Review and develop future model for heart failure (by Mar 15) Diabetes • implementation of primary care Diabetes Accreditation Scheme to enhance quality of care (from Oct) • Implementation of integrated model of care, with stronger focus on self management & professional education (Oct – Mar) • Finalise plans for footcare (by Jan) Implement scheme to reduce Influenza and Pneumonia admissions with focus on vaccination coverage and	Diabetes - Implementation of new footcare MDT to reduce foot disease (from April) Review and develop how specialist LTC support will be provided in future through cluster model (Apr – Sept) Commence recommissioning process for LTC (Sept onwards)	New model in place (from Apr 16)	

	admission avoidance (Sept – Dec)			

Key interdependencies for this part of our strategy include:

- Good robust engagement and coproduction with all stakeholders – see our Communication and Engagement Plan for how we are taking this forward.
- Workforce development – a workforce development plan is being developed in 14/15 to underpin the change in culture and new ways of working (including trusted assessor model, person centred planning, motivational skills) required by the cluster model
- Primary care development and GPs signing up to new enhanced service for unplanned admissions – all 33 GP practices have signed up to the new Proactive Care programme.
- Identification of suitable accommodation within each cluster area to provide a team base
- Information sharing agreements and interoperable IT across health and social care settings – we are working with our Commissioning Support Unit (CSU) to develop the appropriate information sharing agreements, templates and IT interoperability. Work is underway to produce a shared care plan prototype using the Hampshire Care Record which will be available for roll out by November 2014.
- Strong leadership – this is provided through the Integrated Care Board which includes leaders from across the health and social care system, as well as the voluntary and community sector, and oversees our Better Care work programme. Leadership is also strong through our Health and Wellbeing Board.

2. RESPONSIVE DISCHARGE & REABLEMENT - SUPPORTING TIMELY DISCHARGE AND RECOVERY

Scheme	14/15 Milestones	15/16 Milestones	16-18 Milestones	18-20 Milestones
Integrated Discharge, rehabilitation and reablement service/hub	Model developed and agreed (by July) <u>Phase I implementation</u> New discharge pathway agreed (by end Aug) Discharge planning to commence at point of admission (by end Sept) Trusted assessor model rolled out, all discharge facilitators and inreach coordinators trained and able to restart and set up simple packages (by end September) Discharge to assess model in place – additional 12 beds commissioned in nursing homes to	<u>Phase II implementation</u> Implementation of wider integration (Jan 15 – May 15) Fully integrated service in place (June 15)	Continue to embed, evaluate and develop model	Continue to embed, evaluate and develop model

		support model (from Sept) IDB manager in place to strengthen leadership (by Nov) Additional domiciliary care resource in place (Feb) Implementation new integrated falls pathway to identify and target all patients who have fallen for rehab and prevention future falls (Jan – Mar) <u>Phase II</u> Work up and Consultation on integration proposals (Sept – Dec) Commence implementation (from Dec)			
	Telecare/telehealth strategy	Maximise potential of existing community alarm service to increase access to telecare (Nov – Jan 15) Market testing and development of enhanced offer (Nov - March)	Implement enhanced telecare/telehealth offer (from Sept)		

Key interdependencies for this part of our strategy include:

- Culture change to build reablement ethos into wider community services, e.g. domiciliary care
- Good robust engagement and coproduction with all stakeholders – see our Communication and Engagement Plan for how we are taking this forward.
- Strong leadership – this is provided through the Integrated Care Board which includes leaders from across the health and social care system, as well as the voluntary and community sector, and oversees our Better Care work programme.

3. BUILDING CAPACITY

Scheme	14/15 Milestones	15/16 Milestones	16-18 Milestones	18-20 Milestones
Development of personalisation	Offer personal health budgets to	Personal health budgets offered	Embed person centred care	

		all people with CHC and increase uptake of direct payments (from Apr 14) Workforce development programme to support person centred care in NHS services in place through contract CQUIN (from Apr 14)	to all adults with LTC and direct payment uptake further increased (from Apr 15) Support planning service in place for direct payments and personal health budgets (from Apr 15)	across all client groups	
	Community development	Implementation of community navigator role across the city (from Jan 15) Community development strategy developed (Sept – Dec) Implementation (from Jan)	Implementation community development strategy Further embed and evaluate community navigator role		
	Supporting Carers	New carers information, advice and support services in place (from Sept) Explore options for carers assessments including delegated powers to 3rd sector agencies, online self-assessment and use of direct payments (ongoing to Mar 15)	Roll out carer assessments Actively Increase identification of carers in primary care (from Apr 15)		
	Developing the market for Placements and packages	Quality and market development programme in place to improve capacity (from Apr)	Embed changes to residential, day and respite provision (Apr – Sept)	Development of extra care accommodation in city	Continue to embed evaluate and develop

	Demand and capacity scenario planning tool developed (by Jan) Review of day and residential services (Jun – Dec) Redesign day and residential services (Jan – Mar) Review of Respite services (Sept - Dec) Redesign and implement changes to respite provision (Jan - Mar) Complete domiciliary care tender/new framework in place (by Feb)	Demand and capacity plan in place (by June) Phase One Extra Care Housing development	Phase Two Extra Care Housing development	

Key interdependencies for this part of our strategy include:

- Good access to meaningful, accurate, up to date information.
- Finance systems capable of supporting integrated personal budgets.
- Development of capacity to increase carer assessments. This has been specifically included in the Better Care budget.
- Robust market development. This has been recognised in the development of the ICU which has a specific resource for market development.
- Good robust engagement and coproduction with all stakeholders, particularly patients, service users and carers – see our Communication and Engagement Plan for how we are taking this forward.
- Workforce development – a workforce development plan is being developed in 14/15 to underpin the change in culture and new ways of working (including trusted assessor model, person centred planning, motivational skills) required by the cluster model. A CQUIN scheme has specifically been agreed with NHS providers to develop understanding, skills and knowledge of person centred care.

4. INFRASTRUCTURE & INTERDEPENDENCIES

Scheme	14/15 Milestones	15/16 Milestones	16-18 Milestones	18-20 Milestones
Building the contractual infrastructure	Development of core service specification and integrated	Pooled fund agreement in place (Apr)	Ongoing monitoring and review	Ongoing monitoring and review

	performance framework & vary into 14/15 contract (by Oct) Review alternative contractual models which better underpin and incentivise the behaviours and actions required, eg. alliance model (Jun – Mar) Scope and draft S75 pooled fund agreement (Jun – Oct) Section 75 agreement approved (Nov – Mar)	Implement changes to contractual models (in year for 2016/17)		
Communications and engagement	See separate communications and engagement plan			
Workforce development	Development of workforce development strategy to support new clusters (Oct – Mar)	Implementation workforce development strategy		
IT interoperability	Development of shared care plan prototype using Hampshire Care Record (Aug – Nov) Implement and embed use of shared care plan (November – Mar) Hampshire Care Record upgraded with enhanced functionality (by Dec)	Continue to embed and increase usage of shared care plan		

Further detail of the actions and associated timescales can be found in our Better Care Performance report which is attached.

b) Please articulate the overarching governance arrangements for integrated care locally

Development of Southampton's integrated care programme has been coordinated by the city's integrated commissioning unit through its Integrated Care workstream. The Integrated Care Board was set up two years ago to oversee the development and implementation of the strategy. This includes taking a system-wide view of outcomes and service provision for adults and children across all sectors (health, social care, education, housing, public health, voluntary and community) and ensuring that resources across the board are prioritised and organised in a joined up way so as to maximise good outcomes, quality, safety and equity of provision. Specific functions of the board are to:

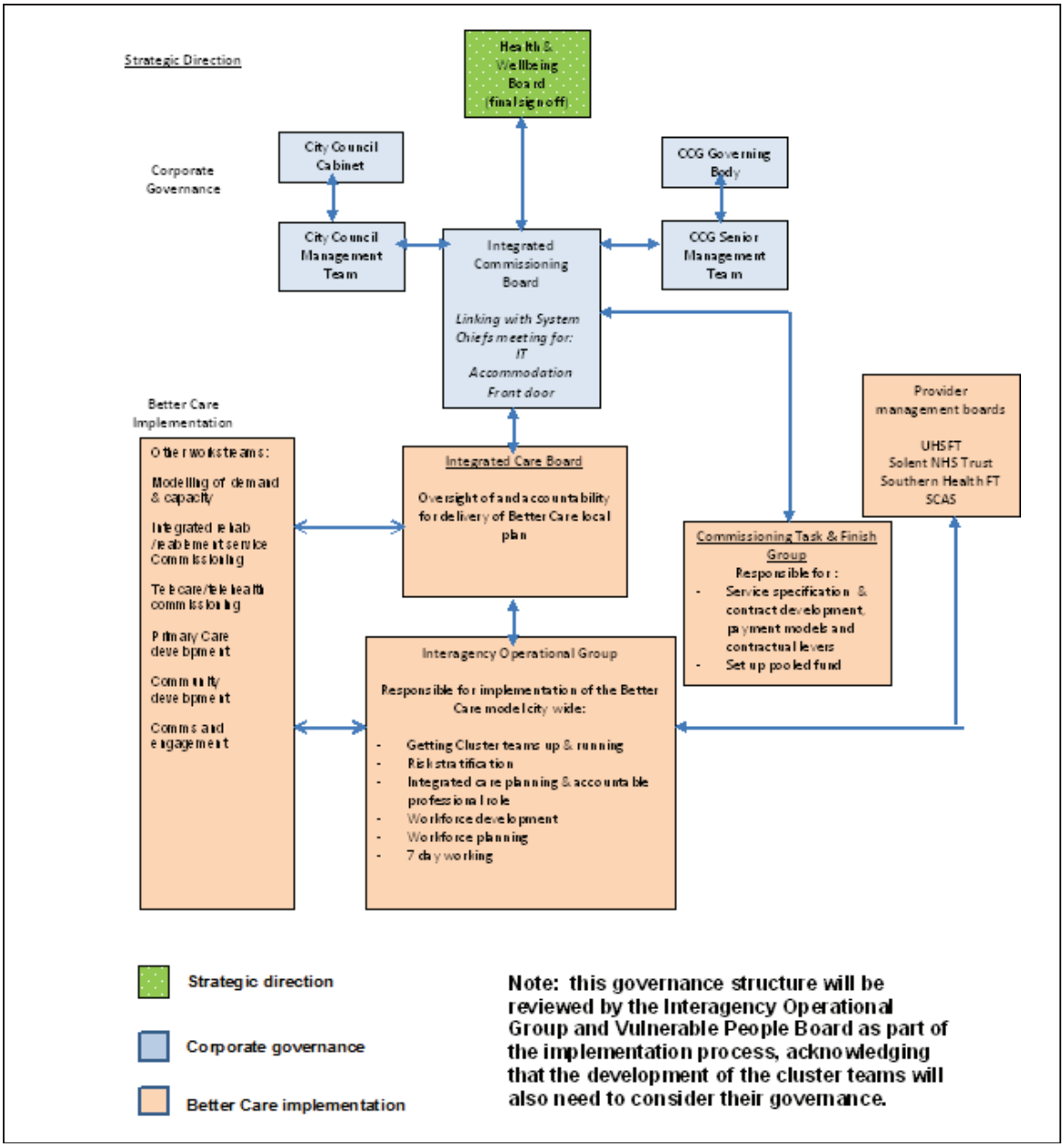
- Strategically inform and manage the delivery of the overall work.
- Review progress, identify any risks, blockages or constraints and ensure they are mitigated.
- Inform and deliver evaluation processes and measures of success that can be monitored.
- Engage with stakeholders to ensure their needs and the needs of all those affected by the Integrated Care programme are recognised and considered and that the aims, objectives and actions of the Integrated Care programme are properly communicated across the system.

Membership of the Integrated Care Board includes CCG clinical and commissioning leads for integrated care, primary care, councillor from Health and Wellbeing board, Public Health consultant, Senior Social Care leads, Community and Acute health provider leads, South Central Ambulance Service, Voluntary sector representative and Housing.

The Board reports monthly to the Integrated Commissioning Board of the City Council and CCG which is a high level board comprising the Chief Executives of the Council and CCG, Director of Public Health, GP Governing Board member, Cabinet member, Chief Finance Officers and lead Directors from the council and CCG. This Board will develop into the Partnership Board for the pooled budget

The Health & Wellbeing Board provides high level oversight of these arrangements, ensuring that partnership arrangements are effective and that plans are robust and both ambitious and realistic in their aspiration.

These arrangements are shown in the diagram below.



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Since submission of our first cut plan and the feedback received, we have been reviewing the governance arrangements to ensure a more robust framework for the operational delivery of the Better Care model in Southampton.

This includes the establishment of the Interagency Operational Group (shown in the diagram above) which brings together clinical and operational management from each of the 3 provider Trusts (UHSFT, Southern Health FT and Solent NHS Trust), the City Council and primary care, along with commissioners, Southampton Voluntary Services and Heathwatch to implement the new structures and ways of working. This includes:

- Establishing the cluster teams

- Risk stratification, integrated care planning and accountable professional role
- Workforce planning and development

A full time Transformation Manager has been seconded from one of the local provider Trusts to support the Operational Group in undertaking these tasks.

A commissioning task and finish group (also shown in the above diagram) has been set up to operate alongside this for a limited period to deliver the underpinning requirements of the model, particularly establishment of the pooled fund, scoping of future contracting and payment models and performance management. This group will be primarily made up of contracting, finance and performance officers.

It should be noted that this structure will be reviewed by the Interagency Operational Group and Integrated Care Board as part of the implementation process, acknowledging that the development of the cluster teams may well lead to some elements of governance being devolved to a locality cluster level.

A Better Care Assurance Report incorporating detailed project plans, progressing monitoring and monthly tracking of performance against the Better Care targets has been produced and is presented each month to the Integrated Care Board, alongside any remedial action plans. A copy of this report is attached. An update on Better Care is also presented at every Health and Wellbeing Board meeting.

Commissioning responsibility for the integrated care model is brought together across care and health services through our Integrated Commissioning Unit. Single, integrated service specifications with an integrated performance management framework will be signed off by the Integrated Commissioning Board. Through the Integrated Commissioning Board, the leadership of the CCG and City Council will have clear and shared visibility and accountability in relation to the pooled Better Care Fund.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Local person centred coordinated care - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working. Including: - Primary care development - Mental health integration
1b.	Long Term Conditions pathways – supporting local person centred coordinated care
2	Integrated discharge, reablement and rehabilitation service Including: - Telecare/Telehealth
3	Community development. Including - Developments to support self management - Community navigation functions
3b	Supporting carers
3c	Developing the market for placements and packages
4	Infrastructure including: - ICU quality, commissioning, market development resource, workforce development - DFG and Social Care Capital Grant

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

The risk log below has been developed in partnership with all stakeholders through the multiagency planning workshops, discussion at HWBB and the Integrated Care Board. It is regularly reviewed as part of the monthy Programme Assurance report to the Integrated care Board.

Risk	Risk likelihood? *1-5*	Potential impact *1-5*	Overall risk factor	Mitigating Actions	Risk Owner & Timescale
Failure to achieve the cultural change required to make this happen	4 Requires very different behaviours and ways of working which will take time	4 If behaviours do not change, new ways of work will not embed. Public will continue to	16	Strong leadership / leadership development programme	CEO/Operational Directors - all providers, SCC, CCG, GP clinical leads, HWB Board (ongoing)

Risk	Risk likelihood? *1-5*	Potential impact *1-5*	Overall risk factor	Mitigating Actions	Risk Owner & Timescale
	to develop. Public confidence in out of hospital services needs to be developed if health service seeking behaviour is to change.	seek hospital based solutions; will be continued over-reliance on public sector.		Robust stakeholder engagement programme Roll out of cluster/locality working during 2014/15 through workshops, co-location, joint working Workforce development programme in place	Comms & engagement leads all partners (ongoing) ICU/Transformation Manager (ongoing) CEO/Operational Directors – all Providers (December 14)
Unable to reduce acute hospital activity leading to failure to release and reinvest funds in out of hospital model or double running and increased costs	3 Target reductions are challenging and buck historical trends. At the same time LTC and frail/elderly populations continue to increase	5 Impact is that we will have £1.5m less to invest in out of hospital model	15	Dashboard in place to report monthly activity against plan to ICB IDB manager in place to strengthen leadership in discharge process	ICU Assoc Director (June 14) CEOs all partners (Nov 14)
Demand for services increases beyond expectation putting additional pressure on system, increasing costs	2 Elderly population is forecast to grow. More and more people with LTCs - however this has been taken into account in our modelling	5 As above. Targets not achieved. Unable to invest in out of hospital services	10	As above plus: Thorough impact assessment to support plans: - implications of Care Act - demographic profiling	ICU Assoc Director (Oct 14)
Failure to establish infrastructure soon enough to support integrated working, e.g. IT systems	2 Plans are in place to develop shared care plan and interoperable IT	4 If shared care planning not possible electronically, less likely to be used and professionals will continue to assess and deliver care in silos. Patients continue to experience uncoordinated care. Care less proactive.	8	Development of shared care plan prototype Information sharing policies in place Hampshire Health Record (HHR) upgrade HHR connectivity with all GP systems and social care	ICU Senior Commissioner/IT lead (Dec 14) As above CCG CEO/CSU (Nov 14) CCG CEO/CSU (Nov 14)
Unable to get buy in from GP practices to the scale of change required	3 GP practices may see this as another top down initiative with little	4 Primary care is central to the success of the model. practices will	12	Extensive primary care engagement programme in place	GP clinical leads/CCG comms lead (Oct 14) GP clinical leads/CCG primary care team

Risk	Risk likelihood? *1-5*	Potential impact *1-5*	Overall risk factor	Mitigating Actions	Risk Owner & Timescale
	meaning to them	be responsible for coordinating care.		Maximise uptake of Unplanned Admissions DES Joint work on model at TARGET Primary care co-commissioning to support delivery of sustainable model of general practice	(Sept 14) GP clinical leads/Transformation manager (ongoing) CCG chair/GP clinical leads
Primary care unable to make the change required due to lack of capacity or resistance to change	3 Capacity in primary care is a major issue.	4 As above	12	As above plus Additional practice based nurses for over 75s in place Targeted support to practices in achieving unplanned admissions DES	CCG Assoc Director (Oct 14) CCG (ongoing)
Unable to get buy in from political leaders to scale of change	2 Political leaders have been involved in workshops and sit on the HWBB. There is good level and engagement and support	3 Failure to agree SCC changes and commitment to model would hamper implementation and impact.	6	Regular updates on BCF at Cabinet Member Briefing and HWBB	ICU Director (ongoing)
Contractual barriers, e.g. unable to secure change fast enough because of contract notice requirements	2 A proactive approach is being taken to reviewing alternative contractual models. Strong engagement & collaboration with existing providers reduces the risk of contracts being used as a barrier to change.	3 Inability to incentivise system to deliver the change.	6	Basic service specification outlining BCF requirements varied into contracts CQUIN in place for person centred care – all NHS provider contracts Alternative contractual models explored Notice given in September contractual letter of any changes during 15/16	ICU Assoc Director (Jan 15) ICU Assoc Director (Apr 14) Integrated Commissioning Board (ongoing) ICU Assoc Director (Sept 14)
Implementing change at scale may destabilise existing providers	2 Likelihood low as intention is to work in partnership with existing providers to deliver model	3 The market is limited and so any destablisation of existing providers will impact on our ability to deliver.	6	Impact assessments completed against the new model of integrated care. Risks to individual providers to be monitored throughout implementation.	CEO/Op Directors all partners via ICB (Aug 14) Integrated Care Board (ongoing)

Risk	Risk likelihood? *1-5*	Potential impact *1-5*	Overall risk factor	Mitigating Actions	Risk Owner & Timescale
Shortage of good quality providers in the market to meet need for home care	3	4 Lack of capacity. Failure to support people in home and inability to prevent admission or enable timely discharge.	12	Joint domiciliary care tender completed Provider Forum established including VCS to share learning and development	ICU Assoc Director (Feb 15) ICU Assoc Director (Jan 15)
Inability to recruit to key posts in out of hospital model, e.g. geriatricians	4 Recruitment to key posts eg. geriatricians, social workers, nursing is currently difficult.	4 Inability to deliver out of hospital capacity required to support people at home. Inability to prevent admission or enable timely discharge.	16	Joint recruitment strategy developed for key posts Workforce development strategy in place (to include consideration of joint posts, joint training opportunities, rotations)	CEO/Op Directors all partners via ICB (Jan 15) CEO/Op Directors all partners via ICB (Dec 14)

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The introduction of the Better Care Fund marks a step change in approach and a new opportunity to make change happen. This nevertheless comes with its own demands – in order to pay for better out of hospital care we have to deliver a corresponding shift of work and money out of acute services. Our plan is to reduce non elective admissions by 3% after population growth (or 2% before population growth is factored in). This is a challenging target. We must also take into account that the Better Care programme is operating in the context of an austere outlook for social care funding which is set to reduce by a third over the coming years.

We will be keeping a tight overview of performance against the Better Care targets, both through our Programme Assurance processes which include monthly reporting of activity against targets to the Integrated Care Board, and through real time information, including the Urgent Care Dashboard and Integrated Discharge bureau. We have profiled our targets month on month over 2014/15 and 2015/16 and are tracking actual activity levels against this profile.

<u>Risk sharing arrangements in place between commissioners across health and social care</u>
We are currently drafting the terms and conditions of the S75 Partnership Agreement for the Better Care Pooled fund. This will include risk sharing arrangements.

<u>Risk sharing arrangements in place between providers and commissioners</u>
The impact of the 2% reduction in unplanned admissions at our local acute trust would see a reduction in expenditure of around £850k, however due to MRET and activity over the baseline being paid at a 30% marginal rate, the actual reduction would be around £250k, with the

balance being released through investment in community services to reduce readmissions. The CCG will hold the reduction in funding from the acute sector and will only release funds into the better care fund at quarterly gateways. To minimise the risk to recurrent MRET investment of around £560k this investment in community services will form part of the Better Care funds; the CCG will not seek to divest of these funds but as the Better Care Fund gains traction use the current investment to refocus upon schemes to further the Better Care aims. The Integrated Commissioning Board will hold a gateway review on a quarterly basis to agree release of investment into the pooled fund.

We are exploring alternative contracting models, recognising that the current contracting system is not conducive to achieving the change we need to deliver:

- Risk and reward (contractual) frameworks for community and acute hospital services are misaligned. Whilst PBR incentivises acute activity, the traditional community block contract presents a disincentive to increasing out of hospital activity.
- Service specifications and contracts are individual organisation/service based (as opposed to focussing on the whole care pathway or person).
- Mental Health services are subject to a separate block contract with limited incentives to work in other health and social care settings.
- There is no open book approach to sharing data and information across the system.

The Better Care Commissioning Group has been specifically looking at alternative models, including prime provider, alliance contracting and year of care tariff options. We are following closely the experience of other authorities and CCGs who are testing these models. In the meantime, our intention is to work with existing providers within existing contracts, and introduce a risk and reward system (potentially tying in CQUIN monies) which focuses on shared delivery of whole system outcomes. This will include the development of a single integrated performance framework across all contracts, as well as revision of service specifications to become outcome based.

It will also involve reframing the block contract arrangements we have with community providers into an outcome based contract with risk and reward payment mechanisms linked to system performance on the Better Care targets. This is in early stage development; our community services provider has been working through a similar reward programme in Portsmouth so we are currently using the learning from here to build into our plans.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Southampton's Better Care plans build on the work we have been doing over the last 3 years under our Integrated person centred care programme and incorporate other initiatives already underway related to care and support. This includes:

- Implementation of Personal budgets and Think Local, Act Personal (TLAP) - Southampton City CCG and Southampton City Council have signed up to Think Local Act Personal (TLAP) and 'Making it Real' (MiR). A programme is in place which continuously reviews our progress against the key features to deliver Personal Health Budgets; 'Making it Real' and 'Integrated Person Centred Care'. This is included in the supporting documentation to our Better Care plans.

- Telecare and Telehealth strategy (included in the attached supporting documentation) – the Integrated Commissioning Unit is currently in the process of rolling out this strategy which focusses on developing robust and far reaching information and advice, increasing the use of telephone consultations, ensuring assessments embed telecare and telehealth by default, harnessing the existing and potential use of personal technology and procuring a new city wide telecare and telehealth service. This has been embedded into our Better Care programme.
- Supporting Carers (including in supporting documentation) – progress to date has included commissioning short break support and a new universal identification, advice and support service which commences September 2014. We have also been working with NHS providers, including primary care, to promote their role in the identification, provision of advice and signposting of carers. The focus going forward is on ensuring the future provision of Carer assessments is both adequate and compliant with the new Care Act. Work will also need to continue to improve the identification of carers within primary care and other NHS providers. This programme of work is fundamental to Better Care and has been integrated into Southampton's Better Care plans and is described in further detail in Annex 1.
- Everyone Counts £5 per head funding – in 2014/15 Southampton CCG is investing an additional £1.287m in practice based nurses to support practices in delivering of coordinated care to patients over the age of 75, including those identified through the DES. This initiative aligns closely to our Better Care cluster model described in Scheme One and provides additional capacity for the more proactive approach we are aiming to achieve.
- The focus on improving discharge processes and supporting people within the community aligns with the refreshed Whole System Urgent Care Action Plan and system priorities identified as part of the Operational Resilience and Capacity Plan for 14/15 which included primary care, in reach co-ordinators / care co-ordinators for enhanced 7 day service and discharge to assess provision.

All the above are integral to Southampton's Better Care programme. The Integrated Commissioning Unit is responsible for bringing these initiatives together and ensuring alignment with the overall Better Care programme.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

All the schemes described in Southampton's Better Care plan are included within the CCG's two year operating plans for 2014 – 2016 and aligned with its 5 year strategic plan: A Healthy Southampton for All - Bringing together a Healthy and Sustainable System. The CCG's plan sets out the following five goals:

- Make Care Safer: We will commission care from safe competent providers. We will listen to local people, gather their feedback on their experiences of local services and act upon it.
- Make it Fairer: We will reduce the inequalities in access to care across our population.
- Improve Productivity (achieving more with less, more effectively): We will prepare the ground for a transformation in care, doing all we can to bring control to the acute healthcare system.
- **Shift the Balance: We will integrate health and care services to ensure a better more streamlined experience for local people. Together with patients, communities and partners we will co-produce coordinated care through the Better Care Southampton programme.**
- Delivering Sustainable Finances: We will plan strategically for sustainable finances ensuring that we are driven by quality whilst being pragmatic about our resources.

The city's Better Care plans have been incorporated into the CCG 5 year strategy and can be found in more detail on pages 19 and 56 of the 5 year plan.

Southampton's Better Care plan is also closely aligned to the JSNA and Joint Health and Wellbeing Strategy. It works to meet a number of the objectives and deliver many of the key actions set out in the Joint Health and Wellbeing Strategy, which was adopted by the Health and Wellbeing Board in March 2013, including to:

- Offer an annual health check to carers and promote support networks for carers across the City
- Review tele-care and tele-health services in the City, re-shape and re-launch these so that local people are more aware of the ways in which they can use technology to retain their independence
- Extend re-ablement services so that people can get help to regain their confidence and skills after an illness or mental health breakdown
- Promote healthy, active lifestyles through a dedicated team of Activity Coordinators
- Increasing the number of people who can say how best to spend the money allocated for their health and care, either through direct payments or personal health/care budgets
- Joining up health and social care services so that the number of assessments is reduced and a person's experience of moving between professionals is much smoother and less fragmented
- Developing a shared understanding of how best to support people to retain their independence and make changes to practice which improve the achievement of this objective
- Promotion of a focus on recovery rather than simply procedures for admission avoidance and/or hospital discharge when people need any form of secondary care
- To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions.
- Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia
- To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions.
- The development of extra-care services for people with long term conditions and those with dementia
- Launching a new approach to provision of aids and adaptations which encourage better access and information for individuals able to fund themselves and improves response times to those requiring equipment to maintain their independence
- Raising awareness amongst all care and health staff about appropriate responses for people with dementia, mental capacity issues including deprivation of liberty guidelines and protocols
- Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system
- Increase public awareness and discussion around death and dying
- Extend palliative care to other diseases besides cancer and ensure access to physical, psychological, social and spiritual care
- Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service)

The Better Care actions are also reflective of priorities in the recently revised City Council strategy 2014-17. These include:

- Prevention and early intervention with outcomes including encouraging active and healthy lifestyles and enabling more people to live independently in their own homes

- Protecting Vulnerable People including work with health to provide effective, seamless services to vulnerable adults
- Affordable housing
- City pride to encourage voluntary work and participation in the life of the city

The Better Care actions are linked to the overall City Strategy 2014-25 which has three key priorities of Healthier and Safer Communities, skills and employment and economic growth with equality. The focus within this includes keeping people healthy, protecting vulnerable people and reducing the negative impact of alcohol with expected outcomes being people staying healthy for longer and improving everyone's wellbeing and people experiencing less social isolation. The City strategy is led by Southampton Connect that brings together senior representatives from business, education , universities, statutory sector organisations, voluntary and community sector.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

A vibrant and sustainable primary care sector is pivotal to our Better Care plans and co-commissioning is therefore potentially a very useful enabler and is likely to have a significant impact on strategic planning over the next five years.

