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Health and Wellbeing Board

Wednesday, 26th July, 2017 at 5.30 pm

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Lewzey
Councillor Payne
Councillor Paffey
Councillor Shields
Councillor Taggart

Rob Kurn – Healthwatch
Hilary Brooks – Interim Service Director, Children and Families Services
Carole Binns – Designated Director Adult Services
Dr J Horsley – Acting Director of Public Health
Dr S Robinson – Clinical Commissioning Group
NHS England Wessex Local Area Team

Contacts

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Senior Democratic Support Officer
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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Responsibilities

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

Smoking policy – The Council operates a no-smoking policy in all civic buildings.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent livesSouthampton is an attractive modern City, where people are proud to live and work

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

Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

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. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public. Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.

Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Dates of Meetings: Municipal Year 2017/18

2017	2018
28th June	17th January
26 July	14 March
18 October	4 April

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED

Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / PUBLIC REPRESENTATIONS

At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

RULES OF PROCEDURE

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

QUORUM

The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

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 ELECTION OF CHAIR

To elect a Chair to the Health and Wellbeing Board for the 2017-2018 Municipal Year.

2 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Board made in accordance with Council Procedure Rule 4.3.

3 ELECTION OF VICE-CHAIR

To elect a Vice-Chair to the Health and Wellbeing Board for the 2017-2018 Municipal Year.

4 STATEMENT FROM THE CHAIR

5 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.

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 28th June 2017 and to deal with any matters arising, attached.

7 PHARMACY CONSOLIDATION APPLICATION PROCEDURE

Report of the Director of Public Health seeking approval of the procedure for responding to Pharmacy Consolidation Applications, attached.

8 BETTER CARE SOUTHAMPTON PLAN 2017/19

Report of the Director of Quality and Integrated Commissioning detailing the draft Better Care Southampton Plan for 2017/19 and seeking agreement for the arrangements for approving the final version, attached.

9 ACCEPTANCE OF ADULT SOCIAL CARE GRANT

Report of the Service Director; Adults, Housing and Communities seeking ratification of proposals for schemes to be funded by the Adult Social Care grant 2017/18, attached.

10 SHARED COMMISSIONING BETWEEN SOUTHAMPTON CITY COUNCIL AND SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP

Report of the Director of Quality and Integration, providing the Health and Wellbeing Board with the report considered by Cabinet 18th July relating to further integration between Health and Social Care in the City, attached.

Tuesday, 18 July 2017 Service Director, Legal and Governance

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 28 JUNE 2017

Present: Councillors Lewzey, Payne, Taggart and Shields (Chair)
Dr Sue Robinson, Rob Kurn, Carole Binns and Jason Horsley

Apologies: Councillors Dr Paffey and Hilary Brooks

1. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Shields declared a personal interest in that he was a Council appointed representative of the Clinical Commissioning Group and remained in the meeting and took part in the consideration and determinations of items on the agenda.

Councillor Lewzey declared a personal interest in that he was a Council appointed representative of Southern Health NHS Foundation Trust and remained in the meeting and took part in the consideration and determinations of items on the agenda.

Councillor Payne declared a personal interest in that he was a Council appointed representative of Solent NHS Trust and remained in the meeting and took part in the consideration and determinations of items on the agenda.

2. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes of the meeting held on 29th March 2017 be approved and signed as a correct record subject to Dr Robinson's declaration of personal interest being amended to reflect it was the Clinical Commissioning Group "Governing Body" and not "Governance Board".

3. **DRUGS STRATEGY 2017/2020**

The Board received and noted the report of the Director of Public Health providing an update on the Drugs Strategy 2017- 2020 which had been approved by the Safe City Partnership. The Board particularly noted the progress that had been made in developing the strategy to date along with the proposals for implementation.

4. **OLDER PEOPLE'S OFFER**

The Board received and noted the report of the Director of Quality and Integration detailing proposals to review support and activity that promoted health and independence for older people. It was noted that proposals for an Older Persons Offer would change the way the Council provided day care for older people in the future, proposals had been developed with engagement from community groups, organisations

and services. Next steps would include engagement with current service users, their carers and staff on the proposed model.

5. **SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE**

The Board received and noted the report of the Chief Officer, Southampton Clinical Commissioning Group providing an update on the Sustainability and Transformation Plan. It was noted that the plan outlined key programmes of work over the next two years to deliver the ambitions set out in the Hampshire and Isle of Wight STP plan in addition to local priorities specific to Southampton.

6. **COMBATING LONELINESS IN SOUTHAMPTON UPDATE**

The Board received and noted the report of the Director of Quality and Integration providing an update on the work taking place to combat social isolation and loneliness in the City and the recommendations for moving forward that had been agreed by Cabinet at their meeting on 20th June 2017.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PROCEDURE FOR RESPONSE TO PHARMACY CONSOLIDATION APPLICATION		
DATE OF DECISION:		26th July 2017		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	Name:	Claire Currie and Amy McCullough	Tel:	023 8083 3694
	E-mail:	claire.currie@portsmouthcc.gov.uk amy.mccullough@southampton.gov.uk		
Director	Name:	Dr Jason Horsley	Tel:	023 8083 3818
	E-mail:	jason.horsley@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY
Since 5th December 2016, the Health and Wellbeing Board ('H&WB') has a statutory duty to make a representation to NHS England on consolidation applications of community pharmacies in its area (i.e. where pharmacy businesses on two or more sites propose to consolidate to a single existing site). The H&WB must respond within 45 days.
This briefing presents the proposed process for formulating a response to a consolidation application of community pharmacies as this may fall outside of the usual schedule of H&WB meetings.

RECOMMENDATIONS:		
	(i)	To delegate authority to the Director of Public Health, following consultation with the Chair of the Health and Wellbeing Board and Ward Members to determine and make representations to NHS England on any pharmacy consolidation application which, at their discretion, is felt to be a non-contentious application.
	(ii)	Where applications for pharmacy consolidation are deemed, at the discretion of the director of Public Health and the Chair of the Health & Wellbeing Board, to be contentious to delegate authority to the Director of Public Health following consultation with the Chair of the Health and Wellbeing Board, the Cabinet Member for Health & Sustainable Living, Ward Members and at least 2 other Members of the Health & Wellbeing Board comprising a representative of the Council and a representative of the CCG to determine and make representations to NHS England on any pharmacy consolidation application deemed to be contentious.

REASONS FOR REPORT RECOMMENDATIONS	
1.	**As specified by the regulations, the H&WB is asked to provide its opinion on whether, if the application were granted, the proposed removal of premises from the pharmaceutical list would or would not create a gap in pharmaceutical services that could be met by a routine application** **(a) to meet a current or future need for pharmaceutical services, or** **(b) to secure improvements, or better access, to pharmaceutical services.**
2.	**The H&WB must respond to NHS England within 45 days of being notified of a pharmacy consolidation application. This may fall outside of the usual schedule of Health and Wellbeing Board meetings. In order to meet the statutory deadlines required for a response to be submitted, the functions of the H&WBB are required to be delegated.**
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
3.	**An extraordinary meeting of the H&WB is scheduled to discuss and approve a response to a consolidation application (unless a scheduled date coincides with the required timescale).**
4.	**This is not recommended as extraordinary meetings should be reserved for exceptional purposes and are costly and difficult to manage within the timescales to ensure a quorum of members may be available to meet. It is not possible to forecast the number of pharmacy consolidations that Southampton City Council H&WB might be required to consider.**
DETAIL (Including consultation carried out)	
Where the Director of Public Health, in consultation with the Chair of the H&WB, believe the application not to be contentious:	
5.	**It is proposed that the Director of Public Health, following consultation with key members of the Board (more board members for more contentious applications) and ward members, is given delegated authority for making a decision on whether a proposed consolidation is likely to create a gap in pharmaceutical services that could be met by a routine application.**
6.	**This will be based upon information provided in the application and, where considered useful, spatial analysis undertaken by the Southampton City Council Intelligence and Strategic Analysis team to support identification of gaps in pharmaceutical provision.**
7.	**The ward members whose wards are impacted by the application will be consulted to inform the decision. The Chair of the Health Overview and Scrutiny Panel will also be informed that the proposed consolidation has been notified to the H&WB and of the final response.** **The Director of Public Health will be responsible for co-ordinating the response to NHS England.**
Where the Director of Public Health, following consultation with the Chair of the H&WB believes the application to potentially be contentious:	
8.	**It is proposed that the Director of Public Health will be responsible for electronically circulating relevant information, within 14 calendar days**

	of notification of the application, to: - **The Cabinet Member for Health & Sustainable Living** - **Relevant ward members** - **NHS Southampton City Clinical Commissioning Group** - **Public Health team, SCC** - **Planning Policy team, SCC** - **Chair of the Health Overview and Scrutiny Panel, SCC** - **Healthwatch Southampton** - **Other H&WB members as set out in recommendation (ii) above**
9.	**Information circulated will include that contained in the application and, where considered useful, spatial analysis undertaken by the Southampton City Council Intelligence and Strategic Analysis team to support identification of gaps in pharmaceutical provision together with the relevant Equality Impact Assessments.**
10.	**Those to whom the information is circulated will be invited to feedback on the proposed consolidation within 14 calendar days of the information being circulated.**
11.	**If a clear response cannot be easily identified and agreed electronically, the above group will be invited to meet for further discussion.** **The Director of Public Health will be responsible for co-ordinating the response to NHS England.**
12.	**As part of this process, all those consulted will be required to highlight any potential conflicts of interest which may arise in response to an application.**
13.	**NHS England will consider all representations that are received and will arrange an oral hearing to determine the application if a matter is identified on which further evidence is needed.**
RESOURCE IMPLICATIONS	
Capital/Revenue	
14.	None
Property/Other	
15.	**None**
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
16.	**The NHS (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016 requires the H&WB to make representations on consolidation applications to NHS England. This amendment came into effect on 5th December 2016. Under the Terms of Reference of the H&WB, the board may delegate authority to an Officer of the Council in relation to any of the functions set out in s.196(2) of the Health & Social Care Act 2006. Such functions relate to the preparation and amendment of any strategic assessment of need relating to the partnering functions between the Local Authority and health bodies and will be deemed to include making representations on assessment of need in relation to pharmacy provisions within the Local Authority area and the extent to which an application for consolidation meets or fails to**

	meet the strategic assessment of need for the area.
<u>Other Legal Implications</u>:	
17.	**Any exercise of any delegation under these proposals will also require an Equality Impact assessment to be carried out in relation to the proposals to help inform the direct impact on strategic need in the area in accordance with the public sector equalities duties set out in the Equalities Act 2010.**
RISK MANAGEMENT IMPLICATIONS	
18.	**None**
POLICY FRAMEWORK IMPLICATIONS	
19.	**The proposals fully accord with the provisions of the Council's Policy Framework.**

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**

<u>SUPPORTING DOCUMENTATION</u>

Appendices

1.	**None**

Documents In Members' Rooms

1.	**None**

Equality Impact Assessment

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

Privacy Impact Assessment

Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**

Other Background Documents
Other Background documents available for inspection at:

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

DECISION-MAKER:		Health and Wellbeing Board		
SUBJECT:		2017 - 19 Better Care Plan		
DATE OF DECISION:		26 July 2017		
REPORT OF:		Director of Quality and Integrated Commissioning		
CONTACT DETAILS				
AUTHOR:	Name:	Donna Chapman	Tel:	023 80 296004
	E-mail:	Donna.chapman@southampton.gov.uk		
Director	Name:	Stephanie Ramsey	Tel:	023 80 296941
	E-mail:	Stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY
Not applicable
BRIEF SUMMARY
The Health and Wellbeing Board is asked to consider the draft Better Care Southampton Plan for 2017/19 and agree arrangements for approving the final version by the deadline of 11 September 2017.
National guidance stipulates that the Better Care Plan should be approved by the relevant Health and Wellbeing Board (HWBB) and by the constituent Local Authorities (LAs) and Clinical Commissioning Groups (CCGs) prior to submission.

RECOMMENDATIONS:		
	(i)	To receive and consider the draft Better Care Southampton Plan for 2017-19, particularly noting the priorities and performance targets.
	(ii)	To agree arrangements for approving the final version of the plan by the national submission deadline of 11 September 2017.

REASONS FOR REPORT RECOMMENDATIONS	
1.	Further to the Integration and Better Care National Policy Framework published on 31 March 2017, the Integration and Better Care Fund planning guidance 2017-19 was published on 4 July 2017 by DH and DCLG. The guidance reinforces that the Better Care Fund provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from CCG allocations, the Disabled Facilities Grant (DFG) and funding paid directly to the Local Government for adult social care services - the improved Better Care Fund (iBCF).
2.	BCF plans must set out how CCGs and local authorities are working towards fuller integration and better co-ordinated care, including how the work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View, the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area covered by the plan.
3.	The guidance sets out the requirement for Local Authorities working with their CCG partners to develop a local Better Care Plan for the two-year period 2017-2019. This must be signed off by the local HWBB.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
4.	**Not applicable. Submission of a Better Care Plan and establishment of a pooled fund is a national requirement.**
DETAIL (Including consultation carried out)	
5.	The key changes in the 2017-19 guidance are that Better Care Plans will now be for a two year period and that the number of national conditions has been reduced from eight to four: • That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWBB, and by the constituent LAs and CCGs; • A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation; • That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and • All areas to implement the High Impact Change Model for Managing Transfers of Care to support system-wide improvements in delayed transfers of care (DTOC).
6.	The 2017-19 guidance places a much greater emphasis on reducing delayed transfers of care (DTOC) than in previous years. The Government has announced a package of measures to address DTOC across the health and social care system. This package includes: • A dashboard showing how areas are performing against a range of metrics across the NHS-social care interface; • Targeted CQC reviews to examine performance in the areas with the worst outcomes across these metrics, with a view to supporting them to improve (Southampton is not part of the first tranche of twelve; but a further tranche of eight will be announced later in the year); • Considering a review, in November, of 2018-19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. Guidance on implementing a Trusted Assessor model.
7.	The NHS England Mandate for 2017-18 sets a target for reducing DTOC nationally (both health and social care attributable delays) to 3.5% of occupied bed days by September 2017. This equates to the NHS and Local Government working together so that, at a national level, delayed transfers of care are no more than 9.4 in every 100,000 adults (i.e. equivalent to a DToC rate of 3.5%). Currently Southampton is at 21.3 per 100,000 adults (based on Feb 2017 - April 2017 data – both NHS and Adult Social Care attributable delays). Its expected level is 11.1 per 100,000 adults.
8.	The BCF submission will consist of: • a narrative plan, including a description of how the national conditions will be met.

	the BCF Planning Return, which will include funding contributions, a scheme-level spending plan, national metric plans.
9.	Plans will be regionally assured and then graded as either approved, not approved, or approved with conditions. Approval will be dependent on: • Meeting all national conditions; • Having an agreed spending plan for the IBCF grant; • Having a vision and progress towards fuller integration of health and social care by 2020; and Having in place a robust approach to managing risk.
10.	Southampton's draft Better Care Plan 2017-19 has been developed prior to receiving the planning guidance in line with the Integration and Better Care Fund Policy Framework and draft versions of the guidance published earlier in the year. It also builds on the progress made against previous Better Care plans and performance to date and it incorporates the priorities identified (as shared with Members) for the iBCF Social Care allocation. Further revisions will be made over the Summer in response to the publication of the final guidance, in particular strengthening references to the wider national and local policy context (e.g. NHS Five Year Forward View, STPs, Care Act) and tightening up the approach to performance and risk management.
11.	The six key priorities remain the same as for 2016/17 but with a reassessment of the focus for each of the two years 17/18 and 18/19: • Rolling out the integration agenda across the full life-course. • A strong focus on prevention and early intervention • A radical shift in the balance of care away from bed based provisions and into the community • Significant growth in the community and voluntary sector • Development of new models of care which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies • New contractual and commissioning models which enable and incentivise the new ways of working
12.	Performance targets have been proposed for each of the key metrics for 2017/18 and 2018/19 based on current performance, historical trends and benchmarking. HWBB are asked to consider the level of ambition to ensure that it is both stretching but realistic.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
13.	**The following table sets out the total estimated value of the BCF pooled fund for 2017 - 19.** ***It should be noted that these figures are draft and still being worked on*.**

Scheme	CCG £000	SCC £000	Total £000
Carers	**1,240**	**134**	**1,374**

	Clusters	47,026	2,212	49,238
	Rehab & Reablement	10,543	4,551	15,094
	DFG (Capital)		1,882	1,882
	Joint Equipment Store	798	803	1,601
	Telecare		250	250
	Direct Payments		500	500
	Long Term Care		2,750	2,750
	Integrated Care Teams – LD	9,894	16,414	26,308
	Prevention & Early Intervention		6,199	6,199
	Total	69,501	35,695	105,196

Property/Other

14.	Not applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15.	The legal framework for the BCF pooled fund derives from the amended NHS Act 2006 (s. 223GA), which requires that in each area the CCG(s) transfer minimum allocations (as set out in the Mandate) into one or more pooled budgets, established under Section 75 of that Act, and that approval of plans for the use of that funding may be subject to conditions set by NHS England. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.

Other Legal Implications:

16.	Not applicable

RISK MANAGEMENT IMPLICATIONS

17.	Not applicable

POLICY FRAMEWORK IMPLICATIONS

18.	Not applicable

KEY DECISION?	**Yes/No**
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION

Appendices

1.	**Draft Better Care Plan 2017-19**

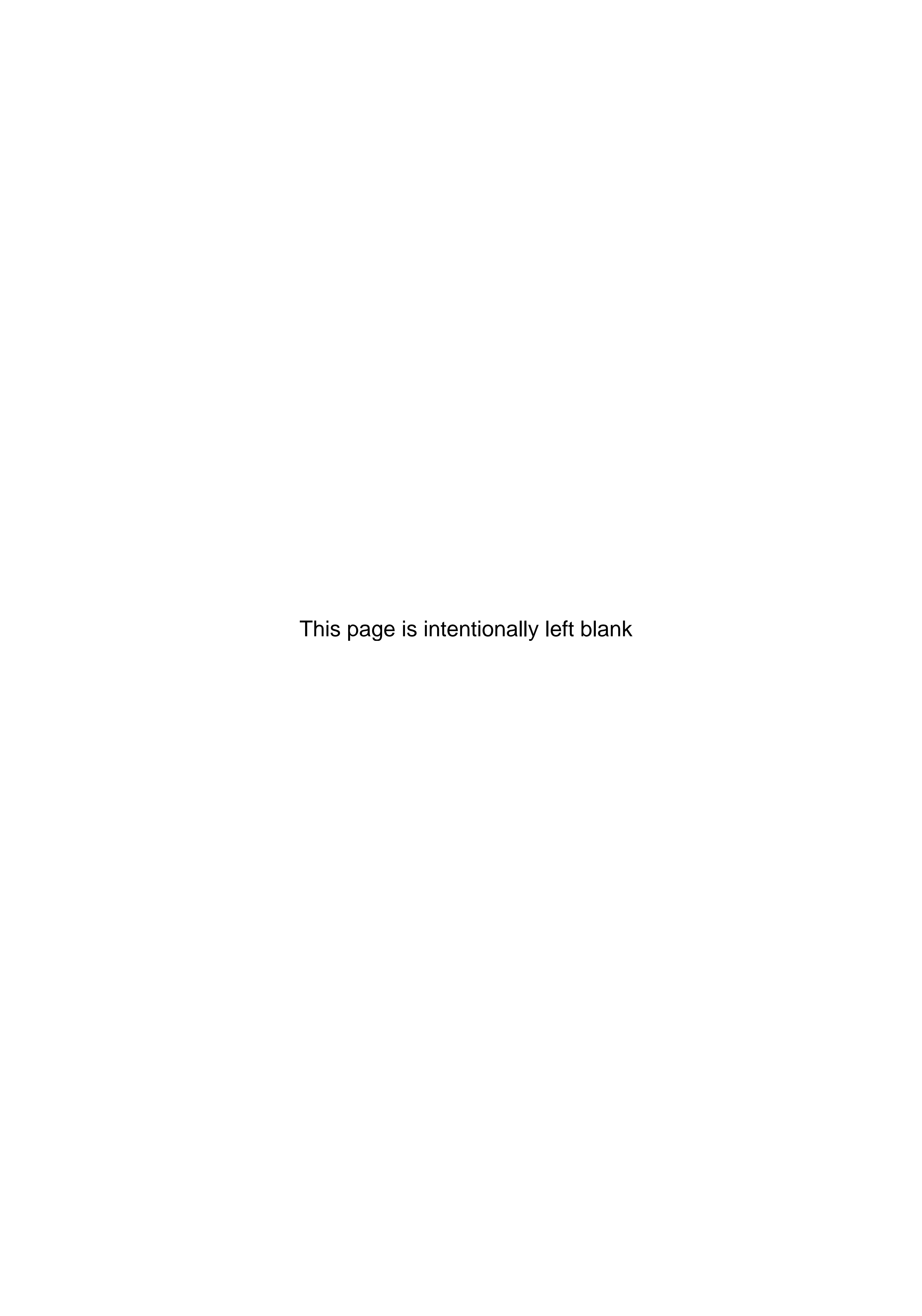
Documents In Members' Rooms

1.	**None**

Equality Impact Assessment

Do the implications/subject of the report require an Equality and	**Yes/No**

Safety Impact Assessment (ESIA) to be carried out.		
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		**Yes/No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	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NHS
Southampton City
Clinical Commissioning Group