There is a recognised need for a clear strategic approach to supporting the development of general practice to create a model of primary care that is sustainable long into the future. The Phase 1 Report of 'A Call to Action for General Practice' describes a model of general practice that operates at greater scale and in greater collaboration with other providers, professionals, patients, carers and local communities. It also pledges to support more efficient ways of working and remove unnecessary bureaucratic burdens on general practice to free up time for delivery of more proactive, person-centred care. In both the CCG strategy and the Better Care Plan General Practice is recognised as a key enabler in the successful delivery of co-ordinated care.

The CCG has and is further developing a vision for a sustainable model of general practice in Southampton which meets the needs of society in the 21st century. This vision is a model which enables patients with increasingly complex problems to be cared for in the community; provides a wider range of services over a longer period of time; and increasingly will be providing proactive care in collaboration with other health and social care professionals, working across organisational boundaries to meet the needs of individual patients. This will require working in larger organisations, but these organisations must ensure that the element of personal continuing care, that is such an important aspect of the ethos of traditional general practice and a vital part of integrated person centred care, continues. Co-commissioning gives us an opportunity to accelerate progress on this redesign.

Practices are already looking ahead and beginning to make plans to create a more sustainable future for themselves, including; proposals for working together; for anticipating the changing role of general practice heralded by the new GMS contract agreements; and for enabling practices to develop their roles as part of the new model of integrated local teams. The CCG has identified resources that have already been made available through a local improvement scheme to support practices to undertake the organisational development necessary to respond to this strategic challenge. Allocated resources are being used flexibly by practices, both individually and together, to explore and develop sensible models that support delivery of the Better Care strategy and meet the needs of the localised population.

As a membership organisation, we are committed to supporting our practices on their evolutionary journey as they adapt in response to current pressures on their own primary care service and on the health care system as a whole. Financial pressures continue to increase, as do the needs and expectations of a growing population. These constraints drive a move towards integration and collaboration, both in terms of joint operational arrangements and service delivery in general practice and also bringing together primary and community services around clusters of practices in a neighbourhood.

Anticipating this direction of travel, in 2013, the CCG began developing a vision for a sustainable model of general practice in Southampton. Co-commissioning gives us an opportunity to accelerate progress. Southampton is one of the two most vulnerable areas for resilience of primary care in the Wessex area. Co-commissioning will allow us the flexibility to resource primary care in a way that will deliver responsible, sustainable general practice long into the future; a fundamental requirement for the success of Better Care.

The CCG has expressed an interest in delegated co-commissioning for local contracts, including enhanced services. The vision for the future of general practice is for locality-based clusters with fully integrated primary and community teams sharing a vision of holistic, person-centred care. Co-commissioning will make it easier to align general practice with the clusters which were designated after an extensive consultation with stakeholders and will be based on natural communities of approximately 50,000 patients.

We also expect to be able to use co-commissioning to stimulate and encourage use of care plans and alignment with Better Care. We recognise the need for system-wide transformation and efforts to review entire pathways of care are hampered whilst primary care is commissioned by a separate organisation.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The local definition is to ensure that resources are available to provide appropriate support for those who meet the current eligibility criteria and effective signposting for those who do not. The key focus for achieving this though, within the challenge of growing demand and increasing budgetary pressures, is to reduce the demand being made on social care. This is through the development of integrated approaches to identify need and intervene earlier as well as helping people regain their independence and through this reduce the need for ongoing care. For example helping older people to be independent for longer and delay the need for long term care services such as care homes.

Eligibility criteria for Social care support in Southampton is assessed for an adult aged 18 years or over, living in Southampton, who needs long term care because of difficulties related to older age, long term illness, disability or mental health problems or a carer who supports an adult with such needs. Eligibility is measured against a range of factors including:

- the risk to persons health and safety
- how much independence and choice they have

- how well the person can manage daily routines
- how far the person can get involved in family and community life

Priority for services is given to those residents whose needs have been assessed (through work with the individual and family or carer) as either critical or substantial, based on Department of Heath Guidance 2010. Those assessed as having either moderate or low needs are “sign posted” to other organisations and services where appropriate.

In addition though, we are maintaining services outside this where a short term piece of work may stop someone slipping into becoming critical and substantial – this means widening numbers who access effective reablement.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

City plans such as the Health and Wellbeing Strategy and Joint Commissioning strategy informed the priorities for use of the funding transfer from the NHS to Social care and use of Reablement money. Part of this was maintaining current eligibility criteria and this element will be maintained within the Local plan. There is especially investment into improving social care outcomes and widening access to reablement to help people support themselves and others in their communities, which has benefits for both health and social care. Within the overall Better Care model adult social care is transforming the customer journey. The vision behind this is “we assist people to find personal and practical support to lead full and active lives, maintain their safety, and have choice, control, independence and dignity”.

The journey will commence with improved single point of contact via single telephone number and improved web pages for initial screening, information and advice and guidance. An online knowledge hub and service directory will help people to be able to help themselves. This element is being developed within the local authority as a basis for a wider system model. The intention will be for increased access to reablement and the spending supports this element. This will be integrated with other rehabilitation services currently provided by health, for targeted support to increase independence. Through these approaches, demand for extended social care involvement for those who meet eligibility criteria will be reduced. The new model will refocus extended involvement from social care onto the regular reviewing of goals set via assessment and support planning.

This change is transformational for Southampton and is starting to show a change. For example in July 2014 64% of people who were supported through the reablement service did not need any further social care support at the end of their reablement period. This is a significant improvement compared to previous years.

Proposed local schemes and spending have also been developed that will further support the commitment to maintain eligibility, including responding to increasing demographic demand. These approaches include:

- maximise independence through improved integrated re-ablement and rehabilitation and responsive discharge
- access to telecare/telehealth services, to help people regain their independence and reduce the need for ongoing care
- supporting increased pace of roll out of personalisation and direct payments – including the market management and peer support development . This will create more choice and control for users and offer better value for money
- ensuring carers have access to appropriate resources and feel supported
- widen peer and community/voluntary sector support availability

The outcome of the social care transformation linked with the initiatives above will reduce demand for long term support or the level of support required.

The development of locality clusters will enable, through the use of proactive risk profiling, the identification of individuals at an early stage who may benefit from support.

There is already a strong commitment in Southampton to focus on outcomes for our population rather than for our organisations and this has been illustrated through proactive partnership working, such as regular joint meetings of the Council and CCG executive teams and the implementation of an Integrated Commissioning Unit. The intention is to build on the resource identified within the Better Care Fund to commit a greater combination of our health and care budgets into a pooled fund and base its use around the localities, people and outcomes, not institutions. This will protect social care services to achieve the outcomes outlined within the plan which support a reduction in demand to allow existing resources to be used more effectively for those who are eligible. This will include use of information sources to target more precisely our increasingly scarce resources and truly find out how many of our resources are ineffectively used at present.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The elements that have been included within the Better Care Fund that are supporting the Local Authority in the implementation of the Care Act in 2015/16 are:

Personalisation	£13,000
Carers assessment and support	£221,000
Information advice and support	£110,000
Quality	£22,000
Safe-guarding, (SSAB)	£36,000
Assessment and Eligibility	£226,000
Veterans	£11,000
Law Reforms	(£40,000)
Total	**£600,000**
IT, (Capital)	£231,000
Grand Total	**£831,000**

This allocation has been integrated within the various schemes outlined in this submission – specifically the carers and placement and packages schemes.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

In line with many other local authorities we are in the process of mapping all the elements of the Care Act, drawing on the draft guidance to establish which areas will continue as currently provided, require a degree of change or require considerable change management to be put in place.

Care Act Steering Group: In Southampton we will maintain oversight through the development of a Care Act Steering Group comprising representatives from Adult Social care, finance, legal and the Integrated Commissioning Unit. The group will invite updates from a range of identified responsible leads who have considered the different elements of the Act and accompanying guidance. Updates will be collated and shared with relevant governance forums.

Responsible Leads
A significant number of the areas set out in the Care Act and guidance documents are likely to be covered by current arrangements within the Council. However, each aspect needs to be checked against current practice and either assurance given to this effect, or appropriate actions put in place to ensure compliance. To undertake this work a number of responsible leads have been identified from within their area of specialism and mandated to undertake this work for their designated area. Responsible leads will be required to provide updates to the Care Act Steering Group on either level of compliance with the Act or progress towards compliance.

Impact modelling of Dilnott reforms
A modelling exercise has been completed which sets out the potential impacts in 2015 and 2016 showing worst and best case scenarios. The Surrey model (produced by Surrey County Council and ADASS South East) was used as a template and adapted for our region/local demographics. The 2015 impacts addressed are related to continued workforce demands from the new 2015 duties and the implementation of ASC funding reforms.

The model has been 'sense' tested by a group of subject area experts including Public Health, MIT team, Finance, Commissioners and Legal. The majority of results were found to be broadly accurate, and some areas were identified as requiring more accurate data. The South East Regional ADASS Care Act Implementation Lead has been clear that Southampton City Council is well advanced in its development of the modelling tool and has adapted it in a more sophisticated manner than she had previously encountered. However, we are now required to undertake a further modelling exercise using the Leicester modelling tool.

Local networks
Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) have formed a workforce development network meeting which links in with the regional Skills for Care and ADASS Care Act regional lead. These regional groups are tasked with development of common tools, systems and workforce/staff planning and development. Modest funding is available for development and the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) group is currently deciding how best to use this. SCC delegates support the development of common policies, tools and processes.

SCC Adult operational lead for care act implementation has initiated meetings of Paris (client data base) using local authorities in England and Wales in order to share common tools, processes and expertise.

Workforce development
Skills for Care have developed a programme which will ensure that all staff are prepared for the Care Act. Southampton are participating so that we will be in a position to roll out this programme from October 2014.

Bi-weekly Care Act Briefings covering specific subject areas are being produced by SCC Practice Support Officer and have been sent to all ASC staff to ensure that they are familiar with the Act and its' requirements in the interim.

Implications on workforce and capacity to deliver Care Act requirements will be monitored via the Care Act Steering Group.

Local impact
Through the Care Act Steering group and reports from Responsible leads, initial work has commenced on understanding where and what the impact will be.

- ***Financial***: through two modelling exercises and working with other authorities we are developing a more robust understanding of what the financial impact will be in both April 15

and April 16. Findings from this work have been presented to Corporate management for consideration and agreement to undertake further checks. This work includes establishing a proposal for using the anticipated funds allocated by the government for 2015-16

- ***Other resources:*** additional resources will need to be recruited to respond to the increased demand for assessments and it is noted that a number of authorities have already started working with agencies to ensure resources will be available. Locally it is agreed to commence discussions with relevant agencies to identify the necessary increased workforce.

- ***Delegation:*** Work will commence shortly on preparing an options appraisal on the delegation of assessment and/or other functions once the new power is available to the council. This will include carer assessments and setting up care accounts.

- ***Systems and process:*** There are numerous implications for existing systems and processes, primarily across Adults but also affecting Finance, Business Support, Children's and other services. In all cases, existing arrangements will need to be reviewed to ensure they are compliant; in a significant proportion change and development will then be required.

- ***Legal:*** Beyond the legal requirement to implement the Act, there are several other potential impacts on Legal teams:
  - Potential increase in appeals
  - Increase in demand on legal teams supporting the deferred payments process
  - Understanding any legal implications, should a decision be taken to delegate any functions to other organisations.

- ***Services:*** A number of service areas will be impacted, the full extent of this will be, in part, dependent on other decisions, e.g. delegation of powers, but the following are within scope for change:
  - Information & Advice will be delivered using an online approach supported by a range of community based services and aligned to the Local offer.
  - Procurement of a new advocacy service is underway, which will retain the option of extension to cover developments within the Care Act and the Children & Family Act.

Care & Support planning, along with other areas of service delivery are being incorporated within a wider transformation programme within the Council.

v) Please specify the level of resource that will be dedicated to carer-specific support

£813k will be dedicated to carer specific support from the Better Care pooled fund and will be spread across a broad range of service areas.

Identification, advice and support for adult carers combines both CCG and SCC funding to a total annual value of £253k. This service supports the early and wide reaching identification of carers resulting in increased provision of information, advice and support – further information is contained in Annex 1, Detailed Scheme: Carers

A further £91k is being jointly invested by the CCG and City Council in a Young Carer service which will provide timely and effective support to young carers and their families.

Integral to all NHS held contracts is the requirement to identify and signpost carers into appropriate services. Further work will be undertaken to establish the value of this element of service delivery and consider the most appropriate approach for identifying carers in health

settings and ensuring they gain access to information, advice, support and assessment as relevant to their circumstances.

The CCG also makes a contribution to a number of other carer based services, notably respite and short breaks. These are incorporated into relevant section 75 and section 256 arrangements. We are currently undertaking a piece of work to establish the funding levels involved in all the NHS areas of service delivery with a view to informing future commissioning intentions in line with Better Care requirements.

The Local authority is currently exploring the options for providing carer assessments and meeting eligible needs. This work includes consideration of delegated powers to 3rd sector agencies, online access to self-assessment and use of direct payments. This work will inform the use of the remaining allocated carer funding within the Better Care Fund.

Impact on Carer experience of these developments

Carers will find information, advice and support readily available in a greater number of settings. More carers will receive support whether online, through volunteer or buddy schemes or directly through the new service.

The carer is expected to experience improved mental health (as shown by study into informal carers of first time stroke survivors by C Simon & Kendrick 2009), as a result of being provided with access to social support. Also, when provided with access to emotional support and training, it will significantly delay the need for the person receiving care from going into residential care (MS Mittelham 1196).

Impact on patient outcomes

Currently it is estimated that carers save the UK economy £119 billion a year in care costs. This equates to £18,473 per year for every carer in the UK. Supporting carers is a vital element in maintaining this input into the health and social care economy. A study concluded that 20% of the over 75 year olds they tracked were admitted to hospital because of the breakdown of a single carer on whom that person was mainly dependent (Study in Surrey 1998). The changes set out above will contribute to carers planning for a change in their circumstances and avoiding both a breakdown for themselves (the carer) and reducing the impact on the person they care for.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

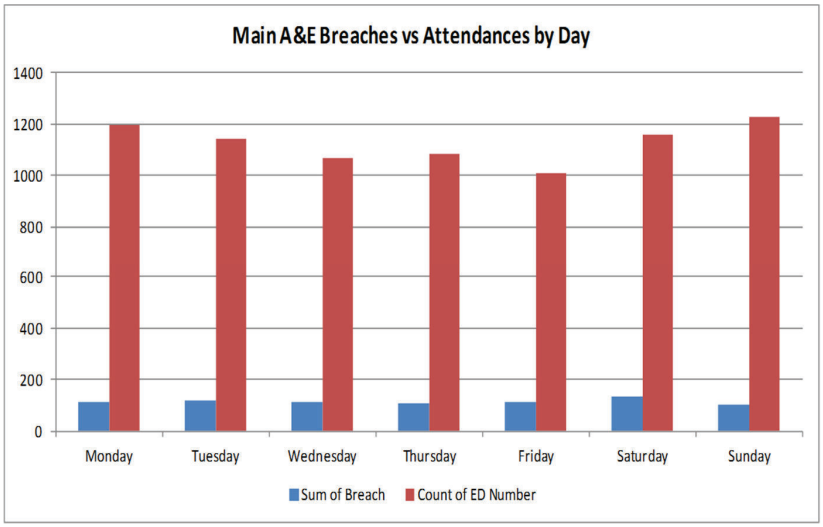
The level of funding available for the protection of Social Care and for the implementation of the Care Act has been unaffected by the re-submission.

The risk of not achieving the level of admission reductions alters the value of total funding that can be planned to be used effectively to reduce costs across the system. In turn this could potentially reduce the ability to fund greater levels of preventative social care activity for the benefit of the overall Health and Social Care system.

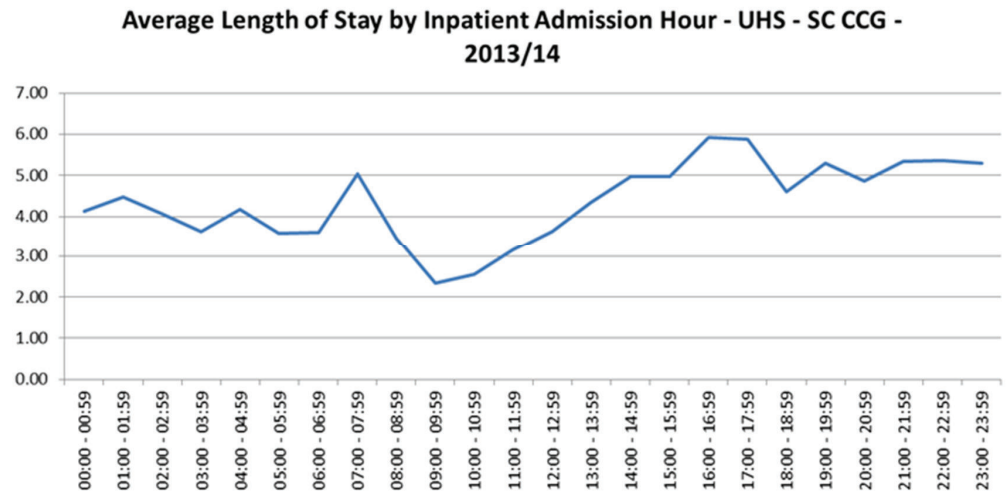
b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Need for health and social care is not limited to specific days/times of the week. Although some services like hospitals are open every day, services at weekends are often reduced. The limited availability of some services across the health and care system at weekends can have a detrimental impact on outcomes for people. Local data shows that ED attendances are generally higher at weekends and early evening.



Discharges are lower over the weekend and data suggests that patients admitted later in the day have longer lengths of stay.



Locally we are committed to delivering the clinical standards for 7 day services (7DS) contained in the Service Development and Improvement Plan section of the NHS local contract. Our contracts for 2014/15 already include an expectation of providers that they will

begin scoping work and readiness planning in preparation for the standards and requirements that will emerge from the national Forum on 7 day working.

Social Care are currently reviewing their out of hours provision to increase 7 day availability and this will be further strengthened through the integrated rehabilitation and reablement model – Scheme Two.

Our plans for 7 day working are outlined below:

Year 1 (2014/15)
- All NHS providers contracts have a clause which allows for in year service reconfiguration to take place which is in line with the implementation of Better Care
- Map existing services 24/7capacity and demand identifying gaps and opportunities to redeploy resources to maximise effectiveness.
- Review of processes to embed 7 day discharge into community bed capacity
- Review of community nursing capacity and demand to ensure resources are appropriately targeted to meet peak times of demand and linked into primary care and Out of Hours urgent care provision.
- Consider which of the 7DS clinical standards should move into the quality section of 2015/16 contracts.

Year 2 (2015/16)
- Review current access routes to services to streamline entry and management of referrals for both health and social care.
- 7 day ward rounds and establishing a pull system by community staff to support early discharge.

Year 3 (2016/17)
- Full implementation of 7 day working and audit of processes to ensure that care is provided on the basis of right time, right place, right workforce.
- Ensure all 7DS clinical standards are included in the quality section of the contract.

Key risks relating to the move to 7 day services include:
- Access to reablement services are not maximised due to risk averse culture in inpatient settings
- Reduction in bed based capacity and shift in resources to community solutions is unable to cope with surges in demand.
- Recruitment of skilled social staff becoming difficult as the local economy improves and reduces pool of potential workers.
- Nursing staff find model of working unattractive due to increased requirement to work unsocial hours and perform social care tasks alongside health duties.
- Hand off arrangements remain difficult between discharge, reablement, cluster and long term care management teams.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number is seen as a key factor in promoting greater information sharing between Social Care and Health.

All health services use the NHS number as the primary identifier in correspondence and Adult Social Care is using the NHS Number as the primary identifier, with 83% of known individuals

having this recorded. By using the NHS Number Adult Social Care services are able to link data with health information though the Hampshire Health Repository (HHR). The Council has achieved NHS Information Governance approval to share data.

In June 2014, Southampton City Council completed a pilot project linking PARIS, the Social Care records system, to the NHS Personal Demographics Service (PDS). A full scale deployment is now planned. The PDS module of PARIS will enable Social Care records to be synchronised with the NHS demographics held for a person. The synchronisation process automatically downloads the person's NHS number into PARIS.
The PDS matching (and retrieval of NHS number) process is started when a client record is opened (and there are changes at either end i.e. a record is not synchronised, and when a new client record is created. This ensures that NHS number capture takes place as early in the care management pathway as possible.

A core principle of the Better Care agenda is to deliver integrated care, single person centred care plans and seamless service delivery coordinated through a single lead professional. A key enabler for this to be achieved is to have IT based systems which share information which is relevant to the person and clinician's needs in order to inform decisions and deliver care. Currently Southampton and surrounding areas benefit from having access to the Hampshire Health Record (HHR). The HHR gathers patient information from health providers (primary care, acute, community and specialist health providers and from social care). Over the past few years the HHR has developed technically and now has the capability to share information and care plans electronically with anyone who has authority to view with consent from the individual patient. In addition through the Common Assessment Framework 2 programme (CAF2) a patient portal has been developed through the "Say it once" project. The" Say it Once" project has delivered a mechanism for patients to share practical information about themselves.
There is some evidence to show that the sharing of data using the HHR can reduce length of stay in hospital. The table below shows the length of stay per spell on those occasions where there has been no attempt to view the patient's information on HHR compared to those occasions where records were viewed.

Preliminary findings (not validated)

HHR and Inpatient length of stay

HHR View Status	Number of Spells	Average Length of Stay per Spell (days)
No Attempt To View	52123	3.5
Record Viewed	17695	10.3
Unsuccessful View	1557	12

All health providers including primary care services have agreed to implement "single sign on" to the HHR for clinicians. Single sign on means that a clinician types in one security password and authority is automatically given to access a number of IT clinical systems. Clinical staff at Southampton General Hospital have significantly increased the use of the HHR due to this approach.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

It is planned that HHR during 2014/15 will under undergo a significant upgrade. This will provide greater functionality to push and pull data, to allow user specific views, so that pertinent

data is seen first, to improve patient access to their health records, to allow data to be imported from patient purchased Apps and to improve the general experience and navigation of using the HHR system. These improvements are being taken forward by all partners to the HHR across Hampshire. A prioritisation exercise is due to take place in the coming months to identify which HHR development opportunities to accelerate and to agree the programme plan for the coming years.

Discussion has commenced with independent social care providers (nursing, residential and domiciliary care) to allow them access to the HHR and support them to move towards electronic care records which are integrated with statutory provision.

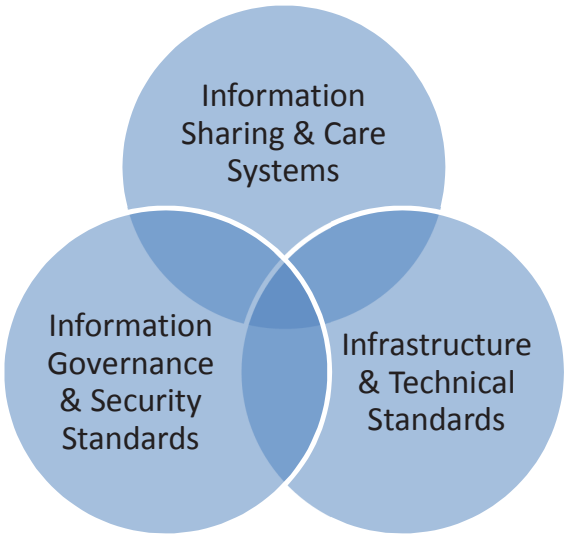
Southampton City Council is PSN (Public Sector Network) compliant level 2.

The Council has also achieved GCSX and N3 compliance with the ability to connect to the NHS spine.

Solent NHS Trust and Southern Health NHS Foundation Trust are currently not fully compliant (National BT system Rio),or able to share real time currently. However they are looking to re-procure by Oct 2015 to become fully compliant.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The HHR governance arrangements have been reviewed following the formation of CCG's across Hampshire. There is a strong emphasis on clinical / carer and patient led delivery of Interoperability Information Sharing Programmes. We believe this is the right way to decide what information needs to be shared and how systems should look and feel to do this. The new governance arrangements for the HHR has resulted in the formation of 3 groups (below) being formed representing patients, clinicians from data providers and users, IT technical experts and information governance leads from health and social care. These groups report to the HHR Board which reports directly back to partner CCG's.



The CCG achieved Level 2 in IG Toolkit status (submission of 31 March 2014). An action plan has been developed to gain level 3 by 2016, however takes each element of the toolkit and identifies progress, gaps and controls each year. An interim submission will be undertaken in October 2014.

The CCG and health local health providers have taken on board the requirements set out in Caldicott 2 and have undertaken the following:

- Caldicott Guardian and SIRO in place with appropriate training.
- Quarterly reports to Board and monthly briefings to the Caldicott Guardian on the status of the action plan including how we will mitigate against any risks.
- Examined existing arrangements, policies, protocols, procedures and training materials which are currently being refreshed.
- Clearly explaining to patients and public how their personal information will be used including updating the Privacy Notice.
- Commissioners access to patient identifiable data (PID) has been restricted and can only be used once consent has been gained.
- Mandatory e-learning have been completed by all staff (this has to be undertaken yearly).
- Information Governance arrangements are included as part of our induction programme
- All activities comply with the Information Governance Framework

The CCG and City Council are also working closely on IG issues that have arisen due to the establishment of the Integrated Commissioning Unit. We have also attended a national seminar to try and seek clarity on some of these issues and are looking at working with a law firm to take this work forward.

The overarching information sharing agreement which is in place for the HHR is currently being between commissioners and providers to support all of this work.

The City Council has achieved level 2 IG Toolkit status and have in place an improvement plan. A Caldicott Guardian and SIRO for Social Care with appropriate training are in place. The IG activity will be reported quarterly to the Council's Information Management Board and Council Management Team following review of existing terms of reference. A complete review is underway with regard to how the Council shares PID with its partners and work is ongoing to further assure procedures with regard to the main PID recording systems utilised within the Council. E-learning is in place covering 4 modules with a specific module designed for staff who regularly come into contact with PID. A review of consent to share documents and privacy notices is underway in light of the transformation work being undertaken as part of the People Directorate. Measures to ensure that direct care teams are better able to share information appropriately according to Caldicott 2 principles is being action planned.

Solent NHS Trust and Southern Health NHS Foundation Trust have achieved level 2 and are moving towards level 3 compliance.

University Hospital Southampton Trust is aiming to achieve level 2, moving towards level 3 compliance.

The CCG has reviewed the contracts it has with providers of healthcare to ensure that health data will be shared within information governance frameworks and that providers have a commitment to deliver interoperability changes to their clinical IT systems.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

In accordance with the Proactive Care Programme, 2% of the population are identified as at high risk of hospital admission. Tools used to identify these patients include the ACG tool, frailty indicators, long term conditions registers, end of life register, clinical knowledge and judgement, care home residents, co-morbidities and the CCG's urgent care dashboard.

Work is underway to include information from the housing sector and establish a data feed into the ACG tool from the ambulance trust, social care and 3rd sector in order to enhance the intelligence available for risk stratification.

The CCG has procured access to the Adjusted Clinical Group tool in partnership with other CCG's in the South Central area to enable primary care and integrated care teams to risk stratify the population. Partner CCGs are in the process of procuring a new tool which will provide greater functionality and take into account social care data and risk factors. This new tool which will be IG compliant will be available from April 2015.

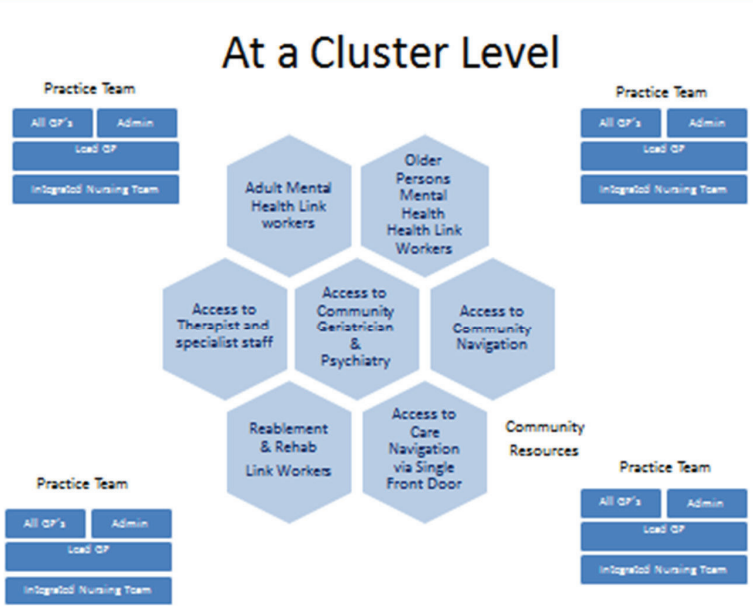
In addition to focussing on the top 2% of the population most at risk of hospital admission, the Better Care model we are implementing will also seek to identify a further 3% of the population just below this level where more proactive assessment, care planning and support will prevent their escalation to high risk. It is believed that the greatest dividends will be gained from focussing lower down in the risk stratification pyramid, where there is more opportunity to maintain people's independence, change behaviours and achieve strong engagement.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

All GP practices in the City are signed up to the Proactive Care Programme and working to deliver the specification. This includes risk assessment, development of care plans based on the Proactive Care guidance and identification of lead professional.