DRAFT SOUTHAMPTON CITY BETTER CARE PLAN 2017 - 19

June 2017

1. Introduction and Strategic Context

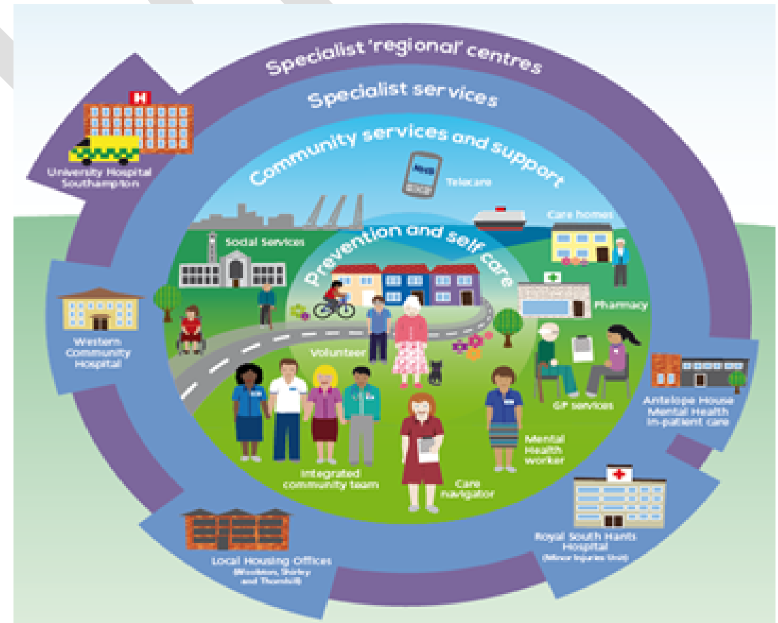
1.1 This report sets out Southampton City's plans for Better Care for the next two years. It builds on the scale of ambition and significant progress outlined in previous plans and sets out a programme of activities aimed at achieving the next steps in Southampton's journey towards total integration.

1.2 To support this direction of travel, the city has embarked on two underpinning programmes of work during 2016/17: the development of integrated provision driven by collaboration between providers and exploring an enhanced model of integrated commissioning between the Council and CCG which will build on its current integrated commissioning arrangements.

2. Vision and Strategy

"Southampton is our city where everyone thrives; we build on the strengths of our communities and our services are joined up around individuals"

2.1 The vision we share for health and care in the city has evolved out of strong and inclusive partnerships between commissioners, providers, communities and citizens, built painstakingly over a number of years. It is fundamentally simple and compelling, being based on the notion of Better Care that is joined up and co-produced with people, respecting their independence as individuals and drawing strength from the resourcefulness of communities.



2.2 Person centred care will be at the heart of everything we do. This means:

- Putting **individuals and families at the centre of their care and support**, meeting needs in a holistic way
- Providing the **right care, in the right place, at the right time**, and enabling individuals and families to be independent and self resilient wherever possible.
- Making **optimum use of the health and care resources** available in the community
- **Intervening earlier** and building resilience in order to secure better outcomes by providing more coordinated, proactive services.
- **Focusing on prevention and early intervention** to support people to retain and regain their independence

2.3 With the development of Southampton as a "Local Delivery System" within the wider Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) comes the opportunity to continue this journey with greater momentum through aligned leadership and a city identity as a "place based system of care" (Kings Fund 2015).

2.4 Through our shared commissioning we will promote the development over the next two years of fully integrated city provision based on the following principles:

- using the now established six Better Care clusters as the building blocks around which to organise integrated teams;
- a fully integrated bio/psycho/social model of care bringing together the three dimensions of primary and community healthcare, health and social care, physical and mental/emotional health;
- co-production of care with empowered individuals, carers, families and communities moving away from dependency / paternalism towards a strengths-based approach that prioritises prevention and early intervention.

2.5 Success is defined in the diagram below:

What will success look like by 2021/22?

Integration	✓ Person centred, joined-up care and support delivered through an integrated approach which is centred around 6 clusters in the city. ✓ Families experience a seamless journey of support that enables children to have the best start in life. ✓ Delivery of care and support centred around integrated care planning through interoperable systems. ✓ Individuals and families being in control of their care or support with the help of a lead professional role (where this is required) or simplified information and advice systems. ✓ Effective hospital discharge with seamless arrangements in place to support an individual's recovery.	✓ Access to community resources which have been developed by a strong community solutions approach driven by the community of Southampton. ✓ Effective crisis support when needed regardless of the day or time of the week, that enable families/individuals to recover quickly and get back on track. ✓ Total commitment to collaboration – over £150M of CCG and Council resources pooled to support joined up provision, with an increased proportion invested in community based services to reflect the shift in the balance of care
Prevention & Early Intervention	✓ Individuals take more responsibility for their own health and wellbeing ✓ The balance of care and resources has shifted from treating acute illness, towards prevention and earlier intervention ✓ People are encouraged and supported to change behaviours which lead to long term health and social care need ✓ Earlier intervention prevents needs escalating and helps people to stay independent for longer ✓ Fewer people are lonely and socially isolated	✓ There is access to accredited information and advice which enables people to take more control over their lives ✓ There is a range of community resources which people can access easily and which supports their independence ✓ Community solutions and assets in turn reduce demand for funded care ✓ Carers are supported in their caring role and have access to services to maintain their own health and wellbeing ✓ Health inequalities are reduced
Commissioning Safe & High Quality Services	✓ Individuals are safe and protected appropriately as part of high quality care provision ✓ Choice and diversity to enable sustainable informal care arrangements in the community ✓ Evidence based, measuring what matters, commissioning for outcomes and quality	✓ A safety culture which is open, honest and continuously learning. ✓ Well managed and quality assured market for nursing, residential and domiciliary care ✓ Working with all providers in health and social care settings to further improve quality following CQC inspections
Managing & Developing the market	✓ We have a sufficient and diverse local supply of the care and support services needed to deliver the best health and social outcomes for the city ✓ Best value principles underpin the ICU's approach to purchasing, contract design/ review, and procurement strategy development ✓ Organisational form and contracting arrangements redesigned to support the delivery of integration.	✓ A wider range of options available for individuals whose needs can no longer be safely/ cost-effectively met in their own home ✓ A commercial relationship with our suppliers of care and support services ✓ A robust approach to the performance management of services under contract ✓ Involvement of providers and communities in the development of commissioning intentions

Governance

2.6 The Southampton Integration Board was established in 2013 to oversee the development and implementation of person centred integrated care. Since then it has expanded its remit to take a system-wide view of outcomes and service provision for people of all ages across all sectors (health, social care, education, housing, public health, voluntary and community sectors) 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:

i. Strategically inform and manage the delivery of the overall work programme

ii. Monitor and drive progress, identify any risks, blockages or constraints and ensure they are mitigated.

iii. Interpret, critically assess and challenge the potential impact of proposed activity to ensure it delivers improved outcomes, tackles inequalities and makes best use of limited resources, achieving efficiencies where possible

iv. Inform and deliver evaluation processes and measures of success that can be monitored to ensure the on-going quality and effectiveness of joint commissioning strategy and service provision.

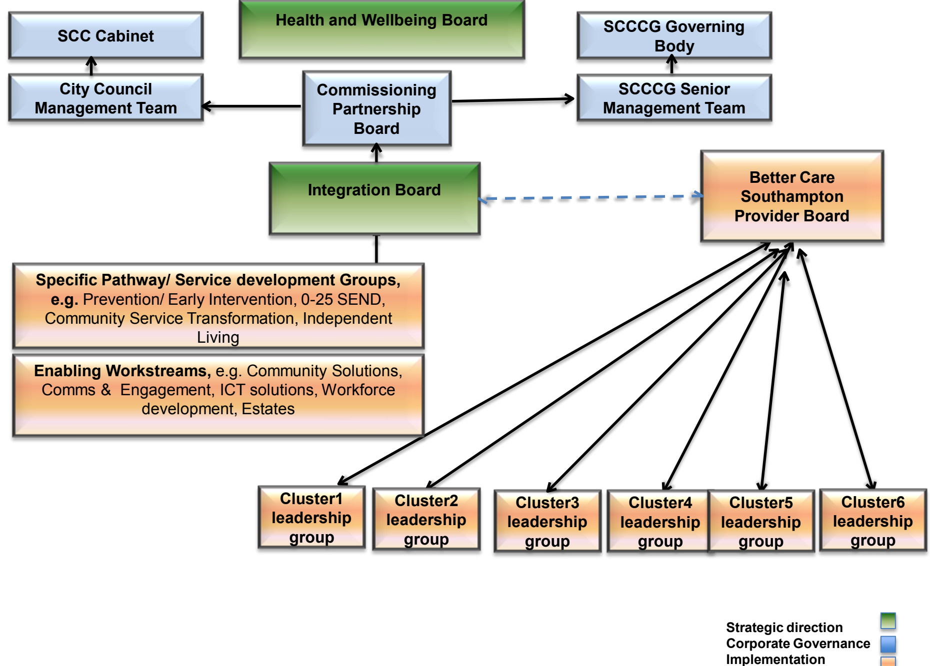
v. Ensure that local people (adults, children and young people) are at the centre of decision making and that their voices are heard.

2.7 Membership of the Integration Board includes CCG clinical and commissioning leads, primary care (including Southampton's GP Federation Southampton Primary Care Ltd), local councillors, the Director of Public Health, the Director of Adult Social Care and Housing, the Director of Children's Services, directors and clinical leads from within community and acute health provider organisations, South Central Ambulance Service, Hampshire Constabulary, chairs of the local primary and secondary school fora, Healthwatch and voluntary sector representation.

2.8 The Board reports to the Health and Wellbeing Board which 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.

2.9 Alongside the Integration Board, the Better Care Southampton Board was set up in 2016/17 as a collaboration of local providers to lead on the development of integrated provider services. This Board has representation from Solent NHS Trust, University Hospital Southampton NHS Foundation Trust (UHSFT), Southern Health NHS Foundation Trust, Southampton Primary Care Ltd (local GP federation) and Southampton Voluntary Services. The leads from each of the 6 Better Care clusters are also represented on Better Care Southampton and the Board oversees the development of cluster plans and progress.

2.10 The diagram below illustrates these governance arrangements:

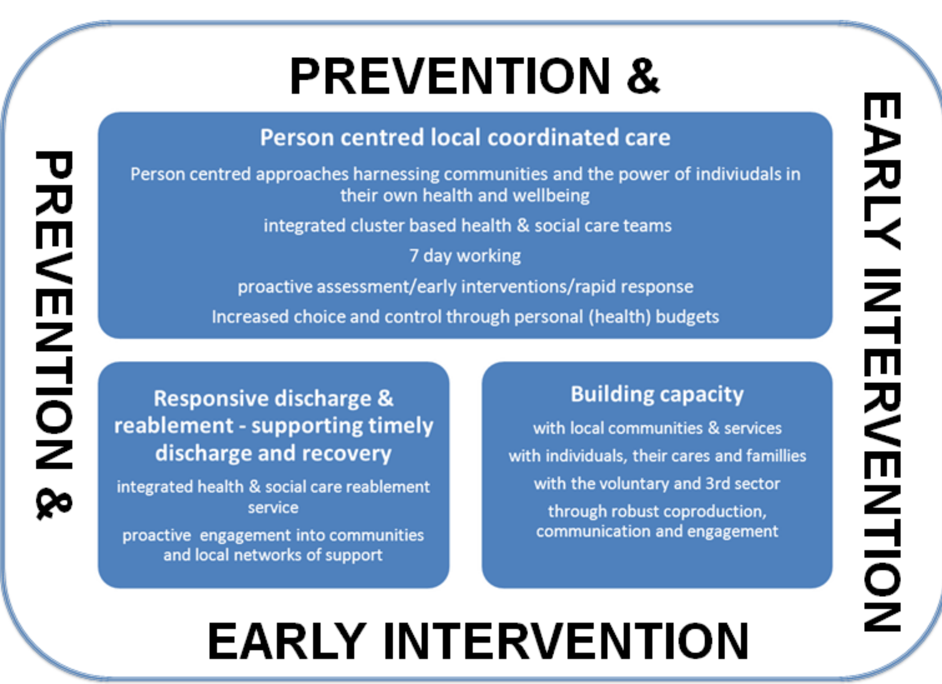


2.11 Governance for the Section 75 BCF Partnership Agreement sits with the Commissioning Partnership board (CPB). Meeting monthly, CPB comprises the Chief Executives of the Council and CCG, Director of Public Health, CCG Governing Board clinical lead, Cabinet member and Chair of the Health and Wellbeing Board, CCG lay member, Chief Finance Officers and lead Directors from the council and CCG. This Board has oversight of all schemes established under the Better Care Section 75. This includes shadow monitoring of schemes under development and scrutinising their suitability for future inclusion in the BCF Partnership Agreement. The board receives and reviews quarterly reports on each Better Care pooled fund scheme.

2.12 It is the responsibility of CPB to assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes, monitor financial contributions of the Council and the CCG and make recommendations regarding future financial contributions, receive and sign off all BCF performance reports prior to onwards presentation to the Health and Wellbeing Board for approval and submission to NHSE and provide the Council Cabinet and CCG Governing Body with an annual review of the S75 Better Care Partnership Agreement arrangements.

3. Progress to date

3.1 The diagram below illustrates Southampton's three areas of focus for its Better care Programme. Running through all three areas is a strong emphasis on prevention and early intervention.



3.2 Plans for 2016/17 specifically included:

Person centred local coordinated care

- **Further development of clusters** – extension to working age adults, impacting on high users of health care; closer alignment of social care staffing.

Responsive Discharge and Reablement

- **Integrated Rehab and Reablement and supported discharge functions** – consolidating the integration that began in 2015/16.

Building Capacity

- **Supporting carers** – continuing to increase numbers identified and supported.
- **Telehealthcare** – developing the vision, cultures and preparing for a wider expansion of use within health and social care settings.
- **Developing the community prevention and early intervention offer** – building on the 2015/16 Community Solutions work and re-commissioning services in the following areas to redirect resources to key priorities: Information and advice services; Developing community resilience; Behaviour change and Housing related support
- **Market Development –** shaping the market to promote independent living.

Person centred local coordinated care

<u>Further development of clusters</u>

3.3 At the core of Southampton's Better care principles are its cluster teams – multidisciplinary working has been organised across 6 areas of the city (see figure 3), aligned to GP practice populations and ward boundaries. This brings together health staff (community nursing, therapists, geriatrician, MH nurses, primary care staff), housing

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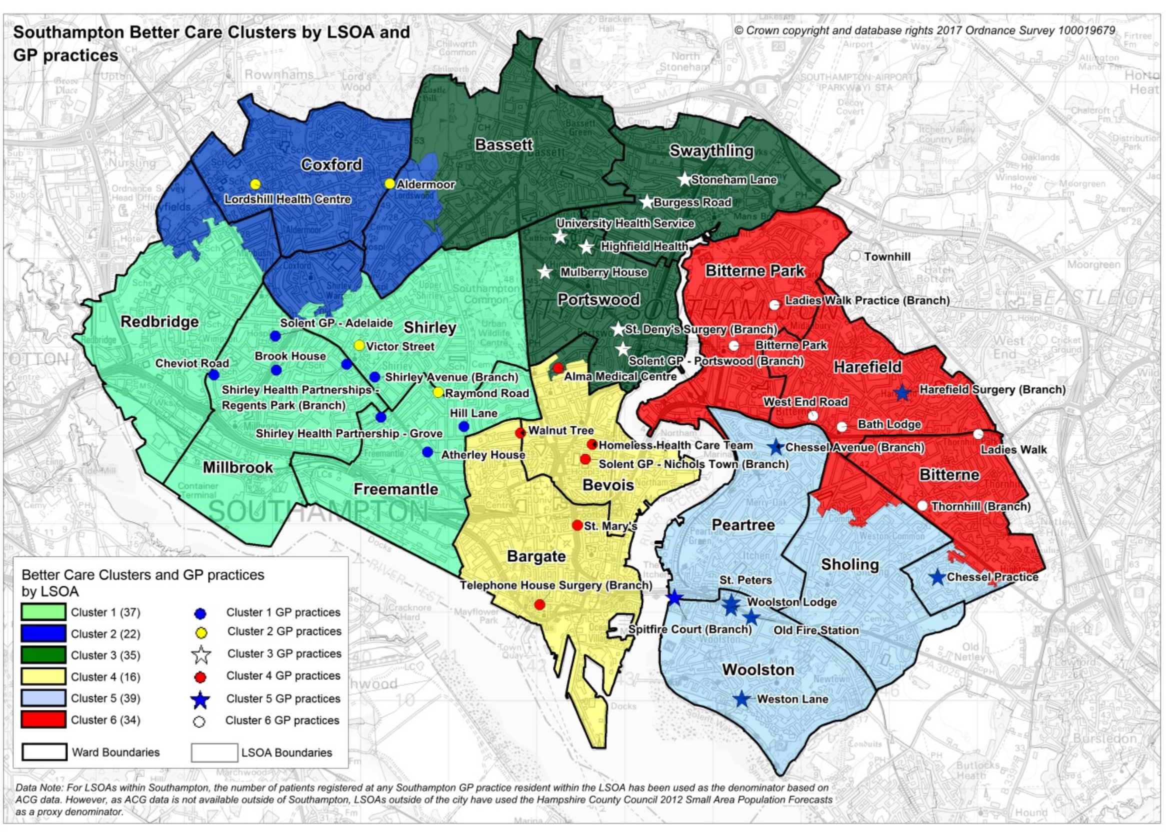
workers, voluntary sector, and social care to focus on the needs of a single geographical area, using joint assessment and planning approaches, including risk stratification, to identify needs early and intervene in a coordinated person centred way. Each cluster covers a population of approximately 30,000 - 50,000.



3.4 Cluster working has been defined in Southampton as having the following key characteristics:

- Understanding our population - who are the most vulnerable/most at risk and agreeing the primary focus for 'joining up care'
- Key worker/lead professional role implementation
- Sharing of key information, including care plans
- Engagement of key services within cluster working, including – community nursing, therapies, supported housing, adult social care, primary care, older people's mental health services (OPMH) and adult mental health services (AMH). Inclusion, where deemed appropriate, of other services, e.g. police, substance misuse services.
- Shared leadership and management
- Workforce development – training and education opportunities
- Supported self-care – making it real

3.5 The focus of cluster development in 2015/16 was older people. In 2016/17, cluster working has been extended to working age adults and children's services. Looking back over the past 12 months, the following has been achieved:

- Introduction of working age adult facing services to the integrated cluster model specifically adult mental health and substance misuse services.
- Re-commissioning of the Over 75 nurses as a Community Wellbeing Service for adults of all ages.

- Piloting of a children's locality clinic model in 3 of the 6 clusters and an MDT approach in cluster 1.
- Development of an integrated prevention and early help service model for children and their families, formally bringing together public health nursing with children's centre and troubled families services (going live during 17/18)
- Development of cluster leadership teams (comprising four key leadership roles: lead professional, lead operational manager, lead community representative, lead commissioner)
- Introduction of a self assessment and peer approach to evaluation, based around the key characteristics above
- Strengthening the integration of the Social Care long term care teams into the 6 clusters
- Workforce development with the creation of on line training modules for cluster staff

3.6 Specific developments in individual clusters are shown in the diagram below:

Cluster 2
- Modelling an approach to promote joint working between mental and physical health services
- Focus on frail elderly and end of life – high numbers supported housing and residential care
- Making links with Domiciliary care providers

Cluster 3
- Undertaking complex care discussions within cluster meetings
- Focus on mental illness and cultural diversity
- Sharing care plans across the system
- Housing and police engaged in cluster meetings
- Scoping implementation of key worker role – skills, remit etc
- Developing approach to supported self care

Cluster 6
- Promoting access
- Empowering communities
- Information sharing

City wide
- Introduction of working age adult facing services to the integrated cluster model, specifically AMH and Substance Misuse
- Re-commissioning of the Over 75 nurses as a Community Wellbeing Service for adults of all ages
- Piloting a children's MDT and locality clinic model in 3 of the 6 clusters
- Development of a cluster leadership model
- Introduction of a self assessment and peer approach to evaluation
- Strengthening the integration of the Social Care teams into the 6 clusters

Cluster 1
- Modelling an approach to promote joint working between mental and physical health services
- Piloting a closer relationship between primary/community and acute care for children.
- Focus on mental health, substance misuse and isolation
- Developments around local Comprehensive Geriatric Assessment

Cluster 4
- Undertaking complex care discussions within cluster meetings
- Focus on mental illness and cultural diversity
- Sharing care plans across the system
- Housing and police engaged in cluster meetings
- Scoping implementation of key worker role – skills, remit etc
- Developing approach to supported self care

Cluster 5
- New approach to practice MDT meetings
- Leading on developing a single anticipatory (crisis) care planning model.
- Local solutions group mapping neighbourhood resources
- Admission avoidance & frequent users
- Focus on residential & nursing homes
- Further engagement with police, AMH and domiciliary care

3.7 A specific focus of work within clusters has been falls prevention. Developments over the last 12 months have included:

- Implementation of falls champions in residential care homes
- Development of fragility fracture clinics in UHS and fracture liaison functions within the community to facilitate early identification and assessment.
- Targeted falls exercise classes for people at high risk of falling run by Age UK and Saints Foundation with +90% engagement and continuation success rate
- Development of a pathway from the community alarm service for comprehensive falls assessment so individuals are identified before needing urgent care support

3.8 Looking forward to 2017/18 and beyond the focus for clusters will be on:

- Continuing to strengthen cluster leadership to embed the new cultures and characteristics of integrated working and ensure that each cluster has a robust programme of activity in place which drives achievement of the city's key performance targets to reduce NELs, falls, XBDs, admissions to NH/RHs.
- Continuing to embed the working age adults involvement and monitor the impact of the children's MDT pilot.
- Implementation of the integrated prevention and early help offer for children and their families.
- Development of an Enhanced Health Support offer to nursing and residential homes (based on the Vanguard models outlined in NHS England's Enhance Health in Care Home Framework)
- Expanding falls champions to Extra Care Housing schemes and Domiciliary Care providers
- Expanding fragility fracture clinics and developing a hospital based fracture liaison function for identification and increasing referrals for comprehensive falls assessment
- Working with voluntary sector partners and exercise providers to increase the available exercise offer for all older people in the City, ensuring that exercise is providing core stability and strength benefits.
- Continuing to develop more integrated approaches for adults and children with learning disability and special educational needs and disability (SEND) by bringing together health and social care teams.