GP practices are at the heart of Southampton's Better Care model which in turn is supporting practices in delivering their responsibilities under the DES.

The relationship between the cluster teams described in Section 2c Changes to Service Delivery (person centred local coordinated care) and GP Practice teams is illustrated below.



The core functions of the cluster team have been agreed as follows:

- To work with and support the GP practice teams in the cluster to:
  - identify people at risk of deterioration such that they would need admission/ long term care
  - comprehensively assess need through an assessment which is:-
    - Person Centred
    - Comprehensive (Comprehensive Geriatric Assessment) – encompassing physical, medical, social needs, function, daily living/psychological – wellbeing
    - Formulation of needs/issues – causes/factors/links
  - develop care plans which are anticipatory and goal orientated
  - coordinate care – supporting the GP practice in providing a single lead professional for each service user
  - manage crises/change in care needs
  - facilitate discharge from acute care
  - facilitate access to aids, adaptations, telecare/health to promote independence
- To promote self-management
- To sign post to community resources within the local area

Key principles of cluster working have been agreed with all stakeholders:

- Interactions with patients and service users will be person centred and needs led – this means that people will feel empowered and supported where necessary to find their own solutions to their needs and manage their own conditions and circumstances. People's responsibility for their own health and care will be respected.
- Staff will respect each other's professionalism and trust each other's assessments, without the need to duplicate.
- Teams will work in a more inter-professional way, recognising that individuals have core skills and expertise but at the same time promoting a common, holistic approach.
- A recovery and reablement focus will be built into all interactions with people.
- Decisions will be based on the needs of the person as opposed to our organisations.

The CCG has agreed to fund the development of an automated care plan using existing data collated in the HHR. The data that is pertinent to urgent care staff (Out of Hours doctors, ambulance crews, clinicians in ED), will be shared in a user friendly format to aid them in making appropriate clinical decisions. It has been found that using paper versions of the care

plans reduces the need for conveyances and admissions to acute care and increases the likelihood of patients being supported with community solutions. This care plan will be in place by December 2014.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

1% at March 2014 (per Risk Profiling DES)
2% at September 2014 (per Proactive Care Programme)
£5 per head funding to identify top 5% of patients at risk who are over 75 years of age.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

We have a continuous programme of patient/service user and public engagement in developing our plans for the Better Care Fund. Engagement and participation activity to date has involved 3 stakeholder workshops plus presentations at:

- Service user focus group
- Service users forum (Consult and Challenge)
- Patients Forum
- Older Persons Forum focus group
- Communications and Engagement reference group
- Pensioners Forum
- Equality Reference group
- Healthwatch
- Carers Strategic group

Service user and public insight has also been gained from a number of other sources e.g. complaints and patient experience data, NHS Choices, local services survey (online), Call to Action survey (online), carers network event and the stroke 'Have your say' event.

Our vision is based on what people have told us is important to them. Through the above consultation and engagement routes, we know what people want is more choice and control, good quality services and for their care to be planned with them and their families/carers and coordinated by a key worker or case coordinator to simplify communication and provide consistency. They tell us that good information and advice along with good communication are key. They want us to make better use of IT and technologies such as telecare/telehealth as well as computer and mobile phone support. The people we talked to also highlighted the important role of the voluntary sector and the need to make staff in statutory services more aware of what is out there in the community. One key point that came out of several

consultations was how much people value NHS services and the principles of the NHS constitution and so we are mindful of the need to ensure we protect and build on what is good.

We have worked with people to come up with our vision statement "**Health and social care working together with you and your community for a healthy Southampton"** and will be working with them over the coming weeks to produce a user friendly summary of our plan. We are encouraging people to comment on our plan and give us their views via a number of routes, e.g. on line, e-mail, social media, website. Web pages have been developed with our Better Care branding and can be found on the CCG website to ensure that we can continually update people about our progress. On 11 March 2014 we held a large public and other stakeholders event in the City which involved further discussion on our Better Care Fund plans and the CCG and Southampton City Council are currently developing plans to establish a citizens' council.

Healthwatch is represented on the Integrated Care Board and Interargency Operational Group and have been supporting the work we are doing to co-produce different elements of the model, specifically the development of the Community Navigation function.

We have also worked with the CCG's Equality Reference Group to develop our indicator for patient/service user experience, seeking service user views about the most appropriate metric.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Southampton City CCG commissions NHS care from the following main providers:

- Care UK (Elective and GP Out of Hours care).
- Solent NHS Trust (for general community and child and adolescent mental health services)
- South Central Ambulance Service NHS Foundation Trust
- Southern Health NHS Foundation Trust (adult mental health services)
- University Hospital Southampton NHS Trust (which incorporates our main acute Hospital)

NHS provider engagement has been strong in the development of our Better Care plans. The Integrated Care Board which oversees our programme has representation from each of the local health providers (Primary care, South Central Ambulance Service, Solent NHS Trust, University Hospital Southampton NHS Foundation Trust and Southern Health NHS Foundation Trust), along with the City Council Heads of Service, Public Health and the Voluntary Sector (Southampton Voluntary Services).

In developing our vision back in the latter part of 2013/2014, we held three large stakeholder workshops, in addition to meetings and individual discussions with providers. The workshops were held on 16 November 2013, 12 December 2013 and 17 January 2014 and involved a wide range of stakeholders from all of the local health providers, primary care, voluntary sector groups, City Council housing and social care. The workshops were led by the Director of Public Health, CCG GP clinical lead for integrated care and chair of the Health and Wellbeing Board who is the Cabinet Member with the portfolio for Health & Adult Social Care.

All providers have presented an impact assessment against our plan to the Integrated Care Board and we have also agreed our plan and discussed the implications at "System Chiefs", a

forum which brings together the City Council Director of People, Chief Officer for the CCG and the Chief Executives of each of the NHS provider trusts.

More recently we have undertaken further reviews of discharge processes from acute care, supported by ECIST, the resulting action plans from which are changing significantly how care is planned and organised in the City and have influenced our Organisational Resilience and Capacity Plan. This has been described in more detail in Section 2.

During May and June of 2014 we held 3 locality workshops across the city which were well attended by all NHS providers alongside community groups, primary care, social care and housing and were used to consult on our Better Care clusters and consider how our processes could be simplified and better coordinated.

ii) primary care providers

Southampton City CCG has 33 constituent member GP practices. The CCG has a number of clinical GP leads who provide leadership to strategy and planning and play a significant part in engaging the member practices. The Chair of the Integrated Care Board is the CCG lead GP for integrated care and the board is also attended by two other of the CCG clinical GP leads. One of these leads also sits in an advisory capacity on the Operational Group responsible for operational delivery of our Better Care Programme and has clinically led a project involving two practices, social care, health providers and the local community to pilot elements of our Better Care model (in particular risk stratification, integrated care planning and community navigation). The other has been piloting a model of self management in partnership with a voluntary sector provider in his inner city practice and is also a member of the Better Care Commissioning task and finish group advising on alternative contractual models and approaches.

Practices have been engaged in the development of our plans through locality meetings and also TARGET which is a forum which meets quarterly and provides time out for audit, research, governance, education and training.

In developing our plans for cluster working, we consulted with all GP practices through the locality workshops (mentioned above) as well as by individual letter and made a number of changes to the proposed cluster configuration as a result of their feedback.

As already mentioned, we are piloting 3 different approaches to increasing practice based nursing capacity using the Everyone Counts £5 per head initiative, following discussion with GPs at locality and city level.

Practices are working hard to deliver the Proactive Care Programme and to build stronger relationships within their locality clusters to support delivery of the £5/head proposals. A city-wide GP federation is also in development.

iii) social care and providers from the voluntary and community sector

Social Care and the voluntary and community sector are also represented on the Integrated Care Board and have played an active part in all the workshops mentioned above. Social care is also part of the System Chiefs group mentioned above.

The integrated commissioning unit works across both the CCG and City Council reporting to the Integrated Commissioning Board which comprises the Chief Executives and Chief Finance Officers of the City Council and CCG, the Director of People in the City Council, the Director of Public Health, the Director of Quality and Integration for the CCG and City Council, the GP Clinical Chair and HWB Chair who is also the Cabinet member with responsibility for health and social care.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

Better Care Southampton is focussed on a balanced approach across the breath of integrated care with ambitious targets to:

- Reduce avoidable emergency admissions where we benchmark poorly including better management of frailty including falls avoidance
- Better reablement outcomes (ensuring reablement is more effective in restoring independence and thereby also reducing repeat admissions)
- Impact on reducing length of stay, specifically reduced DTOC (quicker discharge from hospital into agreed packages of care)
- Reduced nursing and residential home admissions (thereby ensuring that NH/RH capacity is more readily available for those who need it)

Throughout 2013, it became clearer that sustained very high levels of bed occupancy (in excess of 95%) were creating difficulty in admitting patients in urgent need, and creating unacceptable risks to the safety and quality of patient care across the hospital. We are starting to see a decline in the number of A&E attendances and there is some evidence that the growth in emergency admissions has been stemmed. There is renewed determination across the whole system to build on progress, to sustain efforts to alleviate these problems and to support the hospital in every way possible. However, performance against the 95% standard remains less than acceptable and this is important because this standard is a key indicator of challenges across the entire system: failure to safely and effectively discharge people leads to significant pressure on elective capacity which in turn means that meeting other crucial national standards (such as referral to treatment times and waiting times for cancer) becomes challenging.

Better care provides us with an opportunity to really focus on tackling patient flow through the system (which has been shown to be a key pressure in the current system – see Case for Change) at the same time as maintaining our QIPP focus on reducing NEL admissions. We will continue to focus on reducing NEL admissions through:

- Alternatives to ED attendance (which has not grown in 2013/14) including the newly commissioned enhanced MIU service
- Improved treatment pathways from ED that will reduce the need for admission including
    - the community assessment facility for frail elderly introduced in 2014/15 and
    - new chest pain and abdominal pain protocols introduced in 2014/15 to reduce very short stay admissions (which have hitherto) been responsible for 80% of the NEL admission growth).

However, we see Better Care as a prime opportunity to focus on improving patient flow through the system and reducing pressure in social care. This is reflected in our activity plans and

targets (a 2% reduction between 2014/15 and 2015/16 in NEL admissions) and in our schemes.

Unplanned admissions/Non elective (NEL) admissions

The contribution of Better Care to reducing NEL admissions is focused upon tackling avoidable emergency admissions. This will be a result of better proactive care of people with long term conditions so that they are less likely to have an acute episode requiring admission to hospital, together with more proactive integrated care in the community and improved effectiveness of reablement so they are not readmitted.

Our plan is based on a 2% reduction (before growth) in NEL admissions between 2014/15 and 2015/16. Without growth factored in, this equates to 570 admissions. With growth factored in at approx 1%, this would equate to 850 admissions or a 3% reduction. In actual numbers this amounts to between 2 and 3 less admissions a day.

In summary our rationale for choosing a target lower than the 3.5% national expectation is set out below:

- NEL growth in 2013/14 was limited to 2.7% in Southampton, a high proportion of this growth being in very short stay admissions. NEL growth is not the principal driver of increased cost in the local system, rather we are focussed on tackling length of stay and hence discharge and onward care, as well as avoiding emergency admissions.
- Forecast NEL growth in 2015/16 due to demographic factors is 1%
- Planned changes of 3% gross to this forecast result from a combination of 1% reduction due to 'QIPP' (which in this context is shorthand for productivity improvements in the acute pathway and alternatives to acute admission) and 2% reduction due to Better Care initiatives such as better reablement, falls prevention and elderly care nursing in community teams.
- Thus, the net NEL reduction against the plan baseline will be 2% (compared to the national expectation of 3.5%).

The key schemes that focus on achieving this are:

- focussed work on specific LTC pathways – specifically in relation to diabetes and COPD
- local person centred coordinated care – offering a more proactive approach targeting those individuals most at risk of admission
- integrated rehab and reablement service – focused on promoting recovery and maintaining people's independence

In financial terms this reduction equates to approx. £849,000 (without growth).

Delayed Transfers of Care (DTOC)

Delayed tranfers of care remain high in Southampton and we have seen significant growth in the beginning of 2014/15 compared to 2013/14. Our plan for 2014/15 is therefore to hold this growth for the remainder of the year at the 2013/14 level. This is a very ambitious target, particularly as the 13/14 figures are artificially low due to norovirus last Winter which meant fewer people were admitted. However we have an ambitious plan this winter which focuses on improving discharge pathways and stronger rehab and reablement. Significant investment is being made to support this. The key schemes include:

- implementation of trusted assessor

- discharge to assess – 12 additional beds
- increased rehab and reablement capacity

In order to achieve our 14/15 plan we will need to reduce DTOC by 5 per day over the remainder of this year from the Q1 and 2 position. On average around 10 Southampton City patients are discharged from Section 2s or 5s each day – this will mean an increase to 15.

Moving forward, our plans are to further reduce DTOC in 15/16 by an additional 3 per day. This will return levels of DTOC to the 13/14 position, an approximate 10% reduction. The main schemes for achieving this additional reduction is our rehab and reablement scheme and placement and packages scheme which will bring together health and social care resources to improve efficiency and capacity.

Impact on income for acute sector

From a provider income perspective, NEL admissions are currently paid for at the marginal rate (30%) so any reduction in real terms will have a beneficial financial impact.

Implications for the acute sector of our plans – new ways of working

There has been extensive engagement from all providers in the development of our plans and agreement of our targets (as demonstrated in Annex 2).

For University Hospitals Southampton, our main acute hospital provider, our plans will require:

- Stronger joint working between secondary, primary and community care to manage risk in the community
- More outpatient activity delivered outside of the hospital
- A more specialist advisory role to the community.

Impact on delivery targets

We expect our plans to improve performance against NHS service delivery targets through:

- a more proactive, pull approach from the community to discharge patients. This will enable more timely discharge and support the hospital to better manage capacity and reduce delayed transfers of care.
- More coordinated, preventative community provision, operating 7 days a week. This will reduce avoidable admissions, thereby reducing pressures on the urgent care system
- Better information available to the hospital on admission (through access to the patient's care plan) supporting assessment and coordination of care.
- Safer levels of capacity for elective activity as a result of improved functioning of the urgent care system

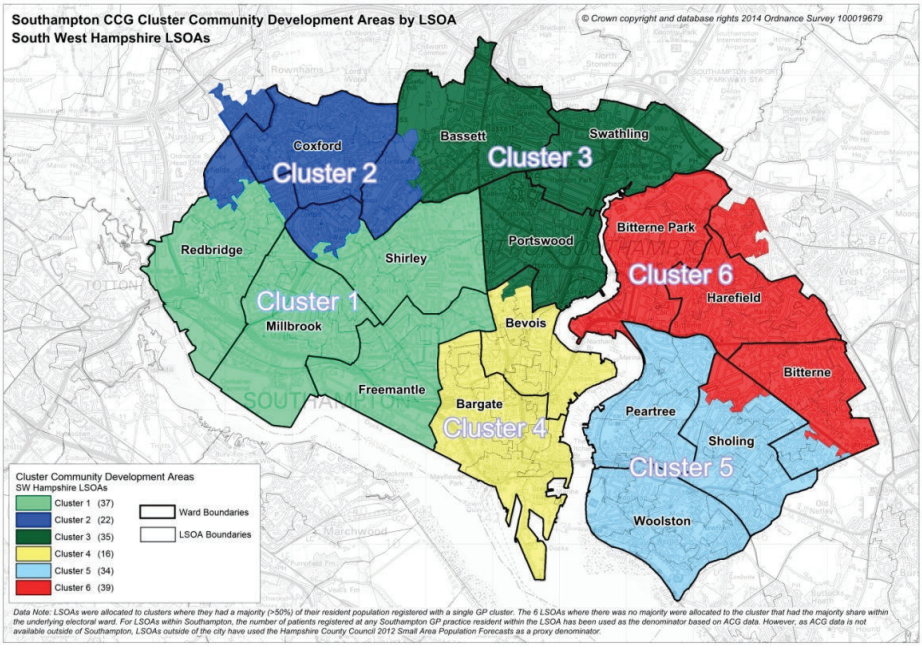
This will improve performance in the following areas:

- Sustainable delivery of Emergency Department (ED) Performance including the Clinical Quality Indicators for ED
- Reduction in very short stay admissions to Clinical Decision Unit (CDU)
- Safer Occupancy levels and a reduction in levels of medical outliers.
- Improvements in Length of Stay and a smoother patient flow through the hospital
- A reduction in the levels of 'on the day' cancellations due to non-clinical reasons
- Sustainable delivery of Referral to Treatment (RTT) standards
- Reduction of delayed transfers of care
- Reduction in levels of unplanned readmissions

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1.
Scheme name
Local person centred coordinated care (Integrated Cluster Team Working)
What is the strategic objective of this scheme?
Over the next 5 years, our vision is to completely transform the delivery of care in Southampton through our jointly led CCG and City Council Better Care programme so that it is fully integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, empowered and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention. The development of integrated working in clusters is a key building block in the new system. These clusters will bring together community nurses, geriatricians, MH workers, primary care, housing and voluntary sector with strong links to social care to work in an integrated way around local people and communities. The clusters will be based on GP practice registered populations. The clusters are intended to be generic in their scope, although initially they will focus on over 75s and adults with complex long term conditions (LTCs). After consultation, the following 6 clusters have emerged:    The intention is to implement the cluster model during 2014/15 with a view to all 6 clusters being up and running in some form by the end of the year.
Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Core functions of the cluster team

The following functions have been identified:

- To work with and support the GP practice teams in the cluster to:
  - identify people at risk of deterioration such that they would need admission/ long term care
  - comprehensively assess need through an assessment which is person centred, comprehensive (encompassing physical, medical, social needs, function, daily living/psychological) and provides a clear picture of needs/issues.
  - develop care plans which are anticipatory and goal orientated
  - coordinate care – supporting the GP practice in providing a single lead professional for each service user
  - manage crises/change in care needs
  - facilitate discharge from acute care
  - facilitate access to aids, adaptations, telecare/health to promote independence
- Promotion of self-management
- Early intervention/prevention
- Sign posting to community resources within local area

Target groups

The clusters will target two groups: those people within the highest risk groups for hospital admission or long term residential/nursing care who account for around 5% of our population (around 12,000 people) and 34% (9,400) of total emergency hospital admissions and those people within the moderate needs group who would benefit from supported self care who account for approximately 15% of our population (35,000 people) and 25.5% of total emergency admissions (7,000). Both these groups will be mainly frail elderly people and people with multiple long term conditions.

The Better Care Operational Group is undertaking further work to scope the needs of these cohorts in order to inform workforce planning and development. However, it is envisaged that the clusters will comprise the following staff:

- community nurses and matrons
- Older people's MH link workers
- Community/acute geriatricians
- Housing staff
- Local voluntary sector
- links to Care Managers and Social Workers
- links with the Fire Brigade
- links to domiciliary care providers

In terms of community nursing, the intention is to develop a much more integrated nursing model around each practice where the community nurses will work in an integrated way with practice nurses and other practice based staff, allocating work between them which maximises the key skills of each discipline.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The model is being developed with existing providers (described in the previous sections) and is being implemented by the Interagency Operational Group described in Section 4b. A

transformation manager with significant operational experience has recently been seconded from Southern Healthcare to champion change and project manage across organisations.

It is planned that within each cluster staff will remain managed by their host organisation/service. However each cluster will have its own identified, named staff.

Coordination of the model will be key to ensuring that each cluster is working effectively, staff are working together effectively (duplication and gaps are reduced) and needs are being met.

To make the model work it is proposed that each GP practice identifies a "link GP" for the cluster (this role could be rotated within the practice). The role of the link GP would be to:

- Become familiar with what resources/skills/expertise are available in the wider cluster
- Act as a conduit of information back to the practice
- Attend cluster team learning and development events to represent primary care

In each cluster there will be a cluster management team made up of a nominated lead GP for the cluster (this role could rotate amongst the link GPs mentioned above), a representative from each statutory organisation and the nominated coordinator for that cluster.

The role of the management team for each cluster will be:

- Overseeing the effective running of the cluster – ensuring processes and staff are functioning effectively
- Development of a cluster development plan
- Workforce planning
- Capacity planning
- Identification and following up any opportunities for improving the model
- Overseeing key performance indicators and trends eg. numbers emergency admissions, permanent admissions to residential/nursing homes
- Identifying population need and planning to meet that need

The role of the cluster coordinator will be:

- Accountability for delivering against key targets
- Coordination and administration of the management team
- Relationship management within the cluster
- Single point of contact for any issues around integrated working in the cluster
- Identification and Escalation of any key issues around operation of the model
- Coordination and administration of the virtual wards

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Three consultation workshops with staff involving the voluntary sector have taken place involving over 200 individuals. Additional consultation also took place with primary care and other staff groups. In addition to this a range of user and voluntary sector forums have been involved in shaping the strategy and its implementation.

The following evidence base has been consulted:

- Kings Fund resources on integrated care "Making it Happen"
- ICASE Integrated Care and Support Exchange
- Nuffield Trust resources on integrated care and risk stratification
- National Voices, Principles for Integrated Care

- Think Local Act Personal
- The Health Foundation, Person Centred Care
- Helen Sanderson Associates Person Centred Planning
- Royal College of General Practitioners, Integration of Care
- Kaiser Permanente, Integrated Health Care and Population Management
- Emergency and Urgent Care Intensive Support Team (ECIST)

The CCG and City Council have also made strong links with other leading sites (Torquay, Greenwich, Leeds) to learn more about their experiences and learning.

The model we are implementing has also been piloted in one neighbourhood (comprising two GP practices, social care, community nursing, older people's mental health services, as well as local voluntary and community groups) specifically in relation to integrated risk stratification, care planning and community navigation. Another pilot in the inner city has been testing out models of promoting self management with a voluntary sector partner. This has been clinically led and is an attempt to implement House of Care at a local level, developing the processes for enabling proactive supported self management, building an understanding of different roles and identifying potential tools and methods

We are also working with Southampton University to evaluate our model and are in the process of developing an evaluation proposal for sign off by our Integrated Care Board.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment shown against this Scheme in Part 2 of our submission is the existing collective spend across the CCG and City Council on services which will make up our local person centred integrated care model, in addition to some additional investment we are making in practice based nursing. The intention is to use the pooled fund to redesign and develop services in a way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The cluster model is expected to impact on all the Better Care targets, most notably:

Fewer avoidable hospital admissions

- Through proactive multiagency risk stratification tools which bring together a breadth of information to identify those people most at risk of deterioration and intervene earlier, maintaining and promoting independence
- Through better use of case management and shared care planning to better manage people at home
- Through a stronger focus on prevention, including falls prevention

It is estimated that the high risk groups account for around 9,400 admissions and we are aiming to prevent approximately 200 (approx. 2%) of these over the next 12 months through a combination of this scheme and the more responsive proactive discharge, rehabilitation and reablement model described below. This scheme also focuses on the medium risk group who would benefit from supportive self care and it is estimated that this group accounts for approximately 7,000 admissions of which we are aiming to prevent 400 (5-6%) through this scheme.

Fewer admissions to long term care, eg. residential or nursing homes

- Through better case management and shared care planning
- Through a stronger reablement ethos
- Through more proactive discharge planning, ensuring that people are only in hospital for as long as they clinically need to be and that their independence is promoted

Fewer delayed discharges from hospital

- Through improved discharge processes which begin to plan for discharge at the point of admission or as soon as possible thereafter and proactively "pull" patients through the system, which will include any assessments for long term care taking place in a community setting
- Through strong joint working between acute and community teams
- Through a stronger more proactive recovery and reablement focus which commences as soon as the patient is clinically fit

Better service user experience

- Through more person centred approaches and self-management which empower people to design and manage their own care/condition
- Through better information about local resources
- Through people feeling less isolated
- Through reduced duplication

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The interagency Operational Group is in the process of developing a set of key performance metrics for each of the outcomes identified above.

Below is a summary of the thinking so far:

- Fewer avoidable hospital admissions
  Suggested KPIs
  - Reduction NEL admissions
  - Reduction NEL admissions of case managed patients
  - Reduction A&E attendances
  - Reduction A&E attendances of case managed patients
  - Reduction injuries due to falls
  - Reduction ambulance attendances for patients who have fallen
  - % of Case managed patients who have received a falls assessment and review in past 12 months
  - Reduction in readmissions within 91 days of discharge

- Fewer admissions to long term care, eg. residential or nursing homes
  Suggested KPIs
  - Reduction permanent admissions to residential and nursing care

- Fewer delayed discharges from hospital
  Suggested KPIs
  - Reduction in excess bed days
  - Reduction in delayed transfers of care

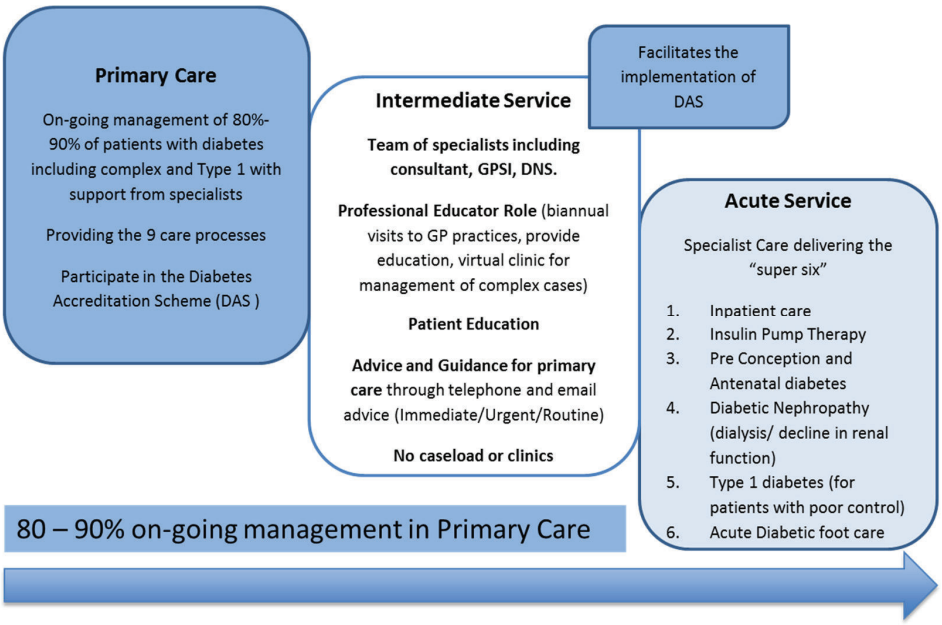
- Better service user experience
  Suggested KPIs
  - % of case managed patients reporting positively to statement "I feel confident in managing my long term condition"

- % of case manage patients reporting positively to statement "I have planned and feel in control of my life and future"
- number of patients in each cluster with shared care plan in place

The intention, having agreed the indicators, is to produce regular performance reports for each of the clusters.

What are the key success factors for implementation of this scheme?

- Co-design, production and Community Development – we have a very positive relationship with Healthwatch who are supporting us on both this scheme and the Community Development Scheme and sit on the Integrated Care Board and Operational Group. We also have support from Think Local Act Personal (TLAP).
- Ability to evaluate and continuously learn from the work we are doing – we have already in place critical friend academic support from Wessex AHSN and Wessex CLAHRC
- Good robust engagement and coproduction with all stakeholders – see our communication and Engagement Plan for how we are taking this forward.
- Workforce development – a workforce development plan is being developed in 14/15 to underpin the change in culture and new ways of working (including trusted assessor model, person centred planning, motivational skills) required by the cluster model
- Primary care development and GPs signing up to new enhanced service for unplanned admissions – all 33 GP practices have signed up to the new Proactive Care programme.
- Identification of suitable accommodation within each cluster area to provide a team base – the Operational Group is currently mapping premises by cluster to enable a decision about bases to be made.
- Information sharing agreements and interoperable IT across health and social care settings – we are working with our Commissioning Support Unit to develop the appropriate information sharing agreements, templates and IT interoperability. Work is underway to produce a shared care plan prototype using the Hampshire Care Record which will be available for roll out by December 2014.
- Strong leadership – this is provided through the Integrated Care Board which includes leaders from across the health and social care system, as well as the voluntary and community sector, and oversees our Better Care work programme. Leadership is also strong through our Health and Wellbeing Board.