Responsive Discharge and Reablement

Integrated Rehab and Reablement

3.9 On 1 April 2016, Southampton's integrated Rehabilitation and Reablement Service went live which brought together 7 different teams across Solent NHS Trust and the City Council under a single management structure (using S75 integrated provider arrangements) to deliver a streamlined offer of support to maintain people's independence for as long as possible and intervene quickly in the event of a crisis which could lead to hospital or care home admission. The integrated service is bedding down positively and achieving its key performance indicators including responding to 90% of crisis referrals within 2 hours, ensuring that 100% clients have an identified lead professional from their home cluster or from the integrated service in place, achieving an improvement in outcomes for 88% clients and achieving reablement goals for 77%.

3.10 During 2016/17 the CCG and City Council have also worked together to redesign the way in which reablement services are provided, moving towards a home based model of care where support is provided wherever possible in a client's home as opposed to in a hospital setting. This included the decommissioning of a bed based unit and redirection of these resources into domiciliary care. A small number of reablement beds were commissioned from the residential care sector for those patients who still require a period of bed based reablement. During the course of 2016/17, we have seen the

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demand for bed based reablement consistently reduce with the majority of patients receiving their reablement package in their own home.

Discharge and Transfers of Care

3.11 A joint DTOC action plan across the SW System has been in place for some time and is overseen by the SW System Integrated Discharge Bureau (IDB) leaders group. The IDB leaders group meets on a monthly basis and includes senior representation from Southampton City CCG, Southampton City Council, West Hampshire CCG, Hampshire County Council, University Hospital Southampton Foundation Trust (UHS), Solent NHS Trust and Southern Health Foundation Trust (SHFT).

3.12 Based on best practice guidance and particularly the 8 High Impact Change Model for managing discharge and transfers of care, three standardised discharge pathways have been adopted across the whole of the SW System in order to simplify and streamline discharge processes:

I. **Pathway 1 Simple discharges** - managed by the wards through trusted assessment with support as necessary from the IDB and strong links back to the patient's community care team who will proactively work with the hospital. Primarily this includes package re-starts and return to home or previous placement. Ward staff are responsible for identifying and assessing these patients and refer onto the discharge officers to organise discharge.

II. **Pathway 2 Supported discharges** - managed by the Southampton Urgent Response Team in the integrated rehab and reablement and supported discharge service working with ward staff to facilitate discharge through a "community pull" approach. This includes those situations where additional support in the community is required for example a long term care package, (including QDS double up), rehabilitation, reablement or bed based care, including hard to place patients. Ward staff are responsible for identifying and directing these patients to the URS.

III. **Pathway 3 Enhanced discharges -** managed by the IDB and hospital discharge team. This involves those patients requiring complex assessments, e.g. those who are likely to be Continuing Care or where there are Safeguarding concerns. Ward staff are responsible for identifying and directing these patients to the IDB.

3.13 Over the last 12 months, Southampton has been working with the rest of the SW System to embed these 3 pathways. Key developments during 2016/17 have included:

- Ensuring that the Hospital Discharge Team is able to sustain a 7 day service to focus on pathway 3 – this has been sustained through 16/17 with locums and the team is currently being remodelled with additional investment from the improved BCF Social Care allocation to put this on a substantive footing.
- Developing a model of trusted assessment that can be rolled out across the wards to enable pathway 1. As a System, we have been working with HCC to develop the protocols and agreements and competency framework between the NHS and Local Authorities to allow this to happen and are now in the process of rolling out training.
- Rolling out discharge to assess for pathway 2 at scale. We have piloted this during 2016/17 with up to 10 patients a week and having made additional investment from the STP will be rolling this out across the whole pathway from June 2017.

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- Improving our CHC assessment processes to better identify those patients likely to be CHC eligible (which has increased our conversion rate from 20% to 69%) and reduced our assessment times from 21 days to an average of 13 days.
- Embedding the SAFER patient flow bundle
- Building our domiciliary care capacity to improve flow through the system. This has been a key area of challenge owing to the increase in demand and complexity of patients (there has been a 24% increase in double up packages compared to last year); however, Southampton has risen to this challenge through a range of approaches in conjunction with providers which have included improving assessment and review systems, developing a 7 day offer, promoting the use of care technology, investigating solutions to parking challenges in the city centre, working with providers to increase capacity and reducing 15 minute calls, through to longer term actions such as workforce development and implementation of care technology.
- Commencement of work with care homes to improve capacity and responsiveness. Four key workstreams went live in January 2017: transition planning for hospital discharge, incorporating relationship building activity between UHS and care and nursing home providers; enhanced health support to care homes, based on the Vanguard models; leadership and workforce development and developing the market for more complex hard to place clients.

3.14 Further detail on our discharge performance and plans can be found in our DTOC self assessment, available on request, which also includes a self assessment against the 8 high impact change model.

3.15 Looking forward to 2017/18 and beyond, the focus for the integrated Rehab and Reablement service and supporting timely discharge will be:

- ***To continue to embed at pace the 3 pathways across the whole system (simple, supported and enhanced)*** with a specific focus on:
  - ➢ Rolling out Southampton's Home First model of Discharge to Assess for pathway 2 (supported) - additional care has now been sourced and goes live this June in order to enable D2A to be fully embedded for Pathway 2.
  - ➢ Developing a bed based Discharge to Assess model with risk share arrangements for Pathway 3 (enhanced discharge). Additional investment from the Social Care allocation (improved BCF) has been made available for sustaining 7 day working and increasing social care professional input in the Hospital Discharge Team/IDB and is now in place. Options are being worked up for sharing financial risk and identifying a mix of beds across the NHS, Local Authority and independent sector. Approx 18 beds at any one time are deemed to be required. Plans are due to be firmed up by July 2017.
  - ➢ Roll out of Trusted Professional Training across the hospital to facilitate discharge on Pathway 1. HCC have been responsible for pulling together the necessary legal documentation, competency framework and training tools for the Trusted Professionals and training is due to go live shortly.
- ***To continue to support and develop the long term care market***
  - ➢ Work continues with the domiciliary care market to build capacity and sustainability as described above. With the end of the current Domiciliary Care contract due in March 2019, work will be shortly underway to plan

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for the procurement of a new Framework. Some of the additional Social Care allocation (improved BCF) is being invested in dedicated planning resource to support the re-procurement.

- Implementation of the care home action plan described above. This particularly involves the establishment of a city wide Care Home Support and Development team which is due to go live this Summer to work with homes, providing support with policies such as nutrition, medication and falls and staff training and development. It also involves additional investment that has been made through the STP in 17/18 in additional case management time to specifically support residential homes which went live in May 2017 with plans to invest further in MDT support.
- In support of the above priority, a significant part of the additional social care allocation for the improved BCF is being invested in transforming long term care. This includes development of additional nursing beds to address challenges in placing clients with complex needs (in particular dementia with challenging behaviour), pump priming plans for increasing the local supply of extra care housing and funding to stabilise the care market, consolidating increased domiciliary care capacity that has been brought on line in recent months and supporting innovation and quality in the domiciliary care market.

- ***To turn our focus also onto improving discharge processes in Southampton's community hospitals, in particular Solent and SHFT***.
  - This includes ensuring that these Trusts are Care Act compliant in their reporting of discharges and working with them to ensure that the policies (e.g. Complex Discharge Policy which has whole system sign off), principles (trusted assessment) and pathways (simple, supported and enhanced) now embedding at UHS are equally implemented within the community hospitals. We are confident that we have sign up to this work as all partners are already represented on IDB. Additional investment from the improved BCF Social Care allocation is also being made available to establish a community hospital Discharge to Assess Scheme.

.Building Capacity

3.16 A key element of Southampton's Better Care programme has been the development of capacity to support the move towards a model where more people are able to enjoy their independence for longer in their own communities/homes and where the majority of care happens outside the hospital and institutional settings. This includes capacity to help people manage in their own homes and maintain their health and wellbeing, be it development of domiciliary care and care technology to provide help and support, community navigation and information, advice and support to put people in touch with what's out there, support for carers, activities and support that build upon community assets, the promotion of personal budgets to enable people to define their own solutions or different types of housing, which provide a level of security whilst at the same time enabling someone to maintain their own household.

3.17 Achievements in this area over the last 12 months have included:

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- Development of a clear vision and strategy for telehealthcare in Southampton with 98% of Adult Social Care staff trained and increasing numbers of referrals from 8 in April 2016, 5 in May, 28 in June, 40 in July, 44 in August, 42 in September, and 87 in December 2016. Although a robust process for benefits tracking has yet to be put in place, a review of referrals is showing that 31% referrals are likely to avoid an immediate increase in costs (61% in Q2), 56% care packages were expected to increase in coming months if telecare not provided (30% in Q2), 13% high cost packages expected to reduce as a result of telecare (9% in Q2).
- Piloting of Community Navigation in 2 clusters
- Procurement of a Behaviour Change Service which is due to go live on 1 April 2017
- Collaborative work with Dom Care Market promoting an increase from 21,000 hours per week in Dec 15 to 22,470 in Dec 16.
- Opening of Erskine Court – 54 beds in total.
- Full 'road map' of extra care need in place and agreed (numbers – 500 over 10 years etc).
- Woodside Lodge development (to 84 units from 2019/20) agreed. Planning permission agreed.
- Implementation of the Carers in Southampton Service which has led to a significant increase in the numbers of carers being identified and assessed (200 carers making contact with services in the last 6 months of 2014/15 compared to 931 in the first 6 months of 16/17, 227 on the database in the last 6 months of 14/15 compared to 432 in the first 6 months of 16/17)

3.18 Looking forward, the next steps are:

- Finalising the strategy for care technology in Southampton to develop and implement a long term approach to the delivery of care technology.
- Development of an integrated 0-19 Prevention and Early Help model for children and their families - as part of the extension of Better Care across the whole lifespan.
- Re-procurement of the community navigation service to deliver a city wide offer
- Development and procurement of an Older Person's offer
- Full implementation of online carer assessments and development of the service in accordance with the option chose through the options paper.
- Procurement of a new advice and guidance service building upon the outcome of SCC grants consultation.
- Further consultation and commissioning of model of support to promote development of community offer
- Promote capacity building within domiciliary care market through leadership, partnership and workforce development
- Extra Care – seek development partner/s to put road map into action

4. Current Position

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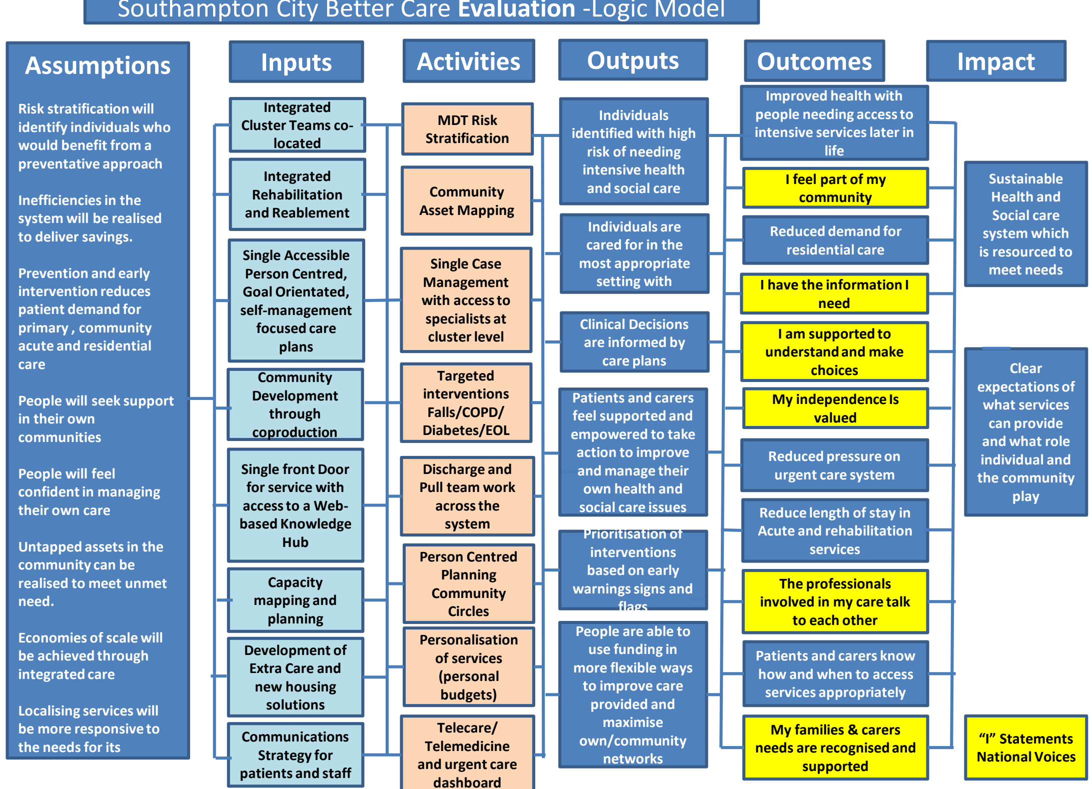
4.1 At the beginning of its Better Care journey Southampton set out the following roadmap for achieving its vision.



The diagram below shows where the city has got to in delivering this road map.

insert logic diagram 2 (use RAG for status of each box)

Service User Experience

4.2 Southampton's original vision for Better Care used 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" to communicate what it would look like for local people.

4.3 From the perspective of patients and service users, Southampton's Better Care programme would mean that:

- **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.

4.4 The diagram below illustrates what has been put in place over the last 2 years to support this vision.

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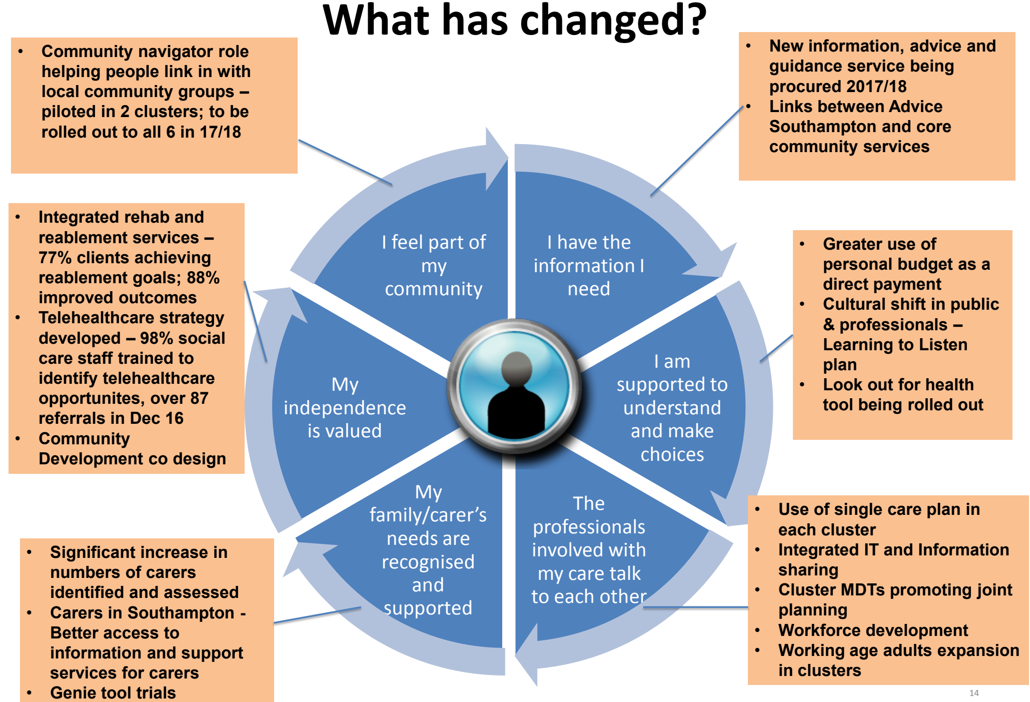

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Progress against the key metrics 2016/17

4.5 Performance against the key BCF metrics is scrutinised on a monthly basis by the Integration Board. Despite good progress within each of the schemes, performance against the national targets has been variable over the last 12 months and particularly challenging with regard to delayed transfers of care (DTOC).

4.6 The following metrics have been on a positive trajectory over the past 12 months:

- **reducing permanent admissions to residential and nursing home** – there has been a significant reduction compared to the previous year and we are significantly over delivering against target. We believe that this is strongly linked to our “home first” approach and strong reablement/maintaining independence ethos.

- **increasing the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehab services** – with the implementation of our integrated rehab and reablement service, we have been seeing a positive improvement trend in this metric over the last 3 years (2014/15, 2015/16 and 2016/17)

4.7 The reduction in **NEL admissions** has been more challenging over 2016/17 with a slight increase (4%) compared to 2015/16, in the adult age groups (admissions amongst 0-18 year olds have reduced), which has meant we have not achieved our 2016/17 target of maintaining activity at 2015/16 levels. Admissions due to falls injuries have particularly increased, although the numbers are small and therefore year on year comparisons can be misleading. Further analysis of NEL admissions shows a particular increase in same day discharges and very short stay admissions (less than 1 day - average LOS remaining static at 4.5 days and 1 day stays

reducing), particularly through ED (this is not reflected in the growth in ED attendances which has been primarily in majors).

- 70% of admissions amongst working age adults are short stay (<24 hours) and 77% are admitted via ED (59% out of hours). The main reasons for admission amongst working age adults are chest pain, abdominal pain, headache, drug poisoning, syncope and collapse and mental health. It is worth noting that there has been a reduction in frequent attendances amongst working age adults. Very short stay admissions (LoS < 4 hours) for working age adults increased overall by 13% from 2015/16 to 2016/17 and particularly in the last few months of the year - March 2017 was 45% higher than March 2016. For Chest Pain the increase was 79% comparing March to March, and likewise 61% for abdominal pain. This suggests the increase in zero day stays was principally driven by increasing very short stay admissions from ED.

- 42% of admissions amongst older people 65+ years are short stay (<24 hours). The main reasons for admissions amongst older people are falls, syncope and collapse, fractured neck of femur, pneumonia, UTIs, chest pain, COPD, other respiratory conditions and heart failure. On average 53% of falls admissions are short stay, although this varies considerably month on month (ranging from 49% to 70%).

4.8 A more detailed review of data at a cluster level shows that there are differing issues in each cluster, often as a result of differing social and demographic profiles:

NEL admission rates:

- Highest rates per 1000 population in clusters 4, 1 and 2 (all adults) in descending order
- Adults in clusters 4 & 1
- Older people in clusters 2,5 & 6
- ED primary admitting route
- main ED attendances rising in clusters 2 and 6
- General reduction in GP referrals over last 18 months

Frequent users -

- Improving picture overall
- Reduction in those with very high nos of admission

4.9 One of the key priorities going forward has to be a stronger focus on reducing avoidable hospital admission and length of stay in each cluster, underpinned by strong cluster leadership to enable devolution of more decision making, along with greater accountability for achieving city wide targets. A key requirement for clusters in 2017/18 will therefore be a multiagency analysis of the local data to better understand the issues impacting on key performance indicators (i.e. avoidable admissions, length of stay and falls), followed by an agreed multiagency action plan to address them. This will be supported by additional investment in leadership development and data being made available to clusters.

4.10 The greatest area of challenge however has been **delayed transfers of care (DTOC)** where we have seen a significant increase in our reported figures for 16/17 compared to 15/16, when we had been seeing a reduction. In terms of the national

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3.5% target, UHS reported 9.6% as at month 12. It should be noted that this metric is measured at Trust level and includes patient delays for West Hampshire CCG as well as for Southampton City CCG. Using a rough 50/50 split of beds (which is broadly representative of the split in UHS activity between the two CCGs), the percentage of bed days lost for Southampton City was 5.2% at month 12.

4.11 We believe that a key contributing factor to the apparent significant increase compared to previous year was the change in recording in February 2016 when our local acute Trust UHSFT became Care Act compliant. (Previously patients were not recorded as being delayed until 3 days after their discharge notification; now delays are recorded from 24 hours post discharge notification. We believe that there is still significant variation in the way that DTOC is reported nationally.)