Scheme ref no.
1b.
Scheme name
Long term conditions pathways – supporting local person centred coordinated care
What is the strategic objective of this scheme?
This scheme supports the model of local person centred coordinated care described in Scheme 1. It includes focussed work that we are doing around specific conditions, particularly COPD and diabetes, to support people to remain well and independent in their own homes and communities, with a strong focus on supported self care, as well as the provision of expert support to the cluster teams who will be working in a more holistic way.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
We have been developing an integrated approach to long term condition (LTC) services. We have made significant changes to community COPD Services, developed a new diabetes care model which is currently undergoing implementation and are reviewing services which support heart failure and neurological long term conditions with a view to developing commissioning intentions and implementing service changes which will deliver improved outcomes for patients. The consistent approach/strategy for LTCs services is delivery of care closer to home in community settings, supported by specialist knowledge through integration, with primary care leading the majority of people's care. The ICU is developing its LTC strategy during 2014/15 to consolidate the work which has been undertaken to date and to inform a 3 year plan for further improvement in the care of people with LTCs in the city. **Diabetes** In Southampton there are 11,545 adults with diabetes (over 90% receive their care in primary care). The model of care for people with Diabetes is as follows: 

We are undertaking specific work with general practice to improve the quality of care, using the NICE 9 key processes of care and have developed a GP diabetes accreditation scheme which we are currently rolling out:


Standards of Diabetes Care - narra


PC - Diabetes Accreditation Scheme

Foot care has been identified as a particular priority for development given the very high rate of amputations in Southampton. This will involve better integration between the community podiatry team and the acute diabetes service in the management of active foot disease and ulceration. The proposed model of care, developed by primary care and endorsed by the providers is as follows.


PC Integrated Diabetes Footcare Pr

A business case to enable the delivery of this new model is currently being developed.

COPD

4810 people in Southampton have COPD. In our case for change, we have identified that respiratory admissions make up 10% of all unplanned hospital admissions. The Southampton City Integrated COPD service is provided by a multidisciplinary team of combined UHS Foundation Trust and Solent NHS Trust staff. The Pathway has a lead Clinician (a Consultant In Respiratory Care), and an operational manager with a clinical knowledge base (an 8a Allied Health Professional (AHP) or Nurse). The service provides both community based consultant and nurse led clinics and home visits to provide admission avoidance and 30 day post discharge support, pulmonary rehabilitation and patient education, and primary care education and support. Because of its integrate nature it has excellent links with the acute respiratory service to enable support for post discharge care, and the Home Oxygen Assessment Service.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The majority of LTC services are currently commissioned solely by Southampton City CCG and on a service by service basis, incorporated within the acute and community NHS contract with providers. Main providers are Solent NHS Trust and University Southampton Hospitals NHS FT.

The integrated COPD Service is a service commissioned jointly from both providers, and is currently undergoing a review regarding meeting the outcomes and objectives set when the service was implemented 2 years ago. It is anticipated that from this review the current contracting method could be improved and other options, for example an alliance contract may be appropriate for this service. If successful it may be used for other LTC services.

Diabetes Intermediate service is commissioned from Solent NHS Trust as a lead provider, and there are sub – contracting arrangements with other providers to support in its delivery.

The Heart Failure service and specialist nurse service for neurological LTCs (Parkinson's, epilepsy and MS) are currently under review, they are currently commissioned from Solent NHST Trust with sub-contracting arrangements in place for the heart failure service.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

For all service developments national evidence is reviewed including:

- Appropriate NICE guidance and clinical standards
- Atlas of Variation
- Public Health Observatory publications
- Parliamentary briefings
- NHS England House of Care model and associated toolkit

In diabetes scheme we have also used local evidence over the last two years to drive the improvements required including:

- Initial Stakeholder Event to identify areas for improvement in 2012
- Findings from 3 GP Locality Projects:
  - West : Integrated Diabetes Foot Care Service
  - East : Self -Management
  - Central: Enhancement of Professional Education in Diabetes
- GP Practice Stock Take in May 2013
- Patient questionnaire
- Insulin Pump patient forums
- Engagement and patient representation from Diabetes UK

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment shown against this Scheme in Part 2 of our submission is the existing spend within the CCG on services targeted at people with specific long term conditions (e.g. diabetes, COPD, heart failure, neurological conditions. By pooling this funding within the Better Care pooled fund, we intend to redesign and develop services in a much more integrated way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme will particularly contribute to achieving the following Better Care targets:

- reduction in emergency admissions – we are expecting the integrated pathway of care we have developed to reduce COPD emergency admissions by 135 and diabetes admissions by 120 (these figures include growth unlike the figures in Part 2 of our Plan)
- reduction in delayed transfers of care
- improved patient experience – this scheme specifically impacts on our chosen target to increase the percentage of people who feel supported to manage their long term conditions

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We will measure the specific impact of this scheme on the Better Care targets above through the following set of specific metrics:

- Reduction in emergency admissions
  - COPD impact to be measured specifically through a reduction in HRG DZ21A to DZ21K admissions - Threshold for 15/16 is 25% reduction on 12/13 baseline actual baseline plus 5% growth

- plus increase in number of patients discharged from Pulmonary Rehab course to have completed nine out of twelve sessions – target is 60%
- plus increase in patients who have completed Pulmonary Rehab showing an increased exercise tolerance – target is 60%

- Reduction in delayed transfers of care
  - COPD impact to be measured specifically through a reduction in excess bed days against HRGs DZ21A to DZ21K – target is 20% against 12/13 baseline plus 5% growth

- Improved patient experience
  - COPD impact to be measured through patients completing the Quality of Life Indicator at the completion of the programme – target is 60%
  - plus all patients seen by the COPD service to have a management plan and an appropriate self-management plan

Quarterly review meetings with the service providers are in place to review performance against the outcome measures/quality indicators.

What are the key success factors for implementation of this scheme?

- good clinical engagement – this is achieved through GPs as clinical commissioners leading the development of service models and driving forward the service model implementations, alongside clinicians delivering community and secondary care.

- Patient engagement – this is achieved through having patient representatives included within project groups/review meetings. We have engaged patients groups (for example through attendance at patient group meetings and events, surveys etc) to highlight areas of improvement and concerns, testing proposed new models and care planning.

Scheme ref no.

2.

Scheme name

Integrated discharge, reablement and rehabilitation

What is the strategic objective of this scheme?

The strategic objectives of this scheme are:-

- To support individuals to live independently for as long as possible within their own communities
- To provide integrated community facing rehabilitation and reablement services that are effective, timely, person centred and are responsive and flexible enough to:
  - ✓ Reduce the number of avoidable admissions to acute services
  - ✓ To reduce the number of delayed discharges of care from hospital

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme will establish an Integrated Out of Hospital Service that brings together a number of existing functions (currently provided separately across agencies) including rehabilitation and reablement, community bed based provision and rapid response into a single integrated service which will:

- Offer a crisis response function – to be able to respond to a crisis situation in the community and when appropriate target health, social care and voluntary resources to keep that person within their home or somewhere close to home whilst further support is planned.
- Operate a service that is able to discharge people out of hospital at the point that their acute episode has ceased – and using a "Discharge to Assess" approach to then respond to that person's needs in a person centred manner within a community setting.
- Link with the "community clusters" to work with people who are identified as potentially at high risk of an acute episode – offering information, advice and guidance or in some instances direct intervention e.g. equipment/therapies, falls prevention. (There will be a pathway for people who have fallen to ensure that all fallers are followed up and an appropriate management/rehabilitation plan is devised, including use of medication and referral to exercise classes to improve core strength and balance.)

Interventions are generally likely to be goal orientated and time limited however the focus of the service will be person centred and needs led. The service will use a Multi-disciplinary Team (MDT) methodology to undertake both generalist and specialist activity as appropriate utilising the skills and experience of a range of professionals including:

- Occupational therapists and occupational therapy assistants
- Physiotherapists
- Consultants in integrated medicine and older people
- Community and inpatient nursing staff
- Community and residential care staff
- Community support workers
- OPMH support workers
- Reablement Care Managers

There would also need to be explicit links/support from other services/process e.g. :-

- Housing
- The "Risk Stratification" process and Care Navigation provision

- Advocacy Services
- Carer Support Services
- Continuing Healthcare Team

The service is designed to support adults aged over 18 years, however, based on current service usage, a growing elderly population with one or more long term conditions and increasingly complex social circumstances, the expectation is that the majority of service users will be over 65 years. The target group will be those in the high risk category shown in the Case for Change section – approximately 5% of the population accounting for 24.8% of total unplanned admissions. We estimate that the service will receive around 2,250 patients a year through hospital discharge and 3,500 patients a year from the community. Over time, we expect the ratio of people coming into the service from the community as opposed to the hospital to grow as the system moves to a more preventative proactive focus.

The preferred option will always be to deliver the service within the community, when necessary using nursing and care staff overnight; however if this is not possible the service will have bed based options in the community if required.

Supporting the model, we plan to develop an integrated telecare and telehealth service that builds on local intelligence and demographics. Target groups will include

- Over 85's
- Case managed patients with long term conditions
- Carers
- People with Dementia
- People who have fallen and so are at risk of future falls

The service will be developed through a staged process that develops from an existing and established community alarm service, through competitor negotiations and procurement to provide an integrated model of telecare and telehealth embedded within assessments and care planning.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The functions which the integrated service will bring together are currently provided by the City Council (in house provision) and Solent NHS Trust. The CCG commissions health provision and makes a significant contribution to the City Council reablement service through the reablement budget.

The concept paper for the new model is currently out to consultation and a detailed business case is in development. This will explore future provider arrangements which may include integrated provision via a pooled budget or a single provider model. The new service will be jointly commissioned by the City Council and CCG through the ICU as part of the Better Care pooled fund arrangements.

The project has an agreed Project Initiation Document which includes:-

- Key actions and agreed timescales
- An established project group with provider and commissioning representation for each aspect of the project (which includes all of the above provider leads.
- Risk Management Plan
- Communication and Engagement Plan

With regard to telecare/telehealth, a business case is being progressed by the ICU for the identified target groups. The new service will include existing provider of Community Alarm while developing new business across wider social care and health settings.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The scheme has been informed by:

- "Better Care Workshops" held over the past year which have given a particularly strong steer that our reablement and rehabilitation services should be more joined up, our processes should be simplified and our planning should be coordinated.
- the knowledge and experience of clinicians and practitioners from a range of services in the form of a "Task and Finish Group" to support the process of designing the scheme.
- the ECIST review of hospital admission and discharge processes out of which there are a number of clear messages which have been incorporated into our thinking:
  - Use community resources where possible to manage crisis through rapid coordinated crisis response and timely follow up planning.
  - Once people are admitted to hospital begin the discharge process at the earliest point possible using "trusted Assessor" approaches and engaging moving on services as soon as possible.
  - Once an acute episode is complete and there is no longer a need to remain in hospital patients should be discharged preferably home or to a community resource using whatever support is necessary to do so (including overnight nursing support) with further assessment of need taking place in the community ("Discharge to Assess").
- A cross agency Occupational Therapy Review undertaken in 2012 that identified many concerns in relation to duplication, communication issues and haphazard processes. The recommendations from this review have been incorporated into this scheme in relation to having shared management and shared processes including a single point of access.
- Social Care Institute for Excellence Research briefing 36 (April 2014) Reablement: a cost effective route to better outcomes identified improvement in outcomes and probability of cost effectiveness. The focus on the need for suitably trained care workers has been explicitly incorporated and the role of Occupational therapy skills.
- The King's Fund convened working group of community providers which explored the steps that are required to change community services in ways that will help create the transformation needed (Nigel Evans – Kings Fund "Community Services – How They Can Transform Care" February 2014). The report that was produced highlighted a number of areas that are reflected within this scheme:-
  - Complexity should be removed with simple patterns of multidisciplinary service delivery developed linking primary care and geographical areas with community and hospital based services.
  - Services need to be capable of very rapid response and to work with hospitals to speed up discharge. The ability to access community beds for short stays is seen as important.
  - Significant numbers of patients occupying hospital beds could be cared for in other settings but only if suitable services are available and can be accessed easily.
  - Community services need to reach out into communities more effectively harnessing the power of the wider community to support people in their own homes.

Telecare and telehealth has a growing evidence base from national schemes including 3 million lives and Kings Fund. Recognising there is a broad range of evidence, both in support of and against the use of telecare and telehealth, the local approach has been to use local intelligence to understand the areas where the greatest benefit can be achieved. Feedback from pilots, professionals and individuals has helped to inform the design of the new service.

Modelling based on reducing pressure continues to inform the assumptions about impact and outcomes.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment shown against this Scheme in Part 2 of our submission is the existing spend within the CCG and City Council on provision delivering rehabilitation, reablement, community rapid response and discharge facilitation. By pooling this funding within the Better Care pooled fund, we intend to redesign and develop services in a much more integrated way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme will make a significant contribution to the following Better Care targets:

- reduction in unplanned admissions – through supporting people to maintain their independence at home in their local community and intervening earlier. People who could benefit from rehabilitation and reablement services will be identified as early as possible through risk stratification and early crisis response and in so doing will reduce future risk of crisis.
- reduction in permanent admissions – through supporting people to maintain their independence at home in their community and intervening earlier
- reduction in delayed transfers of care – through supporting timely discharge and recovery. Our plan is to reduce DTOC in 15/16 by around 3 per day from the 14/15 position.
- improved service user experience – through supporting people to set and achieve their own goals and providing confidence and peace of mind through developments like telecare and telehealth
- reduction in readmissions within 91 days after discharge into reablement services
- reduction in injuries due to falls – through the development of a new falls pathway that ensures that every person who has been injured from falling is followed up and has a falls prevention plan

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following metrics will be used specifically to measure the impact of this scheme:

- reduction in unplanned admissions
    - % referrals to rehab and reablement service coming from community as opposed to hospital discharge (a higher percentage would suggest a greater focus on early intervention/prevention)
- reduction in permanent admissions
    - % referrals to rehab and reablement service coming from community as opposed to hospital discharge (a higher percentage would suggest a greater focus on early intervention/prevention)
    - evidence of improved/maintenance of function at end of reablement/rehab (measure to be developed)
- reduction in delayed transfers of care
    - reduction % delayed transfers where prime reason recorded to be awaiting equipment (this has reduced from 2% to 1% over the last 4 years)
    - Integrated Discharge Bureau daily average discharges (increasing this from 10 to 15)

- % Section 5 Patients discharged within targeted time limits (target is 60% within 3 days)
- reduce number of patients discharged from UHS with length of stay > 30 days

- improved service user experience
  - direct feedback from patients who have used rehab and reablement services (measures to be developed)
- reduction in readmissions within 91 days after discharge into reablement services
  - evidence of improved/maintenance of function at end of reablement/rehab (measure to be developed)
- reduction in injuries due to falls
  - Number of patients in receipt of comprehensive falls assessment
  - Number of patients participating in evidence based exercise programmes.
  - Physical outcome measures at the start and the end of the exercise programmes to be reported quarterly. These outcome measures will be measures that correlate to falls risk therefore improvement in outcome measures reported should correlate to lower falls risk for patients.

What are the key success factors for implementation of this scheme?

- Culture change to build reablement ethos into wider community services, e.g. domiciliary care
- Good robust engagement and coproduction with all stakeholders – see our Communication and Engagement Plan for how we are taking this forward.
- Strong leadership – this is provided through the Integrated Care Board which includes leaders from across the health and social care system, as well as the voluntary and community sector, and oversees our Better Care work programme.
- A diverse and sufficient community market for meeting people's long term needs which promotes a reablement ethos – this scheme is closely linked to Scheme 3C.
- Good systems for identifying and targeting those people early enough to maximise positive outcomes of rehabilitation and reablement – this requires good risk stratification processes and close working with the cluster teams described in team one.
- Commissioning for outcomes instead of outputs and stand alone tasks

Scheme ref no.
3
Scheme name
Community development (including self management and development of a community navigation function)
What is the strategic objective of this scheme?
The objective is to build capacity with and within local communities and create a future health and social care system within Southampton where local communities are equal partners in all planning, strategic thinking and decision making. It requires changing the way we work together with local communities as well as recognising, valuing and working with existing groups and activities. The aim is to build capacity (part of our plan for protecting social care services) and also to shift towards a culture which helps people to find their own solutions, drawing on their own strengths and those of the people around them and feel part of a bigger community network. Tackling loneliness is also a key part of this agenda, recognising the significant proportion of older people who live on their own in Southampton (see Case for Change section).
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme builds on the work already happening in the community. We will continue to work with communities and providers to develop the local markets to maximise local capacity to support health and wellbeing of communities, including local action to reduce loneliness and social isolation and provide exercise classes as part of our falls pathway that we are developing. This will also include proactive support through voluntary sector partners to attract and maximise alternative funding opportunities (e.g. Big Lottery, Trust funds) into local communities of identity (e.g. ethnicity, diagnosis, neighbourhoods). We will review existing provision, building on existing developments like “Time Banks” and contracts to explore opportunities for out-sourcing areas of work/activity to the community and voluntary sector, at the same time as exploring different models of working with the community and voluntary sector which facilitate innovation and growth. Community development is drawn together through a cross sector Community Development group, sponsored by the HWB’s involvement in a draft framework with TLAP to Develop the Power of strong inclusive communities. A particular area of development which is key to our Better Care model involves the Community Navigation function which has been implemented successfully across the country. Community navigation is about supporting people in their local communities to maintain their health and wellbeing, manage their own conditions and access community resources, directly linking people to activities/community resources e.g. leisure, employment, education, welfare rights, housing, friendship schemes, time banking schemes and volunteering. The community navigator will link people into support networks (e.g. health trainers, Steps to Wellbeing) which will help them to develop a plan to manage and improve their health and wellbeing and support them to achieve their personal goals. They will provide a point of contact to access universal services and also actively follow up people to check out that their needs are being met and identify if additional support is required. They will also be in a good position to identify gaps in support and to provide a rich resource of information for commissioners and community groups/voluntary sector providers. The target group for community navigation are people who are both frequent attenders to primary care and or urgent care services, who are not eligible for coordinated care, but have an identified significant underlying unmet need and people who have been identified by the cluster teams as being at moderate risk of deterioration in their health and wellbeing. Generally this

will be the same group of people likely to benefit from supported self care who account for approximately 15% of our population (35,000 people) and 25.5% of total emergency admissions (7,000) as identified above in Scheme One. The community navigator will receive referrals from primary care and cluster teams.

At an individual level we will continue to work in way that helps individuals understand and maximise opportunities for developing their own social capital. A particular area of development is Person Centred Planning with patients who have Long Term Conditions. We are rolling out a scheme which is aiming initially to provide support to 60 patients to develop person centred plans (PCP). These plans will explore areas such as hopes, dreams and fears of the individual, what a good day and a bad day looks like, what's working and what's not working, people's gifts, talents and capacities. Again this will focus on the 15% moderate risk cohort identified above.

People will develop their person centred plan with key individuals (people who they want to help them plan and make the plan come to life) and be facilitated by a skilled volunteer. Assisting people to develop a person centred plan helps them to take control over their own health. It is planned that care plans will be accessible to patients and professionals involved in their care via the Hampshire Health Repository (mentioned above in Section 7c). These plans will inform health and social care professionals and commissioners about how best to deliver care and what needs to be in place to achieve person centred care.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The community development group (mentioned above) reports to the Integrated Care Board and builds on and works with a number of existing initiatives including the community development workers (CDWs) network. The role of the community development group is to:

- to identify priority areas for development
- to map existing community assets against specific needs/priorities
- to introduce the community navigation role
- to attract and maximise alternative funding/support opportunities.
- to support coproduction with voluntary organisations and communities
- to support Better Care communications and engagement
- to evaluate and review initiatives

The community navigation function is being developed through a process of co-production, involving clinicians, cluster staff, voluntary organisations, community leaders and other interested stakeholders. It is envisaged that the function will be delivered by the community and voluntary sector and we are planning to write to potential providers in October 2014 to ask for expressions of interest in moving this forward. A stakeholder event will be held in October 2014. The CCG is providing pump priming funding initially for one year (with a potential extension) to support the sector in setting up and delivering this initiative but the intention is that this will become self funding. The Integrated Commissioning Unit market development function will offer practical support and advice to voluntary organisations in seeking external funding.

In terms of the person centred planning scheme, we are working with a range of voluntary sector organisations and community groups including: Age UK, Alzheimer's Society, Marie Currie, Carers Together, Healthwatch, Woolston Timebank, and a number of faith groups. Currently mapping work is underway to identify the range of community resources available and help prioritise the focus of future community development. The plan is to go back to this network to identify suitable individuals who could be offered PCP facilitator training and support.

The aim is to provide training and support to 20 patients, family members or volunteers (from community groups or voluntary sector organisations) from the demonstrator site to develop their skills in person centred planning, for these individuals to support at least one people to develop a person centred plan following and during the training.

We will invite 10 of the individuals trained to become "Train the Trainers", so they can pass on their growing expertise and experience to others from across the City.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The TLAP draft framework for HWBs states

> "There is compelling evidence that better health and wellbeing can be achieved through developing stronger and more inclusive communities and re-designing and tailoring public services so that professional expertise complements people's own lived experience"

This evidence is provided from proactive agencies such as NESTA, Kings Fund, TLAP, Expert Patients programme and LSE (Martin Knapp).

The community navigation function or similar function has been tested in a number of areas, most notably Torbay, Greenwich and Cornwall. In developing our plans we have established close links with experts from Torbay and have also visiting Greenwich to find out about what they are doing.

The learning from the local pilot of our Better Care model referenced in Scheme One as well as feedback from the Better Care workshops we held in November, January and during April/May highlighted the need for community navigation in Southampton which will support the progression of the Better Care agenda.

With regard to person centred planning, this approach has been well tested with people who have learning disabilities. There is research evidence that even the most excluded and disempowered individuals in society are able to use person centred planning to gain increased control and ownership of their care. By developing a person centred plan individuals will be in a strong position to engage in self management, shared decision making and personal budgets.

The ICU is working closely with academics from the University of Southampton in conjunction with the Wessex CLAHRC (Collaborations for Leadership in Applied Health Research and Care) and the Wessex Health Academic Health Sciences Network. The evaluation is gathering qualitative and quantative data, which is linked to an Agile approach to project delivery so that a PDSA (Plan, Do, Study, Act) cycle can be followed on a 3 month basis. By adopting this approach early lessons learned can be consolidated and new innovative methods adopted both engaging professionals and patients.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

We have badged existing collective spend across the CCG and City Council in the voluntary and community sector relating to the Better Care model against this scheme, in addition to some additional investment we are making in the community navigation and person centred planning developments. The intention is to use the pooled fund to redesign and develop services in a way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme supports the delivery of local person centred coordinated care described in Scheme One and so it is difficult to quantify separately the specific impact in relation to the Better Care targets. The scheme seeks to support individuals to have and maintain for as long as possible a healthy, meaningful life located with the community of their choice being able to actively self manage their conditions. As such it will support the delivery of the following:

- reducing permanent admissions to residential and nursing care
- reducing emergency hospital admissions
- improving patient experience – people feel supported to manage their long term condition

Specifically this will be achieved through:

- Helping people to access through their local communities and networks support and activities that are meaningful to them, give them a sense of purpose, provide friendships and reduce loneliness and isolation
- Enabling people to adopt behaviours to support their health and wellbeing and enable them to overcome blocking factors (income, caring roles, self-esteem, stress and anxiety) which previously resulted in need to access services.
- Reducing the dependency on clinical services for non-clinical problems by offering alternative services to individuals who may be seeking social and emotional support.
- Delaying the need for social care eligible services.
- Increasing compliance with appropriate interventions which will subsequently reduce waste in the health/social care system - reducing attendance at primary care and other health care settings (ED/Ambulance calls & conveyance).

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We are still working through ways of measuring the specific impact of this scheme but are considering the following measures and metrics:

- Number of community groups and activities across the city supporting the target group
- Number of referrals from primary care and cluster teams to voluntary organisations via community navigation
- % of voluntary organisations reporting positively to statement "We are feel we are contributing positively to achieving the Better care agenda" (via survey)
- Samples patients to measure capacity to self-manage using PAM scores collected on a longitudinal basis.
- Reduction in attendance at primary care for non clinical problems

We are working with Healthwatch to explore the development of a patient survey, specifically linked to our local Better Care metric “percentage of people who feel supported to manage their long term conditions”.

What are the key success factors for implementation of this scheme?

- Engagement of community representatives in strategic planning and service developments (coproduction)
- Delivery of the Community development group work plan, through joint working and ownership by Integrated Care Board
- Contributing to the TLAP framework for developing strong and inclusive communities with evidence based case studies.

- Ability to attract funding from external sources to meet gaps identified within local communities but not met by statutory funding.

Scheme ref no.
3b
Scheme name
Supporting carers
What is the strategic objective of this scheme?
To build and develop capacity by identifying an increased number of carers and providing them with information, advice and support to help them maintain their caring role.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Council and CCG are pooling available resources and have recommissioned new adult and young carer services from September 2014. These services will streamline current provision while expanding the identification, advice, information and support provided to the increasing number of unpaid carers. This work will be ambitious in its remit and work with young, adult and older carers in appropriate ways. Services will be asked to meet the critical areas set out nationally and locally, in particular supporting those with caring responsibilities to identify themselves at an early stage, providing accessible and meaningful information through website, literature, face to face contact and wider technical communication channels, recognizing carers in their own right, maximising the education, employment, income and benefits of carers and building community capacity to improve the wellbeing of carers (and those cared for). In particular the scheme will deliver against a number of key themes set out in the revised 2010 national carer strategy: • supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages; • enabling those with caring responsibilities to fulfil their educational and employment potential; • personalised support both for carers and those they support, enabling them to have a family and community life; and • supporting carers to remain mentally and physically well. The new service will continue to work closely with the Local Authority as it continues to deliver carers' assessments, and progress the requirements within the Care Act and Children & Families Act. It is planned to substantially increase the number of adult carers identified from April 2014, rising from under 3,000 to over 5,000 by March 2015 and engage more young carers in appropriate support.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The scope and reach of the new service was developed from a joint strategic carers strategy for Southampton. This was used to inform the Carer Commissioning Framework in 2013 and underpins the basis for jointly commissioning the adult and young carers service. The integrated commissioning unit (ICU) worked on the procurement of the new service, under relevant governance processes for both CCG and City Council. The service was commissioned through a legal procurement process, resulting in a local voluntary sector provider being awarded the contract. The City Council is the lead commissioner for the service. Regular contract monitoring by the ICU will ensure performance, outcomes and quality are achieved.
The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The basis for this scheme and service was drawn from national and local evidence base. The design also went through consultation with local carers.

National evidence shows that good robust and comprehensive support for carers will be essential as the health and social care system deals with the challenge of meeting increasing need with less resource (Dept of Health, Carers at the Heart of 21st Century).

Key but not exclusive national evidence and drivers are set out in:

- National Carers Strategy 2008 and Revised National Carers Strategy 2010; and
- Making it Real for Carers.
- Commissioning for carers: Key Principles for Clinical Commissioning Groups (carers Trust 2013)
- RCGP Commissioning for Carers 2013

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

NB. This scheme includes the additional £221k investment into carers assessment and support being made for implementation of the Care Act, in addition to the existing £600k ringfenced budget for carers and other areas of spend on carers, e.g. short breaks

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme like the Community Development Scheme supports the delivery of local person centred coordinated care described in Scheme One and so it is difficult to quantify separately the specific impact in relation to the Better Care targets. The scheme seeks to support carers in their caring role and thereby will contribute towards achieving a number of the Better Care targets, in particular reducing permanent admissions and improving patient experience.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The contract holds a range of performance and outcome measures which will inform the wider developments within integrated care and carer services.

We will monitor the number of carers (including new carers) identified, engaged and provided with the range of services jointly commissioned. Through a steady yet significant increase in the numbers engaged and provided with the relevant information, advice and support and surveys we expect to see an increase year on year in the number of carers (as a percentage of all carers engaged in the service) reporting that they feel better equipped to continue caring where it is appropriate for them to do so, who feel engagement with the service has resulted in a positive benefit to their life and has helped them maintain and safeguard their own education, employment, income and benefits.

What are the key success factors for implementation of this scheme?

- strong engagement with key care and health settings to achieve greater identification of carers and signposting to assessment and support

Scheme ref no.
3c
Scheme name
Placements and packages
What is the strategic objective of this scheme?
The strategic objectives of this scheme are: • Ensuring people have the right care and support at the right time • Ensuring care and support packages are tailored to the unique needs of the individual and their carers • Enabling people to exercise choice in how care and support is provided • Maximising the use of Direct Payments (DPs) and Personal Health Budgets (PHBs) • Working with local markets to develop flexible and innovative approaches to the provision and delivery of care and support and which support the above objectives
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The city council and CCG are committed to delivering services in a personalised way and maximising the use of DPs and PHBs. This will build on successful local pilots. At the heart of our vision is the view that tailoring care and support to the unique needs and assets of the individual will improve outcomes – individuals know best about what will work for them. Assessment and delivery of care and support will be holistic and we will consider physical and mental health needs together. This will be supported by the whole Better Care programme and the complementary effect of the individual schemes including those focusing on improving access to information and the development of integrated assessments. This scheme will focus on ensuring the quality, availability and diversity of packages and placements. To support this we will: • Implement processes across the city council and CCG which support the take up of direct payments. This will include in-house processes such as finance and payments but also include developments such as pre-payments cards and Individual Service Fund providers (ISF). We already have a Direct Payments Support Service and can build on the lessons learnt from them. We are looking to integrate CHC and Adult Social Care assessment and review processes, using the Care Bill to support this e.g. by removing the restrictions on who can do social care assessments. The team focus would be on personalisation and the ongoing roll out of personal budgets and personal health budgets. • Implement a market development strategy that increases diversity and flexibility of services. This will include increasing access to Personal Assistants, shifting the balance between care and support provided in the home and that provided in residential settings and improving access to accommodation and community support. • We are already reviewing a range of services, including day care and residential services for all care groups and respite provision, and are looking to develop more flexible models of care and support. This will involve a shift away from block purchased contracts towards more individual arrangements. Where we continue to block purchase we will build in arrangements which support personalised approaches and make this contractual – we are already including this in a current re-tender of our domiciliary care framework. We are looking to develop services which better support prevention,

including enabling people to remain living at home and to support carers, contributing to preventing unnecessary hospital admissions and admissions to care homes. In terms of residential care, we are committed to reduce the use of residential care services by providing better alternatives in the community, and increasing options for care in people's own homes. This includes the development of housing with care and support, four schemes of which have already been developed in the city since 2008, with a further scheme planned, which will provide a further 30 housing with care and support places, as part of a wider development of accommodation for older people. It also includes a greater range of realistic options for supporting people to stay in their own homes, and to have greater options to take on and to spend their personal budget on supported access to mainstream and community-based services.