4.12 However, acknowledging that our DTOC rates are significantly high still when compared to other areas across the country, we have scrutinised our figures and the main reasons for delay are:

- pressures in the domiciliary care market resulting from a combination of increased demand and complexity (there has been a 24% increase in double up packages compared to last year), with a small number of business continuity challenges and difficulties in recruiting carers. Southampton has risen to this challenge through a range of approaches in conjunction with the providers in the market itself. The ICU has a plan to continue this process which is monitored through a project group on a regular basis and shared with the system through a monthly briefing. The plan includes short to medium term actions such as improving assessment and review systems, developing a 7 day offer, promoting the use of care technology, investigating solutions to parking challenges in the city centre, working with providers to increase capacity and reducing 15 minute calls, through to longer term actions such as workforce development and implementation of care technology.
- growing delays in access to nursing homes, partly associated with delays in assessment and partly due to the difficulties sourcing placements, particularly for those people with higher level needs, e.g. people with dementia and challenging behaviour. In response to this, an action plan has also been developed with performance being managed in the same way as the action plan for domiciliary care. As a result we are currently in the process of implementing a local model of the Enhanced Health in Care Homes framework using BCF pooled fund investment, which will go live this Summer and are planning to use some of the improved BCF funding to develop in house care home capacity to address some of our more complex needs. We also have strong plans in place for the development of the Extra Care market.

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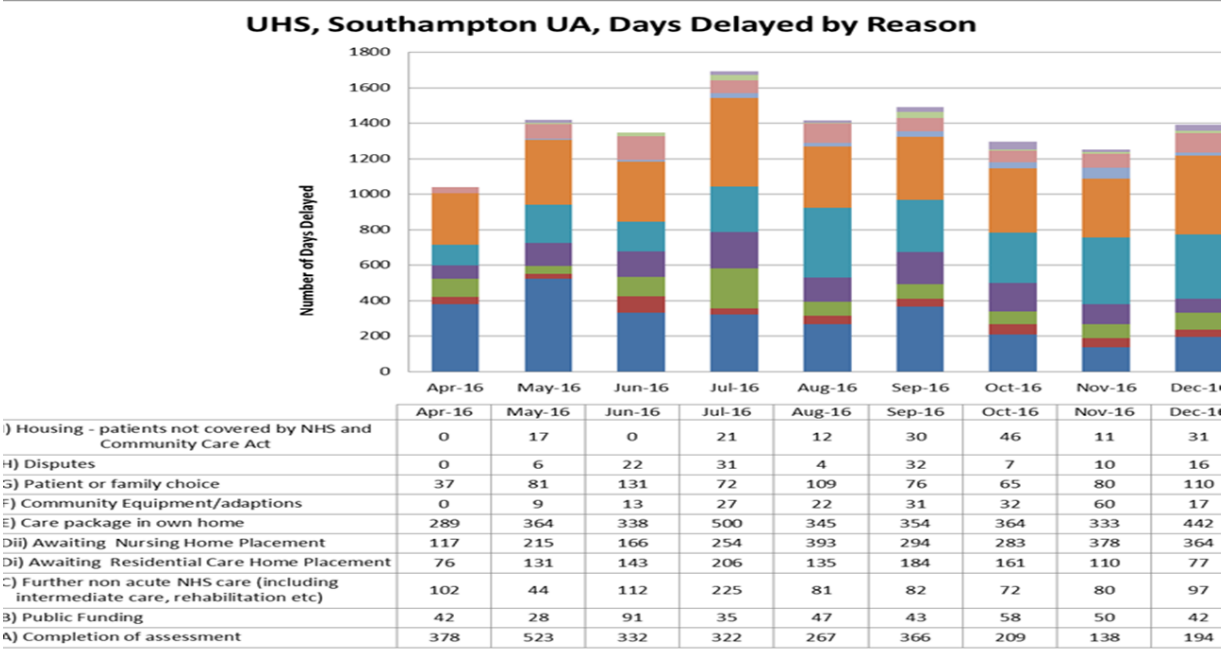

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-1
) Housing - patients not covered by NHS and Community Care Act	0	17	0	21	12	30	46	11	31
H) Disputes	0	6	22	31	4	32	7	10	16
G) Patient or family choice	37	81	131	72	109	76	65	80	110
F) Community Equipment/adaptions	0	9	13	27	22	31	32	60	17
E) Care package in own home	289	364	338	500	345	354	364	333	442
Dii) Awaiting Nursing Home Placement	117	215	166	254	393	294	283	378	364
Di) Awaiting Residential Care Home Placement	76	131	143	206	135	184	161	110	77
C) Further non acute NHS care (including intermediate care, rehabilitation etc)	102	44	112	225	81	82	72	80	97
B) Public Funding	42	28	91	35	47	43	58	50	42
A) Completion of assessment	378	523	332	322	267	366	209	138	194

4.13 Further scrutiny of our DTOC performance is attached in our DTOC self assessment (available on request) and includes DTOC activity in our community hospitals which make up roughly 15% of our overall DTOC.

4.14 Southampton has adopted the 8 High Impact Change Model for managing delayed transfers of care and is confident that the action it is taking along with its partners in the SW Hampshire System through the STP is the right way forward. However we recognise that we need to sharpen our focus and increase our pace in implementing a number of key priorities, as identified in Section 3.15:

- To continue to embed at pace the 3 pathways across the whole system (simple, supported and enhanced) with a specific focus on:
- To continue to support and develop the long term care market
- To turn our focus also onto improving discharge processes in Southampton's community hospitals, in particular Solent and SHFT.

<u>New Performance Dashboard published with Better Care Guidance 4 July 2017</u>

4.15 The performance dashboard includes 6 key metrics to show how health and social care partners in every Local Authority are performing at the health and social care interface. It ranks authorities within a group of 16 statistical neighbours and all authorities in England.

4.16 At an individual indicator level, Southampton ranks worst for:

- Emergency admissions per 100,000 (65+ population) = 130th/150 LAs and 13th/ 16 statistical neighbours
- Length of stay for emergency admissions (65+ population) = 109th/ 150 LAs and 10th/ 16 statistical neighbours
- Delayed days per day per 100,000 18+ population = 135th/ 150 LAs and 13th/ 16 statistical neighbours
- Proportion of older people still at home 91 days after discharge into Reablement Services = 120th/ 150 LAs and 11th/ 16 statistical neighbours

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(however, this is based on 15/16 data and Southampton's performance on this metric has improved significantly since then)

Our performance is however better for:

- Percentage of older people discharged from hospital who receive rehab/reablement services = 58th/ 150 LAs and 9th/16 statistical neighbours (although again this is based on 15/16 data)
- Percentage of discharges following emergency admissions occurring at weekends = 7th/ 150 LAs and 3rd /16 statistical neighbours

4.17 A key focus of the new performance dashboard is on DTOC and the dashboard contains expected levels for each Local Authority against the new metric. These are set out for Southampton below. In Southampton, our focus has been on tackling DTOC at a city wide level (and as part of the wider South West Hampshire system) from both an NHS and social care perspective; we strongly believe that we will best tackle DTOC through strong partnership working and collaboration and this is already evidenced in our action plans and integrated working. *Note: we are currently in the process of reviewing the new performance dashboard and correlating the DTOC expectations to our current trajectories which have been jointly produced, and do not believe this will detract from the plans and work in progress around DTOC we already have in place.*

Total delayed days per day per 100,000 18+ population	Total delays	NHS attributable delays	Adult Social Care attributable delays
Southampton baseline based on Feb 17 - Apr 17 data	21.3	8.7	11.1
Expectation	11.2	5.5	4.1
Southampton baseline based on whole of 16/17	25.4		

5. Priorities for 2017-19

5.1 On 20 April 2016, the HWBB signed off six priorities for 2016/17 and beyond. These priorities remain very much the focus for the 2017 - 19 Better Care Plan and were presented again to HWBB on 29 March 2017 along with proposed areas of focus for 2017/18 and 2018/19. These were supported by HWBB as follows.

- **More rapid expansion of the integration agenda across the full life-course.**

  In 2017/18:

  - Strengthen cluster leadership to fully embed the characteristics of integration, drive cultural change in working with all age groups and make a direct contribution towards achieving the city wide performance against the national Better Care metrics.
  - Continue to roll out the cluster approach to working age adults and children and families.

- Work with the acute sector to embed specialist support into clusters – particularly for people with long term conditions.
- Development of 0-25 models – CAMHS, SEND.
- Integration of health and social care disability services/teams.

In 2018/19

- Consolidation of developments in 2017/18.
- Development of place based commissioning models to delegate more authority and responsibility to clusters.

- **A much stronger focus on prevention and early intervention**

  In 2017/18

  - Procurement of new Information, Advice and Guidance Services.
  - Implementation of "Southampton Healthy Living", the new Behaviour Change Service.
  - City wide procurement of community navigation.
  - Embed Making Every Contact Count.
  - Development of Older Person's offer.
  - Implementation of integrated Prevention and Early Help service for children and their families based around clusters and schools.
  - Expand falls champions to domiciliary care providers, implement the fracture liaison service to identify people at risk earlier and ensure earlier intervention and work with voluntary sector partners and exercise providers to increase the available exercise offer for all older people in the City.

  In 2018/19

  - Consolidate 2017/18 developments and continue to embed Making Every Contact Count
  - Implementation of Older Person's offer
  - Expand falls champions to Extra Care schemes

- **A more radical shift in the balance of care away from bed based provisions and into the community**

  In 2017/18

  - Embed delivery of 7 day services
  - Roll out discharge pathways and processes using discharge to assess and trusted assessment.
  - Implementation of Southampton's frailty model, developing community services to support the management of higher levels of acuity in the community, including community nursing redesign and enhanced health input to care homes.
  - Implementation of Mental Health Matters & CAMHS Transformation to strengthen support in the community to people with mental health problems – including the dementia action plan.
  - Continue to develop and shape the market to meet Southampton's needs and future vision for long term care, building capacity within domiciliary care through leadership, partnership working and workforce development to support more people living in their own homes longer and rebalancing

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availability of nursing and residential care with extra care housing to promote independent living. To include:

    - seeking a development partner/s to put Southampton's Extra Care road map into action to increase the units of Extra Care
    - implementing the care home procurement plan and
    - increasing availability of nursing care capacity for clients with more complex needs (and therefore harder to place), e.g. dementia with challenging behaviour.

  - Embed enhanced access to primary care.

  In 2018/19

  - Consolidate 2017/18 developments.
  - Continue to expand Extra Care - Woodside Lodge development.
  - Re-commissioning of domiciliary care framework.
  - Re-commissioning of enhanced and urgent primary care access alongside NHS 111.

- **Significant growth in the community and voluntary sector**

  In 2017/18

  - Engagement and co-design of community development model.
  - Support to voluntary sector organisations to respond to business opportunities/undertake tenders.

  In 2018/19

  - Implement agreed service model for community development
  - Through community development model, continue to work with the community and voluntary sector to develop capacity particularly in relation to supporting the prevention and early intervention agenda.

- **Development of new models of care which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies**

  In 2017/18

  - Continued development of cluster model, including leadership and workforce development.
  - Support development of more integrated models of provision, working with local providers.
  - Continue to maximise opportunities for using care technology to improve access to health and care and support people's independence.
  - Expansion of personal health budget offer and alignment with direct payments to support choice and innovation.
  - Continue to develop shared electronic records/care plans.

  In 2018/19

  - Align commissioning models to those of delivery – focused upon place based care.

- **New contractual and commissioning models which enable and incentivise the new ways of working**

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In 2017/18

- Agree future integrated commissioning model (CCG/SCC) and commence implementation.
- Assimilate learning from models elsewhere on different approaches to commissioning, contracting and payment that better incentivise the new ways of integrated working.
- Continue the move towards outcome based commissioning.
- Reach a decision on the future integrated model and need for procurement.

In 2018/19

- Development of place based and integrated commissioning models that delegate more authority and responsibility to clusters.
- Explore delegation of key areas of operational commissioning.

6. Work Plans for 2017-19

6.1 For the coming period 2017-19, the areas of focus against each of the core Better Care elements cross referenced to the six priorities are set out below:

Core BCF Element	2017-19 Priority	Outcome	Schemes/Plans 17-19	Description
Person centred local coordinated care	More rapid expansion of the integration agenda across the full life course A much stronger focus on prevention & early intervention Development of new models of care which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies A more radical shift in the balance of care away from bed based provisions and into the community	Care provided closer to home where appropriate Simplified and more responsive services for clients, carers and wider stakeholders Increase in the number of shared care plans Increase in people being case managed High quality integrated EOL care Improved service user outcomes and experience Increased identification of people at risk (e.g. of falling) and referral into support services Increased confidence amongst parents, primary care and community staff in managing common childhood illness in the community Increased emotional wellbeing and resilience Improved delivery of Healthy	1. Shape and support new models of care (through development of clusters) 2. Implementation of Enhanced health in care homes 3. Development of Mental Health Services 4. LD Integration 5. Developing integrated services for children with SEND 6. Developing clusters: To transform Locality care for Children 7. Developing Clusters: To develop responsive Community Services / Nursing to support greater levels of acuity 8. Development of 0-19	*Working with providers to shape and support new models of care, including further strengthening cluster leadership and workforce development.* *Implementation of the Residential and Nursing Care home action plan with a particular focus on improving the hospital discharge process, supporting leadership and workforce development, implementing an enhanced health offer of support and market development* *Implement Mental Health Matters (MHM) and Five Year Forward View (FYFV) for Mental Health to improve local services and meet national targets.* *Creation of an integrated health and social care team to support people with LD in Southampton, putting the individual at the centre* *Continue to develop services to improve outcomes for children/young people with SEND.* *Work with providers to transform locality services for children and families, to better manage acute and common childhood illness outside the hospital setting* *Developing community services, particularly community nursing, to support the management of higher levels of acuity in the community* *Continue to work with Children's Services and Solent NHS Trust to develop an integrated prevention and early help service for children 0-19*

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Core BCF Element	2017-19 Priority	Outcome	Schemes/Plans 17-19	Description
		Child Programme targets, including breastfeeding rates and improved school attendance. Reduction in avoidable admission rates (hospital and RH/NH), XBDs and falls	Prevention and early Help Offer 9. Developing Clusters: To improve End of Life Care 10. Falls prevention	*and their families and develop the wider offer of prevention and early help for children 0-19 and their families in partnership with the voluntary and community sector* *Work with partners to implement the EOL strategy including the development of a hospice at home model and training and support to increase the numbers of people achieving their preferred place of death.* *Implementation of the falls prevention strategy, with a focus on extending Falls Champions to Extra Care schemes and Domiciliary Care providers, expanding the fragility fracture clinics and falls liaison and working with voluntary sector and exercise providers to increase the exercise offer for older people in the City*
Responsive Discharge and Reablement	A more radical shift in the balance of care out of hospital A much stronger focus on prevention & early intervention	Simplified integrated discharge processes Improved outcomes for patients Reduced hospital delays - achievement of national 3.5% DTOC target Reduced XBD's in line with QIPP expectations Reduction in the number of people needing long term packages Reduction in CHC assessments being completed in a hospital setting	11. Roll out Discharge pathways and processes, building on Rehab and Reablement **(See also DTOC Action Plan)**	*Implementing the new discharge system to streamline discharge processes, supported by wider application of trusted assessment and roll out of discharge to assess*

Core BCF Element	2017-19 Priority	Outcome	Schemes/Plans 17-19	Description
Building Capacity	A more radical shift in the balance of care out of hospital Significant growth in the community and voluntary sector Development of new models of care which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies A much stronger focus on prevention and early intervention	All care providers in Southampton rated good or outstanding by CQC Increased extra care capacity NHS Target for PHBs achieved and increased uptake of direct payments Increase in the number of carers identified / supported Improved sense of wellbeing and reduced feelings of loneliness Increased use of care technology to support people in their own home Increase in community voluntary sector activity & Increase in volunteering as a core part of resilient communities offer Improved access to advice services and support. Increased early identification Delayed onset of care and support needs Reduced levels of ED attendance and unnecessary hospital and care home admission. More timely	12. Development of an Older Person's Offer	*Implementation of the older person's offer, promoting independence, health and wellbeing*
			13. Implementation of Personal Health budgets and Direct Payments	*Extending the offer of personal health budgets and direct payments, and exploring the alignment between the two*
			14. Developing supportive communities/ community capacity	*Develop and procure a community solutions service which builds on community assets to increase local services which people can access easily*
			15. Roll out of Community Navigation	*Roll out of community navigation*
			16. Procurement of Advice and Guidance	*Re-commission Advice, Information and Guidance (AIG) services to improve access to accredited information and support self-help*
			17. Supporting Carers	*Agree and implement commissioning intentions for carers support*
			18. Developing Extra Care	*Develop and commence delivery of growth plan for local extra care housing, including establishment of commercial mechanisms for attracting investment and/or land and reducing risk where required.*
			19. Care Home Procurement Strategy	*Develop and implement a procurement strategy for care home provision designed to ensure sustainability, sufficiency, and best value in this segment of the local care market*
			20. Developing Nursing Home Market Capacity to meet need	*Explore options for levering council assets to stimulate growth in the local supply of nursing care for people with complex needs and challenging behaviour*
			21. Developing care technology	*Continue roll out of Care Technology and implement agreed commissioning intentions for next phase*

Core BCF Element	2017-19 Priority	Outcome	Schemes/Plans 17-19	Description
		hospital discharge	22.	

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Core BCF Element	2017-19 Priority	Outcome	Schemes/Plans 17-19	Description
Underpinning programmes	Development of new models of care which better support the delivery of integrated care and support	Skilled workforce able to respond to changing client needs A competitive, diverse, and sustainable market of local care and support services	23. Shape and Support New Models of Care	*Working with providers to shape and support new models of care, including further strengthening cluster leadership and workforce development.*
	New contractual and commissioning models which enable and incentivise the new ways of working	Reducing costs for the wider system, making best use of the Southampton pound Consistent contracting and performance management process supports and mirrors services integration Unified needs assessment process across health, care and wider local services Reducing duplication and realising economies of scale Benefits accruing from integrated services	24. Developing a shared commissioning system	*To develop a single, integrated commissioning approach for health and wellbeing across SCC and SC CCG, based on devolved responsibilities, pooled and aligned budgets and an integrated governance structure.*

6.2 Detailed work programmes for each of these plans are available on request.

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7. Performance Targets 17-19

7.1 Taking account of the performance against key metrics in 2016/17, as well as 2015/16, national and statistical neighbour comparisons, the following levels of ambition have been set.

Metric	15/16 Actual	16/17 Actual	National Average	Stat Neighbour Average	2017/19 Ambition	17/18 projected FOT based on 16/17 + growth	18/19 projected FOT based on 16/17 + growth	Proposed targets		Action to achieve proposed targets
								17/18	18/19	
Non Elective Admissions (all ages)	27,442	**28,320**	N/A	N/A	Hold at 16/17 level + growth for next 2 years with slight reductions for QIPP (1,055 for 17/18 and 507 for 18/19) as per CCG Operating Plan	29,736	29,197	28,525	28,534	Extension of case management Enhanced Health in Care Homes model Strengthened focus on cluster plans and performance Supporting carers Development of Older person's offer Roll out of community navigation Development of care technology Developing supportive communities Shape and support new models of care Development of 0-19 Prevention and Early Help Developing responsive community services to manager greater levels acuity Falls prevention
Admissions associated with Falls Injuries (over 65s) - Local Authority resident	1,025	1,078	832	922	Achieve statistically significant decrease in the rate of falls compared to 2016/17 - equating to 5.9% reduction in 17/18 and 11.5% reduction in 18/19	1,108	1,134	1,038	1,004	Implementation fracture liaison service Continuation of targeted falls exercise Roll out of universal exercise Falls champions in dom care and residential care Ensure appropriate redirection via SCAS, NHS 111
Standard-ised Rate (stat and	2,895	3,013	*2,209*	*2,449*		3,013	3,013	2,821	2,666	

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Metric	15/16 Actual	16/17 Actual	National Average	Stat Neighbour Average	2017/19 Ambition	17/18 projected FOT based on 16/17 + growth	18/19 projected FOT based on 16/17 + growth	Proposed targets		Action to achieve proposed targets
								17/18	18/19	
national estimated on 15/16 difference to Soton)										
Nursing and Residential Homes admissions (over 65s)	368	**289**	207	283	Continue to reduce towards reaching national average by 21/22	292	299	270	250	Enhanced health in care homes model - supporting residential homes to manage and reduce escalation to NHs Embed/consolidate Rehab and Reablement functions Hospital admission avoidance Development of Extra Care Shape and support new models of care Improve EOL care Falls prevention Supporting carers Development of Older person's offer Roll out of Community Navigation Developing Care Technology Developing supportive communities
Rate	1,117	877	628	859		876	876	809.8	732.4	
Effective Reablement (over 65s)	79%	**84%**	83%	80%	Continue to aim for 90% by 18/19	82%	82%	85%	90%	Embed/consolidate Rehab and Reablement functions

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Metric	15/16 Actual	16/17 Actual	National Average	Stat Neighbour Average	2017/19 Ambition	17/18 projected FOT based on 16/17 + growth	18/19 projected FOT based on 16/17 + growth	Proposed targets		Action to achieve proposed targets
								17/18	18/19	
Delayed Transfers of Care days (over 18s)	13,409	**18,397**			To reduce DTOC to achieve our regional target of 4% delayed days as % of all available bed days across all providers by Sept 2017 and then hold this and work towards achieving 3.5% target by June 18. This equates to a reduction in total DTOC between 16/17 and 17/18 of 6,449 (a 34% reduction from the 16/17 baseline) and a further reduction of 3,847 in 18/19 (a 54% reduction from the 16/17 baseline).	18,397	18,397	13,397	11,226	Embed 3 discharge pathways through discharge to assess and trusted assessment Reducing numbers of CHC assessments in hospital Focussed work with community hospitals, including discharge to assess Development of NH capacity for hard to place/care home procurement strategy Ongoing development of Dom care capacity Stabilisation of long term care market Improving EOL care Roll out of community navigation Developing care technology