- Work with staff across the system to support a cultural shift towards an asset based approach which gives more choice and control to individuals.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Delivery of this scheme is being progressed by the ICU. Detailed project initiation documents (PIDs) are in place for the day care, residential, respite and domiciliary care reviews with clearly identified actions, leads and timeframes. All procurement and contracting will be undertaken within the procedures of the two agencies within the relevant governance arrangements. All reviews will be subject to public consultation and will result in option appraisals and recommendations which will be agreed through the governance structures described above.

For domiciliary care we are out to tender and will have new contracts in place by February 2015 to support the model described above. The ICU currently manages a number of separate contracts for domiciliary care. Snapshot data provided in July 2013 identifies that the domiciliary care market within Southampton currently provides care for approximately 1,810 people in any given week (1,750 SCC and 60 SCCCG). There are currently up to 75 providers (65 spot purchased and 10 framework providers contracted) working in the city and delivering care packages on behalf of SCC and the CCG. 48% of domiciliary care is currently spot purchased – the tender aims to reduce this significantly so that the majority of domiciliary care is purchased through the framework to a set specification for quality and price.

The new domiciliary care framework will be managed through the ICU's Care Placement Service. The design of the model of provision to be delivered through the framework agreement is proposed to deliver improvement through:

- Greater flexibility and capacity, whilst still maintaining the geographical focus which recognises the issue of travel time.
- Clearer quality standards and performance indicators (KPIs) linked to contract terms and conditions which will support the drive for quality.
- A more streamlined systems approach as outlined in the service specification with a strong emphasis on promoting personalisation and independence
- A requirement to deliver outcome based support using flexible care plans that shift away from minute by minute calls.
- A more generic approach focussing on need rather than diagnosis

Day care is currently provided in house and through block contracts with external providers or individual packages of support. There are 39 external day care providers. Block contracts are with Age Concern, Headway Southampton, SCA Community Care Services Ltd and provide for 175 users over 65, 20 under 65 years. Internal provision is provided through four centres to 287 users. Provision tends to be based around the needs of specific client groups particularly adults with learning disabilities, physical disabilities, severe and enduring mental health needs

and older people. It is envisaged that future provision will include a wider range of private day service provision purchased through individual care packages or personal budgets. Again this will be purchased through the ICU's Care Placement Service.

Residential care is currently provided in house (through four residential care homes for older people, three of which are dementia long-stay, residential care settings (with some respite). In addition, Brownhill House (a rehabilitation unit) also provides a crisis response and respite facility. Current in-house services account for 11% of placements in all homes - The average for the city's neighbouring authorities is 5%. This figure equates to a total of approximately 21% of placements made by the City in residential care settings.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is evidence to show that personal budgets improve the experience of patients and clients. An evaluation of the pilot programme for personal health budgets suggested that:

- Personal health budgets were cost-effective relative to conventional service delivery – though cost neutral overall, there were some savings for people with the most complex needs.
- People with higher levels of need benefited most regardless of diagnosis, similarly high-value personal health budgets (over £1,000 a year) were found to be more cost-effective than low-value budgets.
- Personal health budgets were found to be effective for both mental and physical health conditions and the net benefits of personal health budgets for Continuing Health Care and mental health were tentatively found to be greater than for other patient groups.
- Most people appreciated the increased choice, control and flexibility that personal health budgets afforded and many chose to use their budget on treatments and services outside NHS provision, including through employing personal assistants

A subsequent survey of personal health budget holders showed that:

- Over 70% of personal health budget holders reported their budget having a positive impact on their independence
- Over 60% of personal health budget holders reported their budget having a positive impact on their physical health (68.8%), getting the support they wanted (68.3%), being supported with dignity and respect (67.9%), being in control of their support (67.7%), being in control over the important things in life (67.2%), and on their mental wellbeing (63.9%).
- Over 50% of personal health budget holders reported their budget having a positive impact on the long-term condition for which they held the budget (59.4%), feeling safe in and outside the home (58.2%), their relationships with people paid to support them (53.1%), and their relationships with members of their family (50.8%).

Local pilots of the use of DPs and PHBs have demonstrated a shift in the way care is delivered, for example in a local pilot we saw a shift from residential to community based alcohol treatment. People also valued feeling more in control. Issues raised included concern about managing the practical arrangements, the availability of services and impact on carers.

There is evidence to show that personal budgets, choice and control improve individual outcomes, quality of life, user satisfaction (Valuing People, Care Act legislation).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

This scheme includes the remainder of the additional investment being made for implementation of the Care Act: £379,000 (excluding the £231k investment for IT which is shown under infrastructure).

It should be noted that the rest of the funding shown against this scheme relates to existing collective spend across the CCG and City Council on placements and packages. The intention is to use the pooled fund to redesign and develop services in a way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme will particularly impact on the reduction in permanent admissions to residential and nursing care and reduction in delayed transfers of care, where lack of capacity and flexibility in the market has led to delays in discharge processes and sometimes over-reliance on residential solutions.

Our Case for Change has already outlined that delayed transfers of care are high in Southampton and this is a key priority for us. An analysis of hospital bed days lost as a result of delayed transfers of care over the last 4 years is showing that:

- family choice of residential/nursing home accounts for around 40% of bed days lost
- and awaiting a care package in own home accounts for around 7.5% of bed days lost

Although this data is a subjective judgement made by staff, it does suggest that there is a strong need to improve capacity, flexibility and responsiveness of community support.

This scheme, working alongside the model of local person centred coordinated care and a more proactive integrated rehabilitation and reablement provision, aims to achieve the reductions in permanent admissions and delayed transfers identified in Part 2 of this submission. It will do this by:

- increasing capacity and flexibility
- supporting a greater take-up of direct payments and personal health budgets leading to a greater focus of personalised approaches in all placement and packages
- encouraging greater use of community based resources as an alternative to the more traditional building based models
- a reduction in block funded care in favour of individual approaches
- higher levels of satisfaction from service users and carers

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We will develop a monitoring framework to track the impact against identified outcomes in order to ensure these are delivered and to enable early identification of any additional risks and opportunities.

This will be overseen by the Integrated Care Board who are responsible for monitoring the system wide impact of the Better care Programme.

Information from the take-up of direct payments and personal health budgets will be used to inform future commissioning intentions and will be incorporated into our market development strategies. We will use this intelligence to stimulate the services people tell us they need.

We will use service user and carer feedback to address the practical arrangements supporting the take up of options including looking for efficient ways to make payments and monitor quality.

Co-production approaches to service redesign are, and will continue to be used to inform service models and specifications.

Successful take up of individual payments will inform decisions relating to procurement – whether to continue block purchase arrangements for example.

Specific metrics will include:

- % domiciliary care purchased outside the framework
- reduction in minute by minute calls for domiciliary care
- increased uptake of direct payments
- reduction in hospital bed days lost as a result of delayed transfers of care related to awaiting a care package at home or family choice of residential care.

What are the key success factors for implementation of this scheme?

- A shift in culture on the part of professional staff and service users and carers to support self-directed approaches
- Practical arrangements for take up of direct payments and personal health budgets that are easily understood by all
- Accessible information people need to make choices
- A diverse marketplace able to meet and respond to the choices people wish to make

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Southampton City Health & Wellbeing Board
Name of Provider organisation	University Hospital Southampton, NHSFT
Name of Provider CEO	Fiona Dalton
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	28, 431*
	2014/15 Plan	28,335 *
	2015/16 Plan	27,768 *
	14/15 Change compared to 13/14 outturn	-0.3% (excluding any adjustment for growth)
	15/16 Change compared to planned 14/15 outturn	-2% (excluding any adjustment for growth)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	380 (includes 1% growth)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	850 (includes1% growth)

* Please note that the above figures are the total number of NEL FFCES (general and acute) **for all providers** for the **Southampton City resident population** (which will be slightly different to the Southampton City CCG population). It is based on provider MAR returns. UHSFT accounts for about 94% of this, the remainder being activity at other hospitals in neighbouring Trust.

For Provider to populate:

Guidance notes: A good provider commentary will:

- Confirm detailed and meaningful provider involvement in the development of the plans, from the major acute providers locally
- Demonstrate clear alignment between the overarching BCF plan and the provider plans
- Provide triangulation to provide reassurance that the projected reductions in planned emergency activity are feasible

- Confirm that providers are implementing their own risk management and action plans to respond to the planned change in activity
- Demonstrate a shared understanding of the critical path to successful delivery
- Articulate local risks and cross reference with the risk log in Section 4

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust understands the rationale used by SCCCG in terms of reduction. Our partner has forecast 1% growth to be reduced via QIPP and 2% baseline reduction to be delivered via Better Care schemes. The Trust reviewed growth as part of the Annual Planning Review and during the years leading up to 2013/14 experienced an annual growth rate of circa 6% growth for NEL admissions. During 2013/14 growth was circa 3%. On this basis the Trust included a 1% reduction for 2015/16 in its 5 Year Strategic Plan submitted to Monitor in relation to Better Care. The remaining 2% growth is above baseline contract.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	The difference between the Trust and CCG projections is highlighted because the Trust has to plan to meet the expected demand that it forecasts and match capacity to that. The CCG planned reductions are more ambitious than the plans included within our Monitor submission, but we welcome the ambition of the health and social care community in attempting to make a radical change. Our Monitor plans, which were developed prior to the development of the CCG initiatives, therefore now reflect a risk that those initiatives may not be delivered as quickly as the CCG expects and that underlying growth could return to pre 2013/14 levels. However, this should not be misinterpreted as a divergence from the CCG plans. Indeed as they are delivered the benefit of the delivery of these schemes will be reflected in the next iteration of our plans. If the SCCG ambition was realised, there would initially be a positive impact on the hospital with less capacity pressures, improved operational performance and reduced financial pressures of unplanned bed openings and agency usage. In the longer term, if these ambitions were realised, we would have to reconfigure the hospital and would be relying on the health care community's commitment to the further centralisation of regional services to maintain a viable high quality organisation. The Trust recognises the CCG schemes and is committed as a local health economy partner to the aims and rational of them. The Trust supports their aims of reducing emergency admissions and more importantly reducing length of stay once a patient has actually been admitted: *Scheme 1 – Local Person Centred Co-ordinated Care & Long-term Conditions Pathways* *The Trust is committed to person centred care and creating seamless pathways across organisational agencies.*

		Reducing non-elective admissions will improve patient flow through the system and reduce pressure in social care, in order that more planned management of demand can be achieved. This will reduce stress in the current system and deliver efficiencies for all partners including Trust length of stay. The focus on elderly is significant as these are the growing pressure in the population in terms of demand, which have long lengths of stay. *Scheme 2 – Responsive Discharge & Reablement – Supporting Timely Discharge & Recovery* *This scheme is a priority for the Trust and links to the local ECIST Plan within the local health economy (LHE) to change the focus of demand management to discharge (back door). This is critical in terms of patient flow, occupancy and Trust performance together with the management of capacity. The Trust has had an overall total of between 130 to 170 delayed transfers over recent times per day. SCCG is committing to reduce these by circa 5 per day then further 3 per day for their related activity.* *Scheme 3 –Building Capacity* *Critical scheme to align demand and capacity across the LHE, transformation of personalised health budgets, sign-posting and carer support, which impacts risk stratification of patients in terms of keeping at home or need for step-up/step down care.* In the long term the successful delivery of the Better Care initiatives will ensure that Trust activity reduces and this will be reflected in the projections we make each year.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes, the Trust considers different scenarios when planning the size and demand requirements of the organisation, in context with both the local and national priorities. It has to make a balanced judgement on the pace of change and delivery of any planned reductions in activity. The Trust also provides specialist regional services, R&D and education when future proofing the hospital.

October 2014

Pooled budgets and the better care fund

Guidance

In association with

CIPFA The Chartered Institute of Public Finance & Accountancy

Contents

This guidance looks at the governance and finance issues underpinning the operation of a pooled budget that CCGs and local authorities need to be discussing now to go live on 1 April 2015

The authors of this guidance were HFMA technical editors Sarah Bence and Debbie Paterson. The support of Alison Scott, CIPFA, is also gratefully acknowledged.

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Introduction

1. Launched through the Spending Round in June 2013 and highlighted as a key element of public service reform, the better care fund (the fund) has a primary aim to '…drive closer integration and improve outcomes for patients and service users and carers[1]'. The fund will be set up as a pooled budget - a type of partnership arrangement whereby NHS organisations and local authorities contribute an agreed level of resource into a single pot (the 'pooled budget') that is then used to commission or deliver health and social care services.

2. This guidance looks at the relevant legislation and regulations that underpin the operation of a pooled budget and the governance and finance issues that clinical commissioning groups (CCGs) and local authorities need to be discussing now in order to be ready for 'go live' on 1 April 2015. It also considers the accounting arrangements that will apply and need to be thought through in advance of preparing the signed agreement that will underpin the pooled budget.

3. The purpose of this guidance is to provide an overview of the governance and accounting issues associated with the operation of the fund. It is not intended to replace or override statutory guidance, accounting standards or prescribed accounting and governance best practice for both NHS and local authority bodies. It is each body's responsibility to determine the appropriate governance and accounting treatment for their pooled budget based on their circumstances.

4. This guidance takes account of the information available at the time of writing (September 2014). More detailed guidance will be made available by NHS England over the course of the next few months.

Relevant legislation and regulations

Overarching legislation

5. The better care fund operates within the context of existing legislation, the key elements of which are:

- ***Section 256 of the NHS Act 2006***, which allows for a transfer of resource between health and local authorities but not a transfer of functions. A contribution is made to support specific local authority services without a delegation of health functions. This power is used at the national level by the Department of Health to transfer funding from the health vote to local authorities, although it is also available to CCGs to transfer funds.
- ***Section 75 of the NHS Act 2006,*** which allows local authorities and NHS bodies to operate pooled budgets (directly replacing section 31 of the Health Act 1999). This is the legislation that allows the establishment of pooled budgets between NHS bodies and local authorities at a local level (see Appendix 1).
- ***Statutory Instrument 2000 617 (SI 2000/617)***, which sets out the regulations governing pooled budget[2] arrangements between NHS bodies and local authorities (see Appendix 1).
- ***Section 195 of the Health and Social Care Act 2012***, which requires health and wellbeing boards (HWBs) to 'encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner'. In particular, HWBs must provide advice, assistance or other support for the purpose of encouraging services to be provided under section 75 of the NHS Act 2006.

6. It should be noted that section 75 is applicable only to prescribed health-related services and prescribed local authority services. It precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services. For local authorities, the services that can be included within section 75 arrangements are broad in scope although detailed exclusions exist. It is therefore imperative to check that services considered for inclusion in the pooled budget can be incorporated legitimately and that no ultra vires spending is incurred.

Individual funding streams

7. The fund is comprised of a number of existing funding streams (as part of 2014/15 allocations to local authorities and CCGs) with legislation and regulations governing each as follows:

- ***Disabilities facilities grant (DFG) – £220m*** This is capital money made available to local authorities as part of their allocations to award grants for changes to a person's home. There is a statutory duty for local housing authorities to provide grants to those who qualify. This part of the fund will be governed by the disabilities facilities grant conditions of grant usage as made by the Department for Communities and Local Government (DCLG) under section 31 of the Local Government Act 2003[3]. Therefore, although officially part of the fund, the money cannot be used for other things and will be paid back out of the fund to the relevant local authorities.
- ***Social care capital grant – £134m*** This is capital funding made available by the Department to local authorities to support investment in adult social care services via a direct grant allocation from the DCLG.

The Department and the DCLG will issue conditions of use of these grants under section 31 of the Local Government Act 2003[4].

1 NHS England Publications Gateway Ref No. 01977, July 2014

2 The statutory instrument refers to a 'pooled fund' as opposed to a 'pooled budget'; this guidance uses the term 'pooled budget' as this is how such arrangements are known

3 See NHS England planning guidance at tinyurl.com/oek7mhc

4 The conditions of the 2014/15 grants are set out in LASSL(DH)(2014)1 See tinyurl.com/q7lb28f

Given that CCGs and local authorities have different statutory bases, it will be for each partner to consider the regulatory impact of the decisions made

- ***Carers' break funding – £130m***
This is funding currently included within CCGs' baseline allocations to support long-term carers. CCGs' general financial duties are set out in sections 223G to K of the NHS Act 2006; section 223GA specifically refers to funding used for integration of health and social care[5].
- ***CCG reablement funding – £300m***
This is funding currently included within CCGs' baselines to support integrated working with local authorities in order to reduce avoidable hospital admissions and facilitate more timely hospital discharges.
- ***Funding already transferred by NHS England*** to support social care in 2013/14 and 2014/15 (£1.1bn) using section 256 of the NHS Act 2006.

8. To these funding streams will be added existing NHS revenue funding from allocations to CCGs in 2015/16 (amounting to £1.9bn at a national level) to give a total pooled budget of at least £3.8bn from 1 April 2015[6]. Some £135m of this funding is to be used to fund additional costs incurred by local authorities as a result of the new duties imposed by the Care Act 2014. These duties relate to new entitlements for carers, the national minimum eligibility threshold, advocacy services and safeguarding duties.

9. Although the better care fund will operate as a pooled budget, the conditions attached to each funding stream will still have to be met. For example, where funding such as the DFG has been earmarked for a particular purpose, it must be used only for that purpose. This may have implications for the related accounting arrangements.

Governance arrangements

10. Although the pooled budget is created from allocations to CCGs and local authorities, the arrangements do not constitute a delegation of statutory responsibilities. These are retained by the CCG governing body and the local authority cabinet/executive.

11. The governance arrangements for the better care fund will therefore have to meet the requirements of all partners to achieve economy, efficiency and effectiveness in their use of resources[7]. Each partner will also need to satisfy itself that the pooled budget complies with the requirements of its appropriate code of governance[8] and annual governance reporting guidance.

12. Each partner must also satisfy itself that all other regulatory requirements are met – for example, that discrete funding streams are only spent appropriately at a local level. Partners therefore need to make arrangements to ensure that that is happening.

13. Given that CCGs and local authorities have different statutory bases, it will be for each partner to consider the regulatory impact of the decisions made. This is likely to be more onerous for the CCGs in the partnership as they work within a tight regulatory framework: they are required to meet both NHS England and the Department's reporting requirements, and their auditors are required to express an explicit opinion[9] on the regularity of their transactions.

Operational structures

14. It is for each local area to determine the operational structure for their local pooled budget. As it has been required to sign off better care fund plans, the HWB provides the means for ongoing oversight.

15. However, consideration needs to be given as to whether the operation of the pooled budget would be more appropriately managed through a formal subcommittee of the HWB – for example, an 'integrated commissioning executive'. If this model is used, the pooled budget agreement could be prepared by the integrated commissioning executive and ratified by the HWB.

16. Below this 'integrated commissioning executive' could sit a delivery team/programme management office focused on operational and financial delivery supported by work

5 Guidance on CCG allocations can be found here: www.england.nhs.uk/2014/03/27/allocations-tech-guide/

6 More money can be pooled locally than the minimum requirement

7 For local authorities, this requirement is set out in section 3 of the *Local Government Act 1999* and for CCGs, section 14Q of the *NHS Act 2006*

8 For local authorities, the CIPFA/SOLACE *Delivering Good Governance in Local Government: Framework and for CCGs*, HM Treasury's *Managing Public Money* and the UK Corporate Governance Code

9 The regularity opinion states whether in the opinion of the auditor transactions included in the financial statements conform, where appropriate, with the legislation that authorises them; regulations issued by a body with the power to do so; Parliamentary authority; and HM Treasury authority

streams for specific schemes and programmes within the pooled budget.

17. The precise arrangements are likely to vary, depending on whether the local authority is coterminous with a single CCG or has a number of CCGs operating within its area. However, such a structure would allow adequate focus on the detail of the pooled budget at an appropriate level and representation from all local health and social care partners, both commissioner and provider. This structure would need to be accompanied by formal delegation arrangements to enable decisions to be made at an appropriate level.

18. The introduction of the better care fund may also mean significant changes to the agenda for HWBs. Consequently, it may be necessary to revisit the membership and terms of reference of the HWB itself to ensure both are appropriate to support the implementation of the pooled budget from 1 April 2015.

19. The governance and financial reporting arrangements will be heavily influenced by the operational structures, so it is important to think through what approach is likely to work best.

Hosting

20. The regulations require that one of the partners is nominated as the host of the pooled budget and this body is then responsible for the budget's overall accounts and audit. The decision as to which partner is to host the pooled budget should be made locally and based on the most appropriate operational requirements. However, the relevant finance department will also need to consider the impact of issues such as:

- ***Value Added Tax (VAT)*** The arrangements for NHS and local authority bodies are very different. It is expected that further guidance will be issued by NHS England in relation to VAT arrangements.
- ***Accounts closedown timetable*** NHS bodies are subject to a short timeframe for the preparation and audit of their accounts, with final completion by early June. Local authorities have longer to prepare their accounts.
- ***Ledger arrangements*** Local authorities determine their own financial ledger arrangements, whereas CCGs are required to use the Integrated Single Finance Environment (ISFE) operated by NHS Shared Business Services on behalf of NHS England. Consequently, there is little local flexibility for CCGs to determine their own coding structure.
- ***Charging arrangements*** Local authorities are able to charge for certain services whereas NHS services are free at the point of delivery.

21. One issue that partners may wish to consider when determining the operational arrangements is the fact that culturally, NHS bodies and local authorities may be different. Care should be taken not to assume that operational arrangements will work in a particular way.

22. The host body will have delegated powers but will need to be able to work within the reporting and management environments of all members of the partnership.

Signed agreement

23. The signed agreement for the pooled budget forms the basis of the governance arrangements and needs to set out clearly and precisely what the overall aims are; who is responsible for what and the associated plans for reporting and accountability. Issues that warrant particular consideration when drawing up the agreement include ensuring that:

- There is a common understanding of the pooled budget's aims.
- Statutory responsibilities of all partners are understood and will be met.
- There is clarity over what is and is not covered by the arrangement.
- Decision-making responsibilities are clear.
- The amount of contribution, both financial and non-financial, to be

To support the measuring and reporting of performance, it is necessary to identify information that might be required so that it is collected from the outset

made by each partner is clear, both in terms of amount and the timing of payments.
- The criteria for making payments for performance are determined.
- There is clarity around which organisation manages the pooled budget and who has the power to commit expenditure (including details of approval levels). This should include consideration of the contracting arrangements. For example, when the provider is an NHS body then the standard NHS contract should be used as it meets all contractual requirements, including those of the Commissioning for Quality and Innovation (CQUIN) scheme.
- There is accurate and timely reporting of financial and non-financial information, including the specification of performance metrics, outcome measures, the partner responsible for production and the accompanying deadlines. To that end, the agreement needs to detail the local 'operating rules' for the above in relation to:

- The pooled budget as a whole
- Individual schemes
- In-year reporting of the cumulative/ year to date position
- The year-end forecast
- Cashflows
- The point of recognition for contributions to, expenditure on and subsequent variances in relation to:

  • A budget for a whole service where it is part of the better care fund
  • Performance-related payments
  • Contributions made to larger budgets from the fund, such as in support of nursing or residential homes. For example, if the larger budget overspends, does the fund take a 'hit'?

24. These budgets could be for both revenue and capital expenditure. Where they are for capital expenditure the relevant capital accounting regime must be taken into account.

25. The agreement should be reviewed regularly to ensure that the arrangement remains relevant to local circumstances and that all those involved are working towards the same goals.

Information requirements

26. To support the measuring and reporting of performance, it is necessary to consider and identify the information that might be required so that it is collected on a regular basis from the outset. This information will be financial and non-financial in nature and is likely to comprise some or all of the following:

- Total emergency admissions (non-elective admissions, general and acute), which is mandatory as it underpins the single pay for performance metric
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Delayed transfers of care from hospital per 100,000 population
- Patient/service user experience
- The proportion of people feeling supported to manage their (long-term) condition
- Estimated diagnosis rate for people with dementia
- The proportion of patients with fragility (hip) fractures recovering to their previous levels of mobility/ walking ability at 30/120 days
- Social care-related quality of life
- The proportion of adults in contact with secondary mental health services living independently with or without support
- Carer-reported quality of life
- The proportion of adult social care users who have as much social contact as they would like
- The proportion of adults classified as 'inactive'
- Injuries due to falls in people aged 65 and over
- Locally determined quality metrics as set out in the plan
- Spending versus budget by scheme

and provider for the year and the year to date, available on a monthly basis.

In-year changes to plans

27. In-year changes to plans must be subject to appropriate authorisation and approval including final sign off by the relevant HWB.

Financial arrangements (in-year)

28. In-year reporting is governed by the requirements of SI 2000/617 section 7 paragraph 4(b) as follows:

- In-year reporting of the performance of the pooled budget to the parties to the agreement must be undertaken by the host on a quarterly basis.
- The host (through a nominated 'pool manager') must provide quarterly details of income to and expenditure from the pooled budget as well as '…other information by which the partners can monitor the effectiveness of the pooled (budget) arrangements.'

29. In practical terms this means that CCGs and local authorities will need to consider a number of general and specific issues as set out below.

General considerations

- The role of the HWB and the in-year monitoring and reporting required.
- The level at which financial and non-financial performance metrics will be reported. For instance, where there is an agreement that is co-terminus with a single unitary authority and more than one CCG, it may not be possible for the local authority to report certain metrics at the CCG level. This is more likely to be the case with non-financial metrics such as service user experience, where the local authority may not be able to identify the CCG area where the service user lives. Where it is important that metrics are determined at a level other than the pooled budget level this should be identified at an early stage to ensure the appropriate data can be collected.
- NHS bodies should be mindful of the fact that their financial information will be consolidated nationally. Experience shows that one barrier to smooth consolidation is different accounting treatments, particularly in relation to accounting on a gross or net basis. The default position in IFRS is gross accounting although there are exceptions. With this in mind, parties should consider maintaining all management accounts on a gross basis as it is easier to produce financial reports on a net basis from gross information than the other way around.
- Parties to the pool will need to appropriately reflect the better care fund in their risk register (associated risks including performance reporting). This should be a requirement of the signed agreement. In the first instance, this should be considered by those charged with governance in the CCG and local authority.
- Consider whether the pooled budget arrangement needs to be reflected in the internal audit programme based on materiality and risk. If those charged with governance consider this to be the case, then plans should be put in place for internal audit review of the pooled budget arrangements on an ongoing basis.
- All parties to the pool will need to discuss with their external auditors[10] the assurances that will be required in order to sign off the year end accounts. This will be a particular issue for those bodies that are not hosting the pool because usually auditors will seek to rely on the work of the host body auditor. This is an efficient arrangement but does require co-operation in advance between auditors to determine the work to be performed and any impact on fees[11].
- For CCGs, the quality committee may consider the review of the quality of services delivered via the pooled budget.
- The host will be responsible for ensuring that the VAT arrangements are compliant with both NHS and local authority VAT regimes as appropriate.
- The host will be responsible for ensuring that appropriate capital accounting arrangements are applied as required.

10 At this stage, parties to the arrangement must be mindful of the changes to external audit arrangements following the enactment of the *Local Audit and Accountability Act 2014* dissolving the Audit Commission on 31 March 2015

11 Paragraph 5.3.7, *NHS Audit Committee Handbook*, HFMA, 2014

Consider the assurances that may be required in order to be able to sign off the relevant accounts

Further considerations for the host

- Appoint/nominate a pool manager whose role is covered appropriately by standing financial instructions/ prime financial policies and the scheme of delegation.
- Ensure arrangements are in place to deliver the quarterly reporting of:

  - Income
  - Expenditure
  - Performance information as data becomes available (via national and local data collection processes) to ensure that progress is transparent and can be regularly reviewed.

- Ensure the regular and timely receipt of performance reports by the HWB (an example financial summary is shown in Appendix 2).
- Ensure that where elements of the pooled budget are ringfenced for a particular purpose, the necessary supporting information is available to provide assurance that those elements have been used appropriately and to support the accounting arrangement applied.

Further considerations for other parties to the pool

- The CCG governing body and the local authority cabinet/executive needs to be familiar with the following:

  - The level of contribution to the pooled budget
  - What has been spent at a point in time
  - What has been delivered
  - How the pooled budget is performing in overall terms.

- Incorporate consideration of the information expected and received into the body's assurance framework.
- Consider where assurances that the information received in relation to the pooled budget is correct and accurate will come from.
- Identify who will review how the pooled budget is performing against planned outcomes, including the process for alerting the CCG governing body and the local authority cabinet/ executive at the first indication that matters are not as they should be.
- Consider what information is required to gain assurance that ringfenced elements of the pooled budget have been spent appropriately.
- Provide right of access to the records of the pooled budget for the auditors of all parties to the pooled budget. This is only to be exercised in exceptional circumstances as auditors will usually seek to rely on the auditor of the host body to maximise efficiency.

Financial arrangements (year-end)

30. There are various issues relating to the year-end financial processes that parties to a pooled budget need to consider in advance of the year-end itself. Although not an exhaustive list, it is helpful to examine the following:

General considerations

- Include in the signed agreement the deadlines as to what must be shared and by when in order to prepare the accounts recognising the difference in NHS and local authority year end reporting requirements.
- The accountable officer/section 151 officer[12] needs to consider the assurances that may be required in order to be able to sign off the relevant accounts that include the transactions relating to the pooled budget arrangement.
- The nature of a pooled budget in accounting terms (see Appendix 3 for more details) – it may be that it is a joint operation in accordance with IFRS 11 but it may be that the substance of the arrangement means it does not meet the standard's criteria for a joint operation. If the arrangement is not a joint operation then its substance should determine the accounting. It may be a lead commissioning or aligned commissioning arrangement.
- The likely impact on the governance statements of the parties to the pooled budget (these will differ depending on whether the organisation is the host or a contributing partner). For CCGs, the exact requirements for the governance statement will be for NHS England to identify. It is expected that CCGs will be

12 This officer is responsible for ensuring that his or her organisation operates effectively, economically and with probity; makes good use of their resources and keeps proper accounts

required to identify if there have/have not been significant issues relating to the operation of the pooled budget during the period covered by the statement. For example, if the pooled budget overspends during the year, this would be a significant control issue. However, other parts of the governance statement, such as those relating to internal control and risk management frameworks, may need to reference the pooled budget where it is high risk and material in nature.

- While records must be kept on a gross basis at the year end, it is envisaged that there will be one calculation setting out the net balance in the pooled budget and the ownership of this balance. Parties to the better care fund must agree its treatment in advance. CCGs cannot carry forward cash balances nor make payments in advance[13].Therefore it is important that likely year-end balances are accurately forecast, so that action can be taken if necessary. If the partners envisage any surpluses to be held in the local authority accounts, so that they can be carried forward, the arrangement must be set up in such a way as to allow this to happen while not breaching the regulatory or accounting requirements with which all partners are required to comply.
- All parties will need to agree the information required by NHS bodies to undertake the annual agreement of balances exercise. As pooled budgets are not entities in their own right, no balances or transactions are with the pooled budgets; they are with the parties to the pooled budget. Guidance on 2015/16 agreement of balances will be issued by the Department and NHS England in due course.
- Consider the role of the auditor and the information they require to be able to give their opinion on the financial statements. The auditors of the parties to the pool will usually seek to rely on the host's auditor for this purpose.

Further considerations for the host

- ***SI 2000/617 paragraph 7(4)*** states that the host is responsible for:

  - Managing the pooled budget
  - Submitting an annual return to the partners about the income of, and expenditure to the pooled budget and any other relevant information.

- ***SI 2000/617 paragraph 7(6)*** currently requires that the host body arranges for their Audit Commission appointed auditor to certify the pooled budget accounts. It is expected that this requirement will be repealed once the Audit Commission ceases to exist in March 2015. This should be kept under review.
- The host must review other requirements specified in the signed agreement and ensure compliance.
- To meet the requirements in relation to an annual return the host must prepare and publish a full statement of spending, signed by the accountable officer/section 151 officer to provide assurance to all other parties to the pooled budget. This is likely to include:

  - Contributions to the pooled budget – cash or kind
  - Expenditure from the pooled budget
  - The difference
  - The treatment of the difference
  - Any other agreed information.

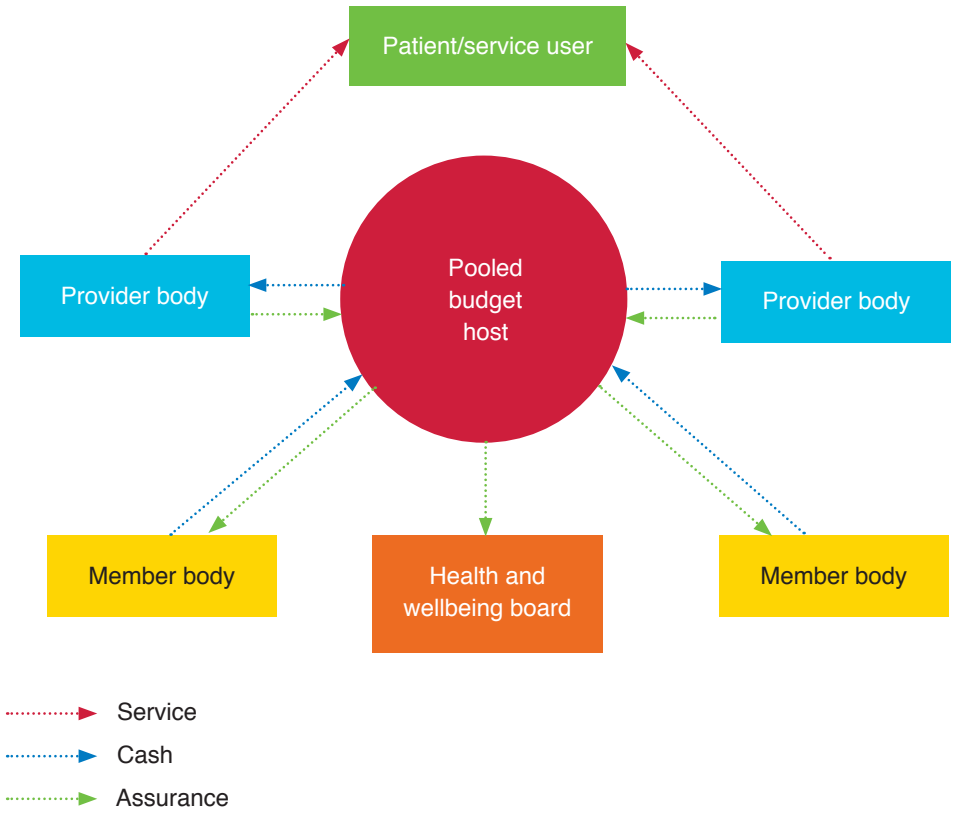
- The host should also liaise with other partners to identify if there is any other information they require for their year-end reporting and the corresponding date that it is required in order to meet external reporting deadlines.

Further considerations for other parties to the pool

- Where the better care fund is material (recognising that the pooled budget may be material to some organisations but not others), disclosure in the annual accounts will be necessary and this will be in the format required by the relevant accounting guidance for 2015/16. Partners will need to liaise with the host body to ensure that the relevant information is available in time to meet external reporting deadlines.
- NHS bodies may be required to provide information for consolidation

13 If the agreement states that any surplus on the pooled budget is held by the local authority at the year end, then CCGs need to satisfy themselves and their auditors that they have not drawn down cash in advance of need

Which bodies need to provide assurance to whom?



purposes even where the better care fund is not material to their own accounts. Therefore all CCGs will need to consider what information may be required for consolidation purposes and maintain their records accordingly.

- The signed agreement needs to reflect when the memorandum account will be available to the parties to the arrangement in line with the external reporting deadlines for each body.

Assurance

31. The better care fund is a high-profile policy. Key stakeholders include:

- The general public
- CCGs and local authorities, both as statutory organisations reporting to their own governing bodies but also reporting to the HWB
- NHS England and the Local Government Association
- Ministers from the Department and the DLGC

32. In order to demonstrate the appropriate use of public sector money and the extent to which the pooled budget has achieved its aims, it is necessary to identify at an early stage which bodies will need to provide assurance to whom, as suggested in the diagram above.

Nature and sources of assurance

33. Those charged with governance in each statutory organisation identified above need to be able to obtain the right information and rely on it. This is particularly important for parties to the pooled budget (other than the host), where key information will come from another organisation.

34. It can be helpful to consider assurances in three broad categories:

- ***First line*** Management assurance from 'front line' or business operational areas

- ***Second line*** Oversight of management activity, separate from those responsible for delivery but not independent of the organisation's management chain – for example, the accountable officer or the section 151 officer
- ***Third line*** Independent and more objective assurance, including internal audit and from external bodies[14].

35. The assurances themselves can take a number of forms (for example, outcome data, process data or reports from reviews carried out) and can be derived from sources that are both internal and external to the organisation concerned. These may include some or all of the examples in the table below[15]:

36. The pros and cons associated with internal and external sources of assurance can be found in Appendix 5.

Underlying data

37. Those charged with governance will need to assure themselves that the data underpinning the above assurances is robust. This involves looking beyond the messages received, critically reviewing the underlying data and ascertaining the source's reliability. Any gaps in assurance will need to be identified and addressed. To that end, the following can be used to evaluate a data source:

- Is the data source valid?
- Is the data complete?
- Is the data up to date?
- Are the messages consistent with other information?
- How is data viewed by the organisation – is it trusted?

The outcome

38. Having identified the assurance and its source, and established the reliability of the underlying data, those charged with governance must then consider the results and their implications for the achievement of the pooled budget's objectives. It can be helpful to consider:

- Whether the overall objective of the pooled budget (or individual scheme if appropriate) is being met
- Whether the main controls are operating as expected
- Any agreed actions for improvement are being implemented.

39. A summary of the essential measures and controls considered as necessary in supporting the successful delivery of the better care fund as set out in this guidance is included as Appendix 4.

Different forms of assurances

Internal sources	External sources
Internal audit (financial and non-financial)	External audit
National and local metrics*	National and local metrics*
Performance reports	External benchmarking (review against local and national peers – as data becomes available)
Clinical audit	National and regional audits
Results of internal investigations	Peer reviews
Patient/ service user experience surveys and reports	Feedback from service users
NHS contract monitoring information	NHS contract monitoring information
Staff satisfaction surveys	Feedback from other partners
	Service auditor report (ISAE 3402)

***Note:** the performance of national and local metrics could be internal (for the host) or external (for other parties to the pool)

14 *NHS Audit Committee Handbook*, HFMA, 2014

15 *NHS Audit Committee Handbook*, HFMA, 2014

Appendix 1: Section 75 and the associated regulations (SI 2000/617)

Section 75 of the NHS Act 2006 allows the secretary of state for health to set out in regulations the arrangements that NHS bodies and local authorities can enter into to exercise their health related functions. Together the section and associated regulations set out the bodies that can enter into such arrangements. As this is the legislation that underpins all pooled budget arrangements it is important to understand what it says. Both the section of the Act and the regulations are copied below[16].

Section 75 of the NHS Act 2006: Arrangements between NHS bodies and local authorities

(1) The secretary of state may by regulations make provision for or in connection with enabling prescribed NHS bodies (on the one hand) and prescribed local authorities (on the other) to enter into prescribed arrangements in relation to the exercise of:

(a) Prescribed functions of the NHS bodies
(b) Prescribed health-related functions of the local authorities, if the arrangements are likely to lead to an improvement in the way in which those functions are exercised.

(2) The arrangements that may be prescribed include arrangements:

(a) For or in connection with the establishment and maintenance of a fund:

(i) Which is made up of contributions by one or more NHS bodies and one or more local authorities
(ii) Out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body or bodies and prescribed health-related functions of the authority or authorities

(b) For or in connection with the exercise by an NHS body on behalf of a local authority of prescribed health-related functions of the authority in conjunction with the exercise by the NHS body of prescribed functions of the NHS body
(c) For or in connection with the exercise by a local authority on behalf of an NHS body of prescribed functions of the NHS body in conjunction with the exercise by the local authority of prescribed health-related functions of the local authority
(d) As to the provision of staff, goods or services in connection with any arrangements mentioned in paragraph (a), (b) or (c)
(e) As to the making of payments by a local authority to an NHS body in connection with any arrangements mentioned in paragraph (b)
(f) As to the making of payments by an NHS body to a local authority in connection with any arrangements mentioned in paragraph (c).

(3) Regulations under this section may make provision:

(a) As to the cases in which NHS bodies and local authorities may enter into prescribed arrangements
(b) As to the conditions which must be satisfied in relation to prescribed arrangements (including conditions in relation to consultation)
(c) For or in connection with requiring the consent of the secretary of state to the operation of prescribed arrangements (including provision in relation to applications for consent, the approval or refusal of such applications and the variation or withdrawal of approval)
(d) In relation to the duration of prescribed arrangements
(e) For or in connection with the variation or termination of prescribed arrangements
(f) As to the responsibility for, and the operation and management of, prescribed arrangements
(g) As to the sharing of information between NHS bodies and local authorities.

(4) The provision that may be made by virtue of subsection (3)(f) includes provision in relation to:

(a) The formation and operation of joint committees of NHS bodies and local authorities
(b) The exercise of functions that are the subject of prescribed arrangements (including provision in relation to the exercise of such functions by joint committees or employees of NHS bodies and local authorities)
(c) The drawing up and implementation of plans in respect of prescribed arrangements
(d) The monitoring of prescribed arrangements
(e) The provision of reports on, and information about, prescribed arrangements
(f) Complaints and disputes about prescribed arrangements
(g) Accounts and audit in respect of prescribed arrangements.

(5) Arrangements made by virtue of this section do not affect:

(a) The liability of NHS bodies for the exercise of any of their functions
(b) The liability of local authorities for the exercise of any of their functions

16 Note: the extract from the Act has been taken from www.legislation.gov.uk/ukpga/2006/41/section/75 – it may not include all of the most recent changes to legislation

(c) Any power or duty to recover charges in respect of services provided in the exercise of any local authority functions.

(6) The secretary of state may issue guidance to NHS bodies and local authorities in relation to consultation or applications for consent in respect of prescribed arrangements.

(7) The reference in subsection (1) to an improvement in the way in which functions are exercised includes an improvement in the provision to any individuals of any services to which those functions relate.

(8) In this section:

- "health-related functions", in relation to a local authority, means functions of the authority which, in the opinion of the secretary of state:
  - (a) Have an effect on the health of any individuals
  - (b) Have an effect on, or are affected by, any functions of NHS bodies
  - (c) Are connected with any functions of NHS bodies
- "NHS body" does not include a special health authority.

(9) Schedule 18 makes provision with respect to the transfer of staff in connection with arrangements made by virtue of this section.

The regulations that govern pooled budgets are SI 2000/617. This SI has been amended over the years by other legislation; this version includes all of the changes, as set out on the government website[17].

2000 No. 617
NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000

Made: 10 March 2000
Laid before parliament: 10 March 2000
Coming into force: 1 April 2000

The secretary of state for health, in exercise of the powers conferred upon him by section 126(4) of the *National Health Service Act 1977*[18] and section 31 of the *Health Act 1999*[19] and all other powers enabling him in that behalf hereby makes the following regulations:

Citation, commencement and extent

1. **(1)** These regulations may be cited as the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 and shall come into force on 1 April 2000.
(2) These regulations extend to England only[20].

Interpretation

2. (1) In these regulations:

- "the Act" means the *Health Act 1999*
- "the 1948 Act" means *National Assistance Act 1948*
- "the 1983 Act" means the *Health and Social Services and Social Security Adjudications Act 1983*
- "the 2006 Act" means the *National Health Service Act 2006*
- "the Board" means the National Health Service Commissioning Board
- "health-related functions" means the functions of local authorities prescribed under regulation 6
- "local authority" means a body to which regulation 3(2) applies
- "NHS body" means a body to which regulation 3(1) applies
- "NHS contract" has the meaning given in section 9 of the 2006 Act[21]
- "NHS functions" means the functions of NHS bodies prescribed under regulation 5
- "partners", in relation to partnership arrangements, means one or more NHS bodies and one or more local authorities
- "partnership arrangements" means arrangements prescribed under regulations 7, 8 and 9.

(2) In these regulations, unless the context otherwise requires, any reference to a numbered regulation is a reference to the regulation bearing that number in these regulations, and any reference to a numbered paragraph is a reference to a paragraph bearing that number in that regulation.

Prescribed NHS bodies and local authorities

3. (1) The NHS bodies prescribed for the purposes of section 31 of the Act are:
(c) An NHS trust[22]
(d) An NHS foundation trust

17 www.legislation.gov.uk/changes/affected/uksi/2000/617

18 1977 (c. 49); section 126(4) is applied by virtue of section 62(4) of the *Health Act 1999* and was amended by the *National Health Service and Community Care Act 1990* (c. 19), section 65(2) and the *Health Act 1999*, Schedule 4, paragraph 37(5)

19 1999 (c. 8); see section 31(8) for the definition of "prescribed"

20 The functions of the secretary of state under section 3(1) are, so far as exercisable in relation to Wales, transferred to the National Assembly for Wales by the National Assembly for Wales (Transfer of Functions) Order 1999 SI 1999/672 as amended by section 66(4) and (5), *Health Act 1999*

21 Section 9 was amended by the 2008 Act, Schedule 5, paragraph 82 and by the 2012 Act, Schedule 4, paragraph 6, Schedule 7, paragraph 18, Schedule 14, paragraph 4, Schedule 17, paragraph 10(2), Schedule 19, paragraph 9(2), and Schedule 21, paragraph 6

22 See section 5 of the *National Health Service and Community Care Act 1990* as amended by paragraph 69 of Schedule 1 to the *Health Authorities Act 1995* and section 13(1) of the *Health Act 1999*

(e) A clinical commissioning group
(f) The Board.

(2) The local authorities prescribed for the purposes of section 31 of the Act are:

(a) A district council
(b) A county council
(c) A county borough council
(d) A London borough council
(e) The Common Council of the City of London
(f) The Council of the Isles of Scilly.

Partnership arrangements between NHS bodies and local authorities

4. (1) Subject to paragraphs (2) and (3), the partners may enter into any partnership arrangements in relation to the exercise of any:

(a) NHS functions
(b) Health-related functions, if the partnership arrangements are likely to lead to an improvement in the way in which those functions are exercised.

(2) Subject to paragraph (2A), the partners may not enter into any partnership arrangements unless they have consulted jointly such persons as appear to them to be affected by such arrangements.

(2A) Paragraph (2) does not apply where the partnership arrangements have been consulted upon pursuant to section 77(1A)(b) of the 2006 Act and regulation 4 of the *NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012* (consultation requirements).

Functions of NHS bodies

5. The NHS functions are:

(a) The functions of arranging for the provision of services under sections 3, 3A and 3B of, and paragraphs 9 to 11 of Schedule 1, to the 2006 Act, including rehabilitation services and services intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services
(aa) The functions of providing the services referred to in paragraph (a), pursuant to arrangements made by a clinical commissioning group or the Board
(b) The functions of arranging for the provision of services under section 117 of the *Mental Health Act 1983*
(ba) The functions of providing services referred to in paragraph (b) pursuant to arrangements made by a clinical commissioning group or the Board
(bb) The functions of making direct payments under:

(i) Section 12A(1) of the *National Health Service Act 2006* (direct payments for health care)
(ii) The National Health Service (Direct Payments) Regulations 2013

(bc) The function of arranging the provision of Healthy Start vitamins under regulation 8A of the Healthy Start Scheme and Welfare Foods (Amendment) Regulations 2005
(c) The functions under Schedule A1 of the *Mental Capacity Act 2005*[23].

Health-related functions of local authorities

6. The health-related functions are:

(a) Subject to sub-paragraph (k), the functions specified in Schedule 1 to the *Local Authority Social Services Act 1970*[24] except for functions under:

(i) Sections 22, 23(3), 26(2) to (4), 43, 45 and 49 of the 1948 Act[25]
(ii) Section 6 of the *Local Authority Social Services Act 1970*
(iii) Sections 1 and 2 of section 3 of the *Adoption and Children Act 2002*
(iv) Sections 114 and 115 of the *Mental Health Act 1983*

23 2005 c.9. Schedule A1 was inserted into the *Mental Capacity Act* by Schedule 7 of the *Mental Health Act 2007* (c.12)

24 1970 (c. 42); Schedule 1 was amended (by repeal, substitution, or insertion of entries) by the following: section 78 of, and Schedule 7 to, the *Charities Act 1992* (c. 42); section 78 of, and Schedules 2 and 3 to, the *Public Health (Control of Disease) Act 1984* (c. 22); the *Statute Law (Repeals) Act* 1978 (c. 45); the *Statute Law (Repeals) Act 1993* (c. 50); section 73(3) of, and Schedule 4 to, the *Adoption Act 1976* (c. 36); section 57 of, and Schedule 5 to, the *National Health Service Reorganisation Act 1973* (c. 32); section 148 of, and Schedule 4 to, the *Mental Health Act 1983* (c. 20); section 108(5) of, and Schedules 13 and 15 to, the *Children Act 1989* (c. 41); section 89(2) of, and Schedules 2 and 3 to, the *Domestic Proceedings and Magistrates' Courts Act 1978* (c. 22); section 127(1) of, and Schedule 3 to, the *Mental Health (Scotland) Act 1984* (c. 36); section 54 of, and Schedules 2 and 3 to, the *Matrimonial Causes Act 1973* (c. 18); section 35(2) and (3) of, and Schedules 7 and 8 to, the *Supplementary Benefits Act 1976* (c. 71); section 129 of, and Schedule 16 to, the *National Health Service Act 1977* (c. 49); section 66(1) of, and Schedule 9 to, the *National Health Service and Community Care Act 1990* (c. 19); section 20(1) of, and Schedule 4 to, the *Social Security Act 1980* (c. 30); sections 3 and 4 of, and Schedules 1 and 2 to, the *Housing (Consequential Provisions) Act 1985* (c. 71); section 57 of, and Schedule 1 to, the *Registered Homes Act 1984* (c. 23); section 216(3) of, and Schedule 17 to, the *Housing Act 1996* (c. 52); section 582(1) and (2) of, and Schedules 37 and 38 to, the *Education Act 1996* (c. 56); section 1(7) of the *Carers (Recognition and Services) Act 1995* (c. 12); section 3(1) and (3) of the *Community Care (Direct Payments) Act 1996* (c. 30); and section 15(1) of, and Schedule 2 to, the *Adoption (Intercountry Aspects) Act 1999* (c. 18)

25 1948 (c. 29)

(iva) Subject to sub-paragraph (1), section 17 of the 1983 Act
(vi) Parts VII to IX and section 86 of the *Children Act 1989*[26]

(aa) The function of providing Healthy Start vitamins under regulation 8A of the Healthy Start Scheme and Welfare Foods (Amendment) Regulations 2005
(b) The functions under sections 7 or 8 of the *Disabled Persons (Services, Consultation and Representation) Act 1986*
(c) The functions of providing or securing provision of recreational facilities under section 19 of the *Local Government (Miscellaneous Provisions) Act 1976*[27]
(d) The functions of local authorities under the Education Acts as defined in section 578 of the *Education Act 1996*[28]
(e) The functions of local housing authorities under Part I of the *Housing Grants, Construction and Regeneration Act 1996*[29] and under Parts VI and VII of the *Housing Act 1996*[30]
(f) The functions of local authorities under section 126 of the *Housing Grants, Construction and Regeneration Act 1996*
(g) The functions of waste collection or waste disposal under the *Environmental Protection Act 1990*[31]
(h) The functions of providing environmental health services under sections 180 and 181 of the *Local Government Act 1972*[32]
(i) The functions of local highway authorities under the *Highways Act 1980*[33] and section 39 of the *Road Traffic Act 1988*[34]
(j) The functions under section 63 (passenger transport) and section 93 (travel concession schemes) of the *Transport Act 1985*[35]
(k) Where partners enter into arrangements under regulation 7(1) or 8(1) in respect of the provision of accommodation under sections 21 or 26 of the 1948 Act, the function of charging for that accommodation under section 22, 23(2) or 26 of that Act or
(l) Where partners enter into arrangements under regulation 7(1) or 8(1) in respect of the provision of a service under any enactment mentioned in section 17(2)(a) to (c) of the 1983 Act, the function of charging for that service under that section
(m) The functions of local authorities under or by virtue of sections 2B or 6C(1) of, or Schedule 1 to, the 2006 Act.

Pooled fund arrangements

7. (1) Subject to the following provisions of this regulation, the partners may enter into arrangements for or in connection with the establishment and maintenance of a fund ("pooled fund arrangements"), which is made up of contributions by the partners and out of which payments may be made towards expenditure incurred in the exercise of any NHS functions or health-related functions.

(2) A partner which is an NHS trust may not enter into pooled fund arrangements with a partner which is a local authority unless it obtains the consent of each clinical commissioning group with which it has an NHS contract for the provision of services for persons in respect of whom the functions which are the subject of the pooled fund arrangements may be exercised.

(3) Where the partners have decided to enter into pooled fund arrangements the agreement must be in writing and must specify:

(a) The agreed aims and outcomes of the pooled fund arrangements
(b) The contributions to be made to the pooled fund by each of the partners and how those contributions may be varied
(c) Both the NHS functions and the health-related functions the exercise of which are the subject of the arrangements
(d) The persons in respect of whom and the kinds of services in respect of which the functions referred to sub-paragraph (c) may be exercised
(e) The staff, goods, services or accommodation to be provided by the partners in connection with the arrangements
(f) The duration of the arrangements and provision for the review or variation or termination of the arrangements
(g) How the pooled fund is to be managed and monitored, including which body or authority is to be the host partner in accordance with paragraph (4).

(4) The partners shall agree that one of them ("the host partner") will be responsible for the accounts and audit of the pooled fund arrangements and the host partner shall appoint an officer of theirs ("the pool manager") to be responsible for:

(a) Managing the pooled fund on their behalf
(b) Submitting to the partners' quarterly reports, and an annual return, about the income of, and expenditure from, the pooled fund and other information by which the partners can monitor the effectiveness of the pooled fund arrangements.

(5) The partners may agree that an officer of either may exercise both the NHS functions and

26 1989 (c. 41)
27 1976 (c. 57)
28 1996 (c. 56)
29 1996 (c. 53)
30 1996 (c. 52)
31 1990 (c. 43)
32 1972 (c. 70)
33 1980 (c. 66)
34 1988 (c. 52)
35 1985 (c. 67)

health-related functions which are the subject of the pooled fund arrangements.

(6) The host partner shall arrange for the audit of the accounts of the pooled fund arrangements and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under section 28(1)(d) of the *Audit Commission Act 1998*[36].

Exercise of functions by NHS body

8. (1) Subject to the following provisions of this regulation, the partners may enter into arrangements for the exercise by NHS bodies of health-related functions in conjunction with the exercise by such bodies of their NHS functions.

(2) Where the partners have decided to enter into arrangements under paragraph (1) the agreement must be in writing and must specify:

(a) The agreed aims and outcomes of the arrangements
(b) The payments to be made by local authorities to the NHS bodies and how those payments may be varied
(c) The health-related functions and NHS functions the exercise of which are the subject of the arrangements
(d) The persons in respect of whom and the kinds of services in respect of which the functions referred to in sub-paragraph (c) may be exercised
(e) The staff, goods, services or accommodation to be provided by the partners in connection with the arrangements
(f) The duration of the arrangements and provision for the review or variation or termination of the arrangements
(g) The arrangements in place for monitoring the exercise by the NHS bodies of the functions referred to in sub-paragraph (c)
(h) In the case of the exercise of functions mentioned in regulation 6(k) or (l), the arrangements in place for determining the services in respect of which a user may be charged and for informing users about such charges
(l) The arrangements in place for the sharing of information between NHS bodies and local authorities.

(3) The NHS bodies shall report to the local authorities, both quarterly and annually, on the exercise of the health-related functions which are the subject of the arrangements.

Exercise of functions by local authorities

9. (1) Subject to the following provisions of this regulation, the partners may enter into arrangements for the exercise by local authorities of NHS functions in conjunction with the exercise by such authorities of their health-related functions.

(2) A partner which is an NHS trust may not enter into arrangements under paragraph (1) unless it obtains the consent of each clinical commissioning group with which the trust has an NHS contract for the provision of services for persons in respect of whom the functions which are the subject of the arrangements may be exercised.

(3) Where the partners have decided to enter into arrangements under paragraph (1) the agreement must be in writing and must specify:

(a) The agreed aims and outcomes of the arrangements
(b) The payments to be made by the NHS bodies to the local authorities and how those payments may be varied
(c) The NHS functions and the health-related functions the exercise of which are the subject of the arrangements
(d) The persons in respect of whom and the kinds of services in respect of which the functions referred to in sub-paragraph (c) may be exercised
(e) The staff, goods, services or accommodation to be provided by the partners in connection with the arrangements
(f) The duration of the arrangements and provision for the review or variation or termination of the arrangements
(g) The arrangements in place for monitoring the exercise by the local authorities of the functions referred to in sub-paragraph (c)
(h) In the case of the exercise of functions mentioned in regulation 6(k) or (l), the arrangements in place for determining the services in respect of which a user may be charged and for informing users about such charges
(i) The arrangements in place for the sharing of information between NHS bodies and local authorities.

(4) The local authorities shall report to the NHS bodies, both quarterly and annually, on the exercise of the NHS functions which are the subject of the arrangements.

36 1998 (c. 18)

Supplementary

10. (1) In connection with any partnership arrangements a partner may agree to provide staff, goods, services or accommodation to another partner.

(2) Partners may form a joint committee to take responsibility for the management of partnership arrangements including monitoring the arrangements and receiving reports and information on the operation of the arrangements.

(2A) Where a local authority in England is operating executive arrangements, a joint committee formed under paragraph (2) may include any person who is a member of that authority whether or not he is also a member of the executive of that authority.

(3) Without prejudice to any complaints procedures under the *Hospital Complaints Procedures Act 1985*[37] or under section 7B of the *Local Authorities Social Services Act 1970* or otherwise, where partners have formed a joint committee under paragraph (2) in respect of partnership arrangements they may agree that a sub-committee, or a member of the joint committee, may consider complaints about the partnership arrangements if the complaints are made by or on behalf of users of services provided under the partnership arrangements.

(4) In paragraph (2A), "executive" and "executive arrangements" have the same meaning as in Part II of the *Local Government Act 2000.*

Signed by authority of the secretary of state for health
Gisela Stuart, parliamentary under secretary of state
10 March 2000, Department of Health

Explanatory note (not part of the regulations)

These regulations make provision for certain NHS bodies and local authorities to enter into arrangements ("partnership arrangements") for specified functions.

Regulation 3 prescribes the NHS bodies and local authorities ("the partners") which may enter into the arrangements.

Regulation 4 sets out the conditions which must be satisfied before the partners may enter the partnership arrangements.

Regulations 5 and 6 prescribe the NHS functions and local authority functions which may be the subject of partnership arrangements.

The regulations also define the nature of the partnership arrangements. They provide for the establishment of a fund made up of contributions from the partners, out of which payments may be made towards expenditure incurred in the exercise of their functions, for the exercise by NHS bodies of local authority functions, and require the partners to set out the terms of the arrangements in writing (regulations 7, 8 and 9).

Regulation 10 makes supplementary provisions.

Explanatory note for SI 2003/629

These regulations further amend the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2001 ("the principal regulations"). These make provision for certain NHS bodies and local authorities to enter into specified arrangements (partnership arrangements) in relation to specified functions.

Regulation 3 adds the Council of the Isles of Scilly to the list of local authorities who can enter into partnership arrangements.

Regulation 4 disapplies the consultation requirement in regulation 2 of the principal regulations in respect of partnership arrangements entered into where those arrangements have been consulted upon in connection with an application for care trust designation pursuant to section 45 of the *Health and Social Care Act 2001*.

Regulation 5 makes amendments to regulation 6 of the principal regulations. The amendments relate to charging for community care services. In particular it adds section 17 of the *Health and Social Services and Social Security Adjudications Act 1983* to the list of functions which, generally, cannot be the subject of partnership arrangements. It also adds sub-paragraphs (k) and (l) to regulation 6 of the principal regulations which enable the specified functions to be part of partnership arrangements provided the function to which the charging function relates also forms part of those partnership arrangements.

Regulations 6 and 7 make amendments to regulations 8 and 9 of the principal regulations so that, where the partnership arrangements include charging functions, the partnership agreement must specify what arrangements are in place for determining the services in respect of which a user may be charged and for informing those users about such charges.

37 1985 (c. 42)

Footnote to para 21 of SI 2010/1000
SI 2000/617 ("the 2000 regulations"). Following the consolidation of enactments relating to the health service by the *National Health Service Act 2006* (c. 41), the 2000 regulations have effect as if made under section 75 of that Act, by virtue of paragraph 1 of Part 1 of Schedule 2 to the *National Health Service (Consequential Provisions) Act 2006* (c. 43)

Appendix 2: Example financial summary

Service area	Plan value (£)	Year to date actual expenditure (£)	Forecast Oct-Dec expenditure (£)	Forecast Jan-Mar expenditure (£)	Forecast outturn expenditure (£)
Community, equipment and adaptations	£		£		
Telecare					
Integrated crisis and rapid response services					
Maintaining eligibility criteria					
Reablement services					
Bed-based intermediate care services					
Early supported hospital discharge schemes					
Mental health services					
Housing projects					
Employment support					
Learning disabilities service					
Dementia services					
Support to primary care					
Integrated assessments					
Integrated records or IT					
Joint health and care teams/ working					
Other preventative services (please specify)					
Other social care (please specify)					
Other intermediate care (please specify)					
Overall totals					

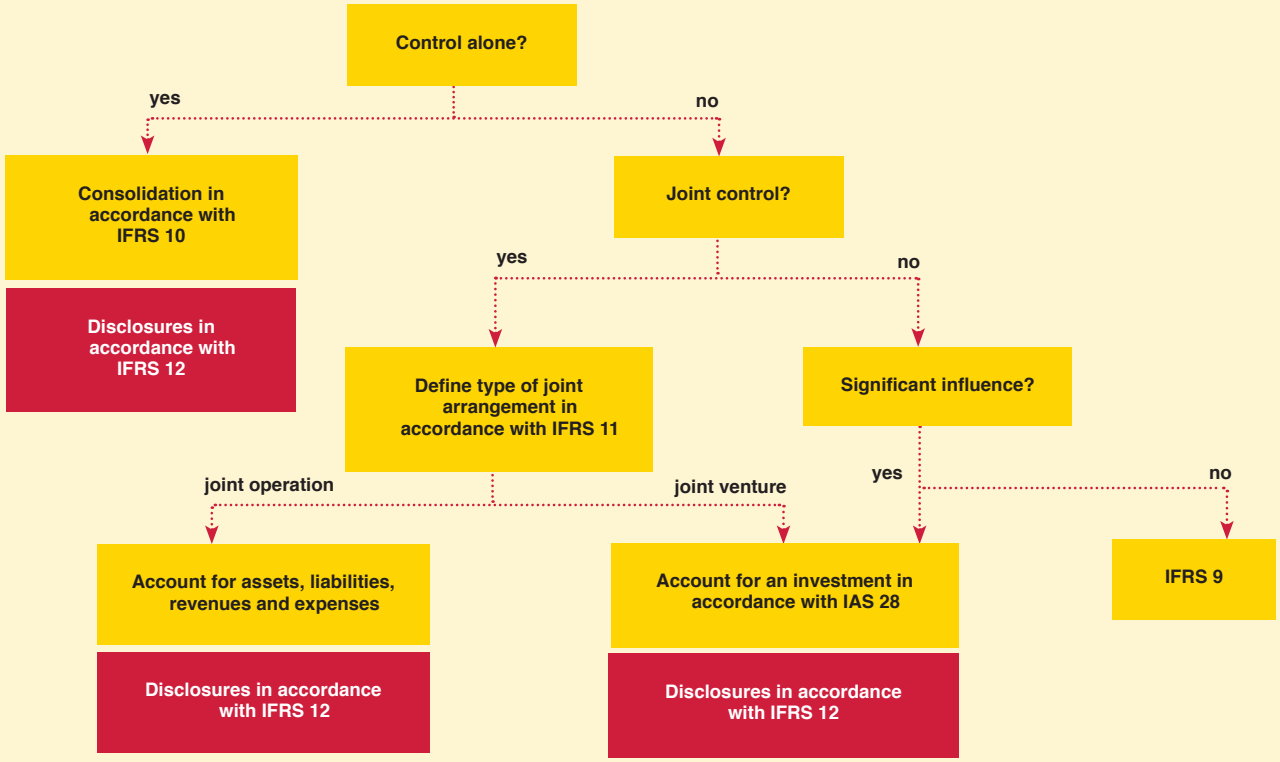
Appendix 3: Accounting for a pooled budget

The accounting standards that apply to pooled budgets are new and revised and effective from 1 April 2014:

- IAS 28 *Investments in Associates and Joint Arrangements*
- IFRS 10 *Consolidated financial statements*
- IFRS 11 *Joint arrangements*
- IFRS 12 *Disclosure of Involvement with Other Entities*[38].

The links between the standards have been illustrated by the IASB:

Interaction between IFRS 10, 11, 12 and IAS 28



Previously, in accounting terms, a pooled budget has been considered a joint arrangement that is not an entity in its own right. Under the new accounting standards, pooled budgets (including the better care fund) may meet the definition of a joint operation. However, this will need to be considered on a case by case basis based on the signed agreement and the working practices in operation.

Control alone

In accordance with IFRS 10, there will be control if one body (the investor) has all of the following:

1. Power over the other body (the investee) – power arises from rights, in particular, the rights to direct the investee's activities. The rights may come from voting rights or from contracts and they do not have to have been exercised to exist
2. Exposure or rights, to variable returns from its involvement with the investee (returns may be positive, negative or both)
3. The ability to use its power over the investee to affect the amount of its returns.

38 Local authorities are required to follow the requirements of chapter 9 of the Code of Practice on Local Authority Accounting in relation to pooled budgets. The Code's requirements are based largely on the accounting standards identified. References to IFRS 11 requirements set out here are consistent with the Code's requirements for local authorities

Where there is more than one investor and no one investor can direct the investee's activities without the co-operation of the other investors, then there is no individual control and the answer to the 'control alone' question would be no. Where 'joint control' exists, the following test needs to be applied.

Joint control

IFRS 11 defines joint control as '…the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control'.
Joint control requires that all the parties, or a group of the parties, must act together to direct the activities that significantly affect the returns of the arrangement – the relevant activities. This means that:

- No single party controls the arrangement on its own
- Any one of the parties in the arrangement can prevent any of the other parties from controlling the arrangement.

The examples provided in the standard (paragraph B8) are as follows:

Example 1
Assume that three parties establish an arrangement: A has 50% of the voting rights, B has 30%, C 20%. The contractual arrangement between A, B and C specifies that at least 75% of the voting rights are required to make decisions about the relevant activities of the arrangement. Even though A can block any decision, it does not control the arrangement because it needs the agreement of B. The terms of their contractual arrangement requiring at least 75% of the voting rights to make decisions about the relevant activities imply A and B have joint control of the arrangement because decisions about the arrangement's relevant activities cannot be made without A and B agreeing.

Example 2
Assume an arrangement has three parties: A has 50% of the voting rights, B and C each have 25%. The contractual arrangement between A, B and C specifies that at least 75% of the voting rights are required to make decisions about the relevant activities of the arrangement. Even though A can block any decision, it does not control the arrangement because it needs the agreement of either B or C.

In this example, A, B and C collectively control the arrangement. However, there is more than one combination of parties that can agree to reach 75% of the voting rights (either A and B or A and C). In such a situation, to be a joint arrangement the contractual arrangement between the parties would need to specify which combination of the parties is required to agree unanimously to decisions about the relevant activities of the arrangement.

Example 3
Assume an arrangement in which A and B each have 35% of the voting rights, with the remaining 30% widely dispersed. Decisions about the relevant activities require approval by a majority of the voting rights. A and B have joint control of the arrangement only if the contractual arrangement specifies that decisions about the relevant activities of the arrangement require both A and B agreeing.

Structure of joint arrangements

A joint arrangement not structured through a separate vehicle is a joint operation. In such cases, the contractual arrangement establishes the parties' rights to the assets and obligations for the liabilities (relating to the arrangement) and their rights to the corresponding revenues and obligations for the corresponding expenses (*IFRS 11, para B16*).

A joint arrangement in which the assets and liabilities relating to the arrangement are held in a separate vehicle can be either a joint venture or a joint operation. Whether a party is a joint operator or a joint venturer depends on the party's rights to the assets and obligations for the liabilities relating to the arrangement that are held in the separate vehicle (*IFRS 11, paras B19 and B20*).

Better care fund pooled budgets and IFRS 11

It is anticipated that all parties to a better care fund pooled budget agreement will have joint control. However, this will be dependent on the exact terms of the signed agreement and the nature of the funding streams covered by the agreement and should therefore be assessed on a case by case basis. As no separate vehicle is created in such an arrangement, where joint control exists it is classified as a joint operation (in accordance with IFRS 11 requirements).

As the better care fund pooled budget is a joint arrangement solely for the purpose of working together, it is anticipated that no single body will have power of control over the other parties to the agreement.

The signed agreement for a better care fund pooled budget should set out the nature of the activities that are the subject of the agreement (as required by SI 2000/617) as well as how the parties intend to operate those activities together. This will enable each party to identify its share of the assets and liabilities for accounting purposes.

Accounting for a joint operation in the financial statements

IFRS 11 paragraph 20 sets out how a joint operation should be accounted for:

a) Each joint operator to the joint operation will recognise (in relation to its interest in that joint operation):

(i) Its assets, including its share of any assets held jointly
(ii) Its liabilities, including its share of any liabilities incurred jointly
(iii) Its revenue from the sale of its share of the output arising from the joint operation
(iv) Its share of the revenue from the sale of the output by the joint operation
(v) Its expenses, including its share of any expenses incurred jointly

b) Each joint operator shall account for the assets, liabilities, revenues and expenses relating to its interest in a joint operation in accordance with IFRSs applicable to the assets, liabilities, revenues and expenses (*IFRS 11, para 22*)

c) When accounting for transactions such as the sale, contribution or purchase of assets between an entity and a joint operation in which it is a joint operator, the entity will recognise the gains and losses resulting from such a transaction only to the extent of the other parties' interests in the joint operation (*IFRS 11, paras B34-B37*).

If a party to a better care fund pooled budget does not have joint control but has rights to the assets and obligations for the liabilities relating to the joint operation, it shall also account for its interest in the arrangement in accordance with paragraphs a) to c) above.

Disclosure

All of the arrangements above are covered by the disclosure requirements set out in IFRS 12. The standard requires the disclosure of information about significant judgements and assumptions made by the entity in determining whether or not it has joint control over another entity.

Also required is the disclosure of information that enables users of its financial statements to evaluate the nature, extent and financial effects of interests in joint operations [better care fund pooled budget arrangements], including the nature and effects of its contractual relationship with the other investors with joint control. For material joint operations, the following will need to be disclosed:

- The name of the joint arrangement
- The nature of the entity's relationship with the joint arrangement (could include description of the nature of activities)
- The principal place of business of the joint arrangement
- The proportion of ownership interest or participating share held by the entity and, if different, the proportion of voting rights held (if applicable).

If any critical estimates or accounting judgements have been made in relation to the joint operation, these should be disclosed in accordance with IAS 1. One judgement which should be considered is whether transactions are made on an agency basis and therefore accounted for net rather than gross. It is expected most transactions will be accounted for on a gross basis but for the financial accounts it may be determined that net accounting is appropriate where payments are simply passed through an organisation. However, management accounts information should be maintained on a gross basis as it is simpler to produce net results from gross information than produce gross from net.

In the event that joint control does not exist, there is no specific requirement for the above disclosures to be made. However, it is recommended that where a party to a better care fund pooled budget does not have joint control but has rights to the assets and obligations for the liabilities relating to the joint operation, any risks associated with those interests should be disclosed.

Appendix 4: Essential measures and controls

Summary of the measures and controls in this guidance and the relevant paragraph reference

Governance arrangements	Paragraph
The governance arrangements for the pooled budget should meet the requirements of all partners	12
Each partner must satisfy itself the pooled budget complies with requirements of its appropriate code of governance	12
Each partner must satisfy itself that all other regulatory requirements are met	13
In-year changes to plans must be subject to appropriate authorisation/approval inc final sign-off by relevant HWB	28
In-year financial reporting must comply with the requirements of SI 2000/617 section 7 paragraph 4(b)	29
Parties to the pooled budget will need to reflect the better care fund in their risk register	30
Risks of pooled budget arrangements must be assessed and as necessary be subject to ongoing internal audit review	30
Supporting assurance must be obtained that the information received in relation to the fund is correct and accurate	30
There must be a process for alerting the CCG governing body and local authority cabinet/executive of concerns about delivery of better care fund projects	30
CCGs will probably be required to identify if there have/have not been significant financial issues relating to the pooled budget for the period of the governance statement	31
Other than the host, parties to the pooled budget must identify what assurance information they require on the projects from other organisations	34
Those charged with governance need to assure themselves that the data underpinning the above assurances is robust, then consider the results and the implications for the achievement of the fund's objectives	38 and 39
Operational structures	
Each local area must determine the operational structure for their pooled budget	15
The HWB must sign off pooled budget plans	15
The HWB must implement measures for the on-going oversight of better care fund projects	15
The operational structure must include formal delegation arrangements	18
The membership and terms of reference of the HWB must be appropriate	19
Hosting	
The decision on which partner hosts the pooled budget should be made locally	21
While the host body will have delegated powers it will need to work within the reporting and management environments of the partnership	23
Signed agreement	
The signed agreement must set out precisely what the overall aims are; who is responsible for what and the associated plans for reporting and accountability	24
The agreement should be reviewed regularly	26
Information requirements	
The information required to support performance monitoring and reporting must be identified in advance and collected on a regular basis from the outset	27
Financial arrangements	
Parties to the pool will need to discuss with their external auditors the assurances that will be required in order to sign off the year-end accounts	30
The pooled budget host must ensure that VAT arrangements are compliant with NHS and local authority VAT regimes	30
The pooled budget host will be responsible for ensuring that appropriate capital accounting arrangements are applied as required	30
Regular and timely performance reports must be provided for the HWB, the CCG governing body and the local authority cabinet/executive	30
All parties to a pooled budget must understand and consider the various issues relating to the year-end financial processes in advance of the year end itself	31
The accountable officer/section 151 officer must consider the assurances that may be required to sign off accounts that include pooled budget transactions	31
For joint operations, parties should account for their share of as the assets, liabilities, income and expenditure in accordance with IFRS 11	31
Under SI 2000/617 paragraph 7(4), hosts must submit an annual return to the partners about the income and expenditure of the pooled fund	31
The annual return must include a full statement of spending, signed by the accountable officer/section 151 officer	31

Appendix 5: Pros and cons of sources of assurance

Table 1: internal sources

Pros	Cons
• Less costly • Testing and reporting determined by the entity so tailored to the system	• Testing and reporting determined by the entity so: o No consistency between organisations o Additional work for each body to develop the work programme o Additional work for each body to review and agree the work programme

Table 2: external sources

Pros	Cons
• Prescribed testing and reporting structure • Known output • Consistency of work and output • Independent	• Can be costly • Can only be used for certain systems

Appendix 6: Further reading

- *Introductory guide for clinical commissioning groups: pooled budgets and integrated care*, CIPFA, June 2011 www.cipfa.org/-/media/files/policy%20and%20guidance/panels/health%20panel/lib_07_cipfa_intro_guide_pooling_budgets.pdf

- *Pooled budgets: a practical guide for local authorities and the National Health Service,* fully revised second edition, CIPFA, 2009

- *Code of practice on local authority accounting in the United Kingdom*, CIPFA (annual publication)

- *Code of practice on local authority accounting in the United Kingdom: guidance notes for practitioners*, CIPFA (annual publication)

- S75 NHS Act 2006 partnership agreements, Commissioning Support Programme, July 2010

- Local Government Association www.local.gov.uk/web/guest/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE

- NHS England better care fund web pages www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

- Template section 75 agreement www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/

- The National Health Service (Conditions Relating to Payments by NHS Bodies to Local Authorities) Directions, 2013 www.gov.uk/government/uploads/system/uploads/attachment_data/file/200460/s256_257_conditions_-_Payments_by_NHS_bodies_to_LAs.pdf

About CIPFA

CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. Our 14,000 members work throughout the public services, in national audit agencies and major accountancy firms, anywhere where public money needs to be effectively and efficiently managed. As the world's only professional accountancy body to specialise in public services, CIPFA's qualifications are the foundation for a career in public finance. We also champion high performance in public services, translating our experience and insight into clear advice and practical services. Globally, CIPFA shows the way in public finance by standing up for sound public financial management and good governance.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the UK representative body for finance professionals working in the NHS and the wider healthcare sector. Our aim is to support the NHS finance function, to promote good practice in financial management and to improve the general understanding of NHS finance issues.

Our work is informed by a number of committees and special interest groups made up of healthcare finance practitioners. We publish numerous guides and briefings aimed at finance professionals, non-executive directors and non-finance staff. We also provide training and development opportunities – including a suite of web based learning modules – across all of these groups.

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DECISION-MAKER:		CABINET		
SUBJECT:		DOMICILIARY CARE RECOMMISSIONING		
DATE OF DECISION:		20 JANUARY 2015		
REPORT OF:		CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Kate Dench**	**Tel:**	**023 8083 4787**
	E-mail:	**kate.dench@southampton.gov.uk**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 8029 6941**
	E-mail:	**Stephanie.Ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

Appendices 2a – 2e and 3 of this report are not for publication by virtue of Paragraphs 3 and 7A of the Council's Access to Information Procedure Rules. It is not in the public interest to release this information as it would prejudice the Council's ability to contract with third parties and obtain best value when entering into competitive tenders with the market.

BRIEF SUMMARY

This report seeks approval from Cabinet for the award of contracts to provide Domiciliary Care provision following a tender process. Tenders have been evaluated according to the most economically advantageous criteria, taking into consideration the criteria of quality and price. The services will be delivered from Framework Agreements which fall into five lots.

RECOMMENDATIONS:

(i)	To approve the award of the contracts which make up the domiciliary care provision to the providers and on the key terms and conditions set out in Confidential Appendices 2a – 2e and 3.
(ii)	To delegate authority to the Director, People, following consultation with the Head of Finance and IT and the Head of Legal & Democratic Services to do anything necessary to give effect to the recommendation above.

REASONS FOR REPORT RECOMMENDATIONS

1	Due to its size and importance in terms of meeting service user needs and enabling the city to meet its strategic requirements, it is essential that domiciliary care provision achieves high standards of delivery, quality and value for money. Currently the service is variable, not sufficiently flexible to meet increasing demands and relies heavily on spot purchase. A framework agreement is advantageous because it offers a structured legal framework to contract over a 4 year period. This provides stability to the successful providers enabling officers to work with them to build capacity within the market. The framework would therefore also provide: • Increased flexibility with changes in demand. • Support of personalisation and Individual Service Fund (ISF)

	approaches, thereby creating more choice and control for users. • Offers better value for money provision.
2.	Cabinet supported the following recommendations in December 2013: (i) To approve the pre-tender considerations and the criteria to be used to evaluate tenders. (ii) To delegate authority to the Director, People to invite tenders and evaluate them in accordance with the recommended evaluation criteria. (iii) To note that the award of the contract will be considered by Council or Cabinet as appropriate as detailed in the procurement timetable (listed in Section 13 of the December 2013 report).
3	Following this resolution the domiciliary care tender commenced in 2014 as part of a joint commissioning exercise between Southampton City Clinical Commissioning Group and Southampton City Council. The tender was advertised in May 2014 and the Invitation to Tender (ITT) stage completed in December 2014. This tender supports the Council and Southampton City Clinical Commissioning Group (CCG) to improve quality and maximise efficiencies.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
4	Not re-tendering would mean that we are not working within the Council's Contract Procedure Rules which requires an opportunity to be given to potential providers, to apply to undertake this work.
5	To undertake a cost and volume contract would not be in line with the personalisation agenda, nor would it provide the flexibility to meet the additional capacity and needs identified.
DETAIL (Including consultation carried out)	
6	**Background**
6.1	Snapshot data provided in July 2013 identified that the domiciliary care market within Southampton provides care for approximately 1,810 people in any given week (1,750 SCC and 60 SCCCG). There are currently up to 75 providers (65 spot purchased and 10 framework providers contracted) working in the city and delivering care packages on behalf of SCC and the CCG
6.2	The Framework Agreement will provide a platform for the delivery of domiciliary care and reablement services for adult and children services in Southampton City Council (SCC) and Continuing Health Care for Southampton City CCG (SCCCG).
6.3	Due to its size and importance in terms of meeting client needs and enabling the city to meet its strategic requirements, it is essential that domiciliary care provision achieves high standards of delivery, quality and value for money. Currently the service is variable and not sufficiently flexible to meet increasing demands. The tender supports four main outcomes: • To improve quality within domiciliary care services • To ensure the best value available within the market • To ensure services are able to respond to changing needs and demands • Support the development of personalisation across the city

6.4	The model of provision has been designed to address areas of improvement by offering: • Greater flexibility and capacity, whilst still maintaining the geographical focus which recognises the issue of travel time • Clearer quality standards and performance indicators (KPIs) linked to contract terms and conditions which will support the drive for quality • A more streamlined system as outlined in the service specifications with a strong emphasis on promoting personalisation and independence • A requirement to deliver outcome based support using flexible care plans that shift away from minute by minute calls • A more generic approach focussing on need rather than diagnosis which addresses individual circumstances • The tender will reduce the number of providers we work with, thereby providing an opportunity to proactively work with a targeted number of agencies to share best practice and work with them to provide solutions to market issues, such as capacity and workforce.
7	**Framework**
7.1	The lots for the Framework include: <u>Lot 1</u> – Adults Providers awarded onto this Lot will provide domiciliary care services to adults over the age of 18 who meet the respective Council's eligibility criteria for funded support in their own home. This lot will cover the following care groups: • People with physical disabilities • People with learning disabilities • People with mental health problems • Older people • Acquired brain injury <u>Lot 2</u> – Accommodation with Care and Support Providers awarded onto this Lot will provide domiciliary care services to adults in care schemes for instance extra care and supported living services. <u>Lot 3</u> – Continuing Healthcare Providers awarded onto this Lot will provide continuing health care services to those meeting CHC eligibility criteria. This Lot will also include providers who can provide case management and the option of BiPAP (Bilevel Positive Airway Pressure) alongside continuing health care if required. <u>Lot 4</u> – Children and Young People Providers awarded onto this Lot will provide services to children or young adults from 0-25 years. This Lot is proposed to support effective transitions into adult services and deliver the principles set out within the Children and Families Bill/Southampton's service structures.

	Lot 5 – Reablement Providers awarded onto this Lot will provide, if required, reablement provision. The increasing demographic changes and the emphasis on recovery, reablement and prevention within the city's transformational change programme, requires a service focussed on enabling clients to regain or achieve an optimal level of independence. This Lot forms a foundation to support the sourcing of further reablement support services should it be identified that meeting demand and improving outcomes will be more effectively achieved through this arrangement. Currently the majority of provision is delivered internally within the council. During the lifetime of this Framework the council's position may change. If it does we may seek to commission such services from this lot.
8	**Tender Process**
8.1	The framework agreement has been created following a two stage restricted tender process, in accordance with the Council's Contract Procedure Rules and the Ethical Procurement Policy.
8.2	Stage 1: pre-qualification stage: Shortlists were drawn up in accordance with the Council's Contract Management Guidelines by a pre-qualification questionnaire (PQQ). The pre-qualification tested the capacity and capability, including quality, of potential bidders as well as potential bidder eligibility to take part in the Procurement. This included the following: • Subcontracting/consortia arrangements • Professional conduct • Economic and financial standing • Insurance • Resources • Health and safety • Quality assurance • Equality • Environmental • Sustainability • Carbon policy • Business continuity • Previous experience and references • Child Protection and Safeguarding Adults • Policies The outcome of this stage presented a list of pre-qualified bidders for the Procurement and a short-list of bidders to be invited to tender.
8.3	Stage 2: Invitation to Tender stage: Tenders have been evaluated on the basis of the most economically advantageous tender in order to award providers onto the framework agreement using the following criteria:

	• Quality Quality consisted of 40% of the evaluation weightings. The quality assessment was evaluated using a range of criteria. Providers had to score at least 50% of the quality scoring to be eligible for award onto the contract. Any providers that did not meet the requirements of 50% of the quality scoring failed this stage in the process. The quality assessment was evaluated using the following criteria: • Meeting the needs of the individual and customer focus • Approach to safeguarding, performance and safe environment • Approach to staff recruitment, retention and training • Mobility and capacity building • Business Continuity Planning • Information systems and its use for monitoring service provision • Approach to partnership working with the Council and others • Price Price consisted of 60% of the evaluation weightings. Differing weightings were given to each individual evaluation criteria and were stated in the tender documentation.
9	**Consultation**
9.1	A market event to stimulate domiciliary care provision was held in February 2014. Included in this event was a Tender Ready session for potential providers. The Integrated Commissioning Unit (ICU) are sending out monthly email updates to providers about issues related to the sector, including any relevant tender information and timescales. There is an email address which we encourage providers to use, if they are not tendering, so we can support the market with potential changes.
9.2	In February and March 2014 the ICU led twelve focus groups with adult clients (including Continuing Healthcare), with approximately 70 people: all adult care groups were covered as some groups were mixed. The reports of the Buzz Network Short Break Event, Children's Domiciliary Care Needs Analysis and SCC's Complaints (April 2012 – October 2013) were also analysed to inform the five specifications and key questions that the ICU used to test potential providers. The requirements that were most important to clients were: • good communications skills between provider staff (office & care workers) and clients; • provider staff that have an attitude fit for the job; • provider staff are provided with the training to have the functional skills and professional competencies to meet the needs of clients; • provider staff are consistent and reliable, but flexible; Providers have: • good organisational systems;

	• high staff retention; • range of staff to match appropriately to client's; • a key worker system; • realistic rotas that take into account travel and needs of clients; • care plans are outcome focused, and understood by all; • clients are in control of their care. The full Report of Domiciliary Care Service Stakeholder Engagement and Report Analysis 2014 is located in Appendix 1.
9.3	The ICU has begun a programme of work with clients, informal carers and families regarding potential changes to the provision. From the 29th September 2014 – 8th October 2014 we held four information events across the city where we used a Frequently Asked Question (FAQ) presentation format, with time for additional questions, to provide information about the forthcoming potential changes and hear any feedback that individuals have. We have sent a newsletter out to all clients recorded as receiving domiciliary care support using the FAQ format. There is another newsletter planned for the end of February 2015. Additionally there is an email address where clients, informal carers and families can contact the ICU directly, if there is any other feedback about potential changes.
9.4	Pending the cabinet decision, an implementation plan will be developed to support the outcomes of the tender including joint work with care management teams to ensure continuity of care for individuals meeting the criteria for domiciliary care services.
RESOURCE IMPLICATIONS	
Capital/Revenue	
10.1	The revenue budget for Domiciliary Care held within Health and Adult Social Care in 2014/15 is £14,510,000. The Southampton City Clinical Commissioning Group also hold a budget of £6,883,000 for Domiciliary Care. The combined budget from which activity purchased under any Framework Contract is £21,393,000 for 2014/15.
10.2	As part of the 2014/15 revenue budget process a saving proposal of £360,000 was agreed at Council in February 2014. This saving will increase to £420,000 in 2015/16. It is anticipated, through modelling of clients in September 2014, that this saving will be achieved through efficiencies gained under the new framework contract in 2015/16.
10.3	The Domiciliary Care provision purchased through the framework will be funded from within the existing budgets as highlighted above.
Property/Other	
12	Not applicable
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
13	The Care Act 2014 requires local authorities to prepare for implementation of the Act in April 2015 and April 2016. The award supports moving to a more personalised service approach ensuring greater compliance with the Care Act. The Act though places various duties and responsibilities on Local

	Authorities about commissioning appropriate services. Local authorities must ensure their commissioning practices and the services delivered on their behalf comply with the requirements of the Equality Act 2010 and should encourage services that respond to the fluctuations and changes in people's care and support needs.
14	The design and the running of this procurement is in accordance with the authority's Contract Procedure and Financial Procedure Rules. Due to the size, value and complexity of this project, the appropriate procurement rules, with the necessary Governance outlined in the above has been followed. The procurement of these contracts has been run in accordance in the requirements outlined within The Public Contracts Regulations 2006 and the EU Procurement Directives 2006.
Other Legal Implications:	
15	The contract has been tendered and managed by the Council through the Integrated Commissioning Unit. SCCCG will be referenced in the contract, and this provides an enabler for SCCCG to have access to the contract. Requirements will be set out within the Call off Contract Process to ensure that SCCCG has a contractual relationship with the providers
POLICY FRAMEWORK IMPLICATIONS	
16	These proposals are aligned to the following priorities set out in the Council Plan 2014 -2017: • Prevention and early intervention. • Protecting vulnerable people. • A sustainable council.

KEY DECISION?	Yes
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Report of Domiciliary Care Service Stakeholder Engagement and Report Analysis 2014
2a – 2e	Domiciliary Care Shortlist Reports Confidential
3	Domiciliary Care Price Evaluation Confidential

Documents In Members' Rooms

1.	
2.	
Equality Impact Assessment	
Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes

Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

Report of Domiciliary Care Service

Stakeholder Engagement

and

Report Analysis 2014

Enc 1

Table of Contents

Report of Domiciliary Care Service Stakeholder Engagement and Report Analysis 2014

1 Executive Summary

All the information gathered support three key requirements for a good quality domiciliary care service and can be summarised as:

- good communication systems;
- good management systems; and
- well trained staff.

Focusing on these key requirements will achieve the outcomes highlighted in yellow in the Adult Social Care Outcomes Framework (ASCOF) 2014/15 and the National Institute for Health and Care Excellence (NICE) Home Care Guidance 2014 (Appendix 1 and 2) :

2 Background

The scope for the procurement of domiciliary care has recently been extended to include all care groups. Some consultation has already been conducted with people with learning disabilities and their carers. This report consolidates the findings from the satisfaction surveys carried out in 2011-12, complaints reports from Southampton City Council (SCC), interview with sensory services in 2013 and service user focus groups in 2014.

3 Purpose

To ensure that the Domiciliary Care Service Specifications reflect how service users say they would like the service delivered in practice.

4 Methodology

A mixture of primary and secondary research was used to inform this report.

Primary research consisted of:

- focus groups with adult service users; and
- interview with Sensory Services Team.

Secondary research consisted of analysis of the following reports:

- Service User Satisfaction Survey 2011-12;
- Buzz Network Short Break Event May 2013;
- Children's Domiciliary Care Needs Analysis August 2013;
- SCC's Complaints (April 2012 – October 2013); and
- SCC's Adult Social Care Survey 2014

5 Findings

5.1 Service User Focus Groups and Report Analysis

Twelve focus groups with adult service users were held, with approximately 70 people: all adult care groups were covered as some groups were mixed. The reports of the Buzz Network Short Break Event, Children's Domiciliary Care Needs Analysis and SCC's Complaints (April 2012 – October 2013), were analysed. A summary of the combined results from the focus groups and reports analyses can be seen in Appendix 3 Service User Focus Groups and Reports Analysis.

5.1.1 Key Requirements

The requirements that were most important to service users largely reflect the results of the surveys in Section 1 of this report and were:

- good communications skills between agency staff (office & care workers) and service users;
- agency workers that have an attitude fit for the job;

- carers are provided with the training to have the functional skills and professional competencies to meet the needs of service users;
- carers are consistent and reliable, but flexible;
- agencies have:
    - good organisational systems;
    - high staff retention;
    - range of staff to match appropriately to service user;
    - a key worker system; and
    - realistic rotas that take into account travel and the needs of service users;
- care plans are outcome focused, and understood by all; and
- service users are in control of their care.

5.2 Interview with Sensory Impairment Team

When domiciliary care is required there are limited agencies that can meet the communication requirements of service users and so support has to be delivered focussing on both areas:

- personal care from a domiciliary care provider; and
- communications provision from a qualified support agency (qualified in sensory impairment communications)

This is expensive as on top of the domiciliary care cost the support worker is approximately £30/hr, however the volume of packages are too low (at present) to attract services[1] with specialist sensory impairment workers to provide a service in Southampton.

5.2.1 Key Requirement

As the population ages, more people will have visual/hearing/dual impairment, the requirement is therefore:

- agency frontline and office staff to attend Sensory Awareness Training[2].

5.3 Service User Satisfaction Survey 2011-12

The total weekly hours of care delivered by the Older Peoples Framework Agreement and spot providers is approximately 11827 per week. This is an increase of approximately 5-6% since February 2012. Regular surveys are carried out by the Quality Team to cover all providers; feedback from these surveys covers approximately 10% of service users. Evidence from the surveys highlight that where there are deficits in delivery, it is mainly an agency organisational issue. A high percentage of service users report good levels of overall satisfaction with the care they receive.

5.3.1 Key requirements

The survey quite clearly identified the key features that ensure a good quality service. The two most important to service users were:

- good communication by the provider to the service user, through the care worker where appropriate, and if not appropriate service users should be told why; and
- consistent, reliable care workers. If service users have regular carers who they come to trust, the quality of the care they receive is good. Quality deficits very often occur because of organisational failings, for example when service users receive care from a large number of carers, and their service is not consistently programmed, the quality of the care received is much more likely to be poor. It is therefore vital that providers have:
    - adequate office resources to ensure good communication and programming and an ability to thoroughly audit and update paperwork;
    - sufficient supervisory staff to support and monitor field workers; and
    - robust absence monitoring.

[1] Only two companies are known of that can provide specialist workers and domiciliary care in one package: Glyn and About Me.

[2] Contact SCC Sensory Awareness Team for current 'Deaf/ Hearing/ Visual/ Duel Sensory Loss Awareness' courses

5.3.2 Other requirements:

- well trained staff, both during induction and throughout a carer's employment
- flexibility
- good recruitment and retention – deficits impact on the ability of providers to meet the demand for care
- positive working relationship with commissioning, where deficits are identified, a common positive approach to improving service delivery is vital
- service users feel they have choice and control over the service provided
- service users are treated with dignity and respect

5.3.3 Supply and availability of care

Supply of care from the framework providers can be poor, particularly at weekends. Almost all have had major organisational problems which have impacted on the ability to increase output. Despite this there is an overall 85 – 90% satisfaction rate amongst those interviewed.

The spot providers frequently deliver smaller volumes in more concentrated areas. They can be eager to support demand but realistic to the challenges when faced with covering a wider area. They appear to be more successful in recruiting and retaining staff. Smaller size probably enables a provider to know its staff and service users better. They are often more successful in meeting the needs of the more complex service user.

5.4 Adult Social Care Survey 2014

The relevant questions in the 2014 Adult Social Care Survey were analysed and the respondent's comments that relate to domiciliary care can be found in Appendix 4 Adult Social Care Survey 2014. Q25 asked respondents what made them feel unsafe, the majority of the answers that domiciliary care can effect, are related to falls: knowing that a carer will be coming *may* alleviate some of their fears. Of those that responded to the survey (144 of approximately 1,800) the majority were either extremely, very or quite satisfied with the service provided. The analysis supports the findings in Section 5.1 and 5.3 of this report and is incorporated into Table 1. Key Requirements for a Quality Domiciliary Care Service and their Relationship to the Outcomes in ASCOF 2014/15 and NICE Home Care Guidance 2014.

6 Summary

Table 1 lists a summary of the key requirements for a quality service, and the relationship between them and the detail of these requirements, and the outcomes that would be achieved within the ASCOF 2014/15 and NICE Home Care Guidance 2014.

Table 1. Key Requirements for a Quality Domiciliary Care Service and their Relationship to the Outcomes in ASCOF 2014/15 and NICE Home Care Guidance 2014

Key Requirement of Agencies	Detail	ASCOF 2014/15	NICE Home Care Guidance 2014 *
Good Communication Systems	Between: • Carers on rotas so that e.g. what is promised to the service user for next day is achieved	• 1A Quality of life • 1B Control • 3A Satisfaction	• 2 Continuity • 7 Quality of life
	• Service user ↔ agency ↔ carer (↔ service user**), for communication of e.g. o notice if carer will be late o staff changes o service user will be late o service user doesn't want / need call * It may not be efficient for service users to have	• 1A Quality of life • 1B Control • 4A Safeguarding • 4B Safeguarding	• 3 Choice, control, dignity • 10 Safeguarding • 7 Quality of life

	direct contact with carers, if this is so it should be explained to them why.		
	Out of hours emergency contact number information	• 4A Safeguarding • 4B Safeguarding	• 10 Safeguarding
	Various communication methods offered to clients - text /email /phone /letters	• 1B Control	• 3 Choice, control, dignity
	Standard of English	• 1B Control • 3A Satisfaction	• 3 Choice, control, dignity • 4 Independence
Good Management Systems	Adequate office resources and robust management of staff: • Absenteeism • Lateness / no arrival • Key worker system	• 1A Quality of life • 4A Safeguarding • 4B Safeguarding	• 4 Independence • 7 Quality of life • 10 Safeguarding
	Working conditions retain staff	• 3A Satisfaction	• 2 Continuity
	Timely communications including billing	• 1B Control	• 3 Choice, control, dignity
	Realistically timed rotas (to allow for travel time and enable care to be given at service user pace) provided to service users weekly, with name of carers	• 1B Control • 1I Social Contact	• 3 Choice, control, dignity • 4 Independence • 5 Daily living activities • 6 Social involvement
	Diversity of staff to match appropriately to service users needs.	• 1A Quality of life • 3E Dignity	• 3 Choice, control, dignity • 7 Quality of life
	Outcome focused Care Plans to include: • social & domestic needs and flexibility within those needs • emergency care	• 1A Quality of life	• 3 Choice, control, dignity • 4 Independence • 5 Daily living activities • 10 Safeguarding
	Carers knows individuals Care Plans before starting to work with them	• 1A Quality of life1B Control • 3E Dignity4A Safeguarding • 4B Safeguarding	• 3 Choice, control, dignity • 7 Quality of life • 10 Safeguarding
	Service users involved in choosing carer	• 1B Control • 3E Dignity	• 3 Choice, control, dignity
Well Trained: • Office and Care Staff	• Dignity of service user • Staff attitude • Equality & diversity (inc. possible conditions of service user) • Sensory Impairment Awareness • Communication skills e.g. reflective listening • Organisation's induction to include communication systems & use of ID	• 1A Quality of life3E Dignity4A Safeguarding • 4B Safeguarding	• 3 Choice, control, dignity • 10 Safeguarding
• Care Staff	• Life skills • Food hygiene & nutrition • Personal care & equipment use • Medications & infection control • First Aid	• 1A Quality of life • 3E Dignity	• 3 Choice, control, dignity • 4 Independence • 7 Quality of life • 9 Health

All of the key requirements will potentially affect Outcome 1, 8 and 11 of the NICE Guidelines, namely:

- 1) Service user and carer satisfaction
- 8) Service users', and their families and carers', experience of home care
- 11) Economic outcomes (including resource use and impact on other services)

There were three issues that service users listed that are outside of the realms of the Service Specifications. Namely:

- supported living and domiciliary care funding should be under one umbrella to allow for more flexibility in care provision;
- combining the councils and care agencies complaints procedures; and
- the councils contract monitoring systems

❖ Appendix 1 Adult Social Care Outcomes Framework (ASCOF) 2014/15

Table 1. ASCOF 20914/15: at a glance

ASCOF Ref	Indicators
1	Enhancing quality of life for people with care and support needs
	Overarching measure
1A	Social care-related quality of life** (NHSOF")
	Outcome measures
	People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs.
1B	Proportion of people who use services who have control over their daily life
1C	**New definition for 2014/15:** Proportion of people using social care who receive self-directed support, and those receiving direct payments
	Carers can balance their caring roles and maintain their desired quality of life
1D	Carer-reported quality of life** (NHSOF2.4)
	People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation
1E	Proportion of adults with Learning disabilities in paid employment** (PHOF 1.8, NHSOF 2.2)
1F	Proportion of adults in contact with secondary mental health services in paid employment** (PHOF 1.8, NHSOF 2.5)
1G	Proportion of adults with Learning disabilities who live in their own home or with their family* (PHOF 1.6)
1H	Proportion of adults in contact with secondary mental health services living independently, with or without support* (PHOF 1.6)
1I	Proportion of people who use services and their carers, who reported that they had as much social contact as they would like* (PHOF1.18)
2	Delaying and reducing the need for care and support
	Overarching measure
2A	Permanent admissions to residential and nursing care homes, per 100,000 population
	Outcome measure
	Everyone has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.
	Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.
2B	Proportion of Older people (65 and over) who were still at home 91 days after discharge from hospital into reablement and rehabilitation services* (NHSOF 3.6i + ii)
2D	**New measure for 2014/15** The outcomes of short-term services: sequel to service.
Placeholder 2E	The effectiveness of reablement services
	When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence.
2C	Delayed transfers of care from hospital, and those which are attributable to social care.
Placeholder 2F	Dementia - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** (NHSOF 2.6ii)

3	Ensuring that people have a positive experience of care and support
	Overarching measure
	People who use social care and their carers are satisfied with their experience of care and support services.
3A	Overall satisfaction of people who use services with their care and support
3B	Overall satisfaction of carers with social services
3E	Improving people's experience of integrated care** (NHSOF 4.9)
	Outcome measure
	Carers feel that they are respected as equal partners throughout the care process
3C	Proportion of carers who report that they have been included or consulted in discussion about the person they care for
	People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.
3D	Proportion of people who use services who find it easy to find information about services
	People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.
	This information can be taken from the Adult Social Care Survey and used for analysis at the local level.
4	Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm
	Overarching measure
4A	Proportion of people who use services who feel safe** (PHOF 1.19)
	Outcome measure
	Everyone enjoys physical safety and feels secure. **People are free from physical and emotional abuse, harassment, neglect and self-harm.** **People are protected as far as possible from avoidable harm, disease and injuries.** **People are supported to plan ahead and have the freedom to manage risks the way that they wish.**
4B	Proportion of people who use services who say that those services have made them feel safe and secure
Placeholder 4C	Proportion of completed safeguarding referrals where people report they feel safe

* Indicator shared: the same indicator is included in another outcomes framework, reflecting a shared role in making progress.
** Indicator complementary: a similar indicator is included in another outcomes framework and these look at the same issue.
Placeholder = a measurement that is being developed.

Outcomes relevant to the key requirements requested by stakeholders as detailed in Table 1. Key Requirements for a Quality Domiciliary Care Service and their Relationship to the Outcomes in ASCOF 2014/15 and NICE Home Care Guidance 2014

❖ Appendix 2 National Institute for Health and Care Excellence (NICE) Home Care Guidance 2014

The NICE 2014 Guidance for Home Care's main outcomes are:

1) service user and carer satisfaction
2) quality and continuity of care
3) choice, control and dignity for service users
4) ability to maximise and maintain independent living at home
5) ability to carry out activities of daily living
6) social involvement, isolation and loneliness
7) service user quality of life outcomes (both health and social care-related)
8) service users', and their families and carers', experience of home care
9) health-related outcomes
10) safety and adverse events
11) economic outcomes (including resource use and impact on other services)

Outcomes relevant to the key requirements requested by stakeholders as detailed in Table 1. Key Requirements for a Quality Domiciliary Care Service and their Relationship to the Outcomes in ASCOF 2014/15 and NICE Home Care Guidance 2014

❖ Appendix 3 Service User Focus Groups and Reports Analysis

Table 1. Domiciliary Care Stakeholder* Engagement 2014 - What Makes a Good Service

Communication / Attitude	Time	Functional	Competencies	Domiciliary Management
Polite & friendly with no moaning at the cared for person	Punctual: especially when cared for has appointments	Domestic help needed to keep house hygienic	Equalities e.g. knowledge of the key needs of care groups / religions / cultures	Care Plan understood by all: cared for; carer; & agency
Being helpful, doing little jobs even if not on Care Plan e.g. tidy towels up after a bath, doing up zips & buttons	Flexible to suit needs e.g. getting up, going to bed, going out	Help with social activities: going out, meeting friends, going on holiday	Knowledge of life skills so can teach cared for to enable independence e.g. catching a bus, cooking, finance	Matched to cared for person: especially for personal care consider appropriate age and/or gender
Domiciliary Carer and Supported Living Carer communicate so nothing is missed out	Reliable	Help with shopping	Food hygiene & nutrition	Where possible communicate with cared for person directly not through carer
Trustworthy	Adequate time for tasks		Sensory impairment awareness: single and dual diagnosis	Continuity of carers, particularly important for personal care
Treated with dignity	Flexible what time they call		Medication	Transparent, honest & trustworthy
Requests / instructions listened to and acted upon appropriately			Personal care	Able to request carer not to come
Flexible in tasks			Able to sign Makaton	Weekly carers rota to cared for
			Infection control	Choice in carer
				Notice of when carer on annual leave
				Adequate staff to cover sickness etc

Key

Most important

* Spectrum, Buzz Network, Continuing Healthcare, Sembal House, Manston Court Memory Cafe, Padwell Rd Day Centre, Headway, Freemantle and Woolston Community Centre Learning Disabilities Groups; Busy People, SCC Complaints for domiciliary care, SCC Sensory Services Team - covering the following care groups: physical disabilities; mental health; children; continuing healthcare; dementia; older people; acquired brain injury; learning disabilities

Table 2. Domiciliary Care Stakeholder* Engagement 2014 - What Makes a Bad Service

Communication / Attitude	Time	Functional	Competencies	Domiciliary Management
Inappropriate communication: rude; angry; bullying	Carers not turning up - can be a safeguarding issue e.g. if miss medication	Not having enough carers to be able to do emergency tasks e.g. pick cared for person up from the floor when they fall	Signs of stroke: signs have been mistaken for e.g. tiredness and therefore carer left home without calling emergency services	Bad communication inc. forwarding information to carers. Should be able to contact carers directly to e.g. say you'll be home late
Cared for not being listened to	15 minutes isn't enough time for e.g. elderly: get to go to loo or have a meal but not both		No training in treating with dignity	Requests e.g. not to have a particular carer/gender specific carer, are not logged
Poor communication	Lateness - very disruptive to life	Carers should report 'house' things to the office e.g. no curtains, broken fridge	Don't prompt to take meds	Staff leaving too often
Not trustworthy	Travel time not accounted for, so carers either late or leave early		No catheter training	Inappropriate age / gender of carer for personal care
Don't always double lock the door when leaving	Too much clock watching / being rushed by carers		Can't use stair lift	No information given when carers don't turn up
Disrespectful e.g. taking chocolates without asking, not knocking to enter house, moving things around without asking	No flexibility		Doesn't know there are different stages/degrees of dementia - I know how to eat, don't need to be fed	Don't send bills in a timely way - let it build up until very expensive
If it's not written on the Care Plan the carer won't help with a task	Not sticking to timetables and keeping cared for informed of changes		Carer doesn't understand my disability	Supervision of visits: carers writing in log book on e.g. Tuesday they visited on e.g. Monday
Doing their own thing when should be looking after cared for person				Changing carers / times - particularly at short notice & with no consultation
Some carers can't speak understandable English				Cared for not on any carers 'list of calls' for a particular day/s
Carers don't really care about the job				No emergency contact outside of 9-5
				Carers don't always wear ID
				Carer and cared for rotas aren't always the same

				Bed times not appropriate e.g. in plan, because carer late
				Inconsistent care: one carer says 'nice bit of fish tomorrow' then next carer can't cook - no fish!
				Would like changes to be sent by text / email
				No staff to cover for sickness etc

Key

Most important

* Spectrum, Buzz Network, Continuing Healthcare, Sembal House, Manston Court Memory Cafe, Padwell Rd Day Centre, Headway, Freemantle and Woolston Community Centre Learning Disabilities Groups; Busy People, SCC Complaints for domiciliary care, SCC Sensory Services Team - covering the following care groups: physical disabilities; mental health; children; continuing healthcare; dementia; older people; acquired brain injury; learning disabilities

Table 3. Domiciliary Care Stakeholder* Engagement 2014 - What Should Change

Communication / Attitude	Time	Functional	Competencies	Domiciliary Management
Friendly, polite	Travel time accounted for	Flexible in practical support to account for cared for persons changing needs	A good training programme to include all things on 'like' and 'dislike' lists	Cared for on interview panel / can choose carers / specify characteristics (age, gender etc)
Flexible when they come and what they do	Keep to agreed times	Supported Living and Domiciliary Care funding under one umbrella - more flexible	Required standard of English for communication purposes	Check attitude when interviewing - do they really want to work in the care industry / are they suitable?
See cared for as a person and not defined by their disability / age etc	Realistic time for care, taking into consideration the individual age / disability etc.	Council to be included in Complaints Procedure - so one point of call for complaints	Continuing professional development to keep up to date with issues / law etc	Person centred Care Plan that is outcome focused (rather than task focused) and flexible e.g. will enable cared for to try different activities
		Council to monitor agency regularly	Office staff should be trained so they understand cared for persons views	Have good communication system and ensure everyone is trained and adheres to it
				Have a key worker system
				Be friendly and approachable
				Consistent carers, particularly for people with dementia
				Carers need decent pay
				Carers should have time to read and understand the Care Plan before the first visit - including what to do in a crisis for THAT person
				Itemised billing

Key

Most important

* Spectrum, Buzz Network, Continuing Healthcare, Sembal House, Manston Court Memory Cafe, Padwell Rd Day Centre, Headway, Freemantle and Woolston Community Centre Learning Disabilities Groups; Busy People, SCC Complaints for domiciliary care, SCC Sensory Services Team - covering the following care groups: physical disabilities; mental health; children; continuing healthcare; dementia; older people; acquired brain injury; learning disabilities

❖ Appendix 4 Adult Social Care Survey 2014

The following are answers to the questions within the Adult Social Care Survey 2014 that relates to domiciliary care services.

Q1) regarding overall satisfaction with the domiciliary care service provided.

ASCS 2014 Domiciliary Care Respondents Question 1

Number of responses	Satisfaction	% of responses
43	I am extremely satisfied	29.9
46	I am very satisfied	31.9
37	I am quite satisfied	25.7
10	I am neither satisfied nor dissatisfied	6.9
4	I am quite dissatisfied	2.8
3	I am very dissatisfied	2.1
1	I am extremely dissatisfied	0.7
Total 144		100.0

Q22) If your current services better meet your needs compared with a year ago, how do they better meet your needs? Domiciliary Care Recipients Only

Comment
From 7.30am til 10pm, support workers on site. I am able to call them if I need further support. This includes during the night when staff sleep in a separate flat.
I now get help with my housework
I have my own cleaner. Comes in once weekly for 2 hours. I pay for 1 time.
The main reason is I have regular young ladies that are quite reliable, before I really never knew who was coming in
After a fall and also my arthritis has got much worse, the morning carer does more for me
I can go to bed and get up when I like
Increase of time
I do not get any help from services. DO NOT send MEN to wash me. I can wash myself
Can visit the community more, more finances to do things

Question 23) If your current services do not meet your need as well as they did last year, why? Domiciliary Care Recipients Only

Comment
Last year I could get [care?] at a time I wanted to
Not enough [carer] time
In general terms, the care agency have not catered adequately for my needs since I have moved to this address
It is very seldom when I can do some domestic work that our flat is required. Moreover at the moment I even am able to go out and leave my child at school. I need help in this area. [ACTIONED by MIT]
I would like a key worker from Social Services. I would like more hours for support. Help with day to day goals in life.

Question 24) If there was one thing we could do to improve the services you currently receive, what would that be? Domiciliary Care Recipients Only

Comment
I would like extra time and more mileage [ACTIONED by MIT]
Carers to complete tasks outlined in the care plan
Not to pay for carers that do not come to me and to have all the time I pay for
My mother does enjoy a regular carer who knows and can sense when she's not right. I know its difficult

to get a regular carer but the ones who are regular to my mother it's a good thing. When I'm not there I know she is being treated with care and respect. Especially tea or lunch time when mum says she doesn't want any food the regular carer will make her a sandwich which she will probably eat on her own. I know it's difficult to get a regular carer but it helps not saying a stranger will be any less caring but it gets along her confidence [??]
Choose carers that are very suited, listen to requests, [name of carer] are in tune with us. We do need regular times, carers not to ask [client] if she needs commode, she will sometimes say 'No' when she does, not to put too much on her plate such as bread, biscuits, cake, little [??]. Make sure she has wash at night also, 4.30 is too early to get her ready for bed. Remove gloves when preparing food, have discussed this with [care manager?] she has agreed to do this.
I would prefer the carers to arrive at set times
Better care agency office consideration and more consistent evening care
Turning up at a regular time
Your staff to have 4 x 4 when it snows!
It would be better if the carers (who come twice a day) could stay longer than 10 minutes and could then have a chat with me
More [carer] time; carers coming at times agreed not hours earlier; carers not rushing in and then say 'I don't have much time'; carers wiping kitchen surfaces after food preparation; washing dishes
Someone to take me out [ACTIONED by MIT]
That carers arrived at the same time each morning, rather than staff time changing when the carer changes
As the carer for my wife [named] I am only aware of the services now provided – I find these very good and much appreciated
Having regular people to attend me
To be more informed with other people needs to be stimulated
Stop being so patronising make sure you know what to do before entering house get to know the person don't just be there because it is my job!!!
Never told about anything, left in dark all the time about any help – no organisation helps or tries to, have to fight for everything then don't get it. The services / medical help is useless and never turn up everything is a battle for my family
I would like my support workers to be able to take me on holiday
More contact from Social Services.
I want to learn to read and write. I struggle with numbers. I want to learn to cook
Remind me to put prescription in on time before [I] run out of medication
[name of provider] could improve – not sure what, staff are good

Q25) If you answered that you felt unsafe in question 7a on page 9 what is it that makes you feel unsafe? Add as many issues as you want. Domiciliary Care Recipients Only

Comment
I don't breathe very well so I have to keep stopping to get my breath as I can't walk very far. Feel unsafe getting in bath. To bath or shower so I don't have one [ACTIONED by MIT]
My mobility makes me feel unsafe because I am afraid of falling
I can only get around with the help of my walker. Also getting out of chair
My mobility makes me feel unsafe
When I am alone I have to be very slow and careful to avoid falling, but I wear an Age Concern Personal Alarm to use if and when I fall
Would like to attend a day centre
Falling
Unable to walk properly. COPD. Loss of balance
Epilepsy seizures, dizziness, depression, high blood pressure
Fear of falling inside or outside of flat

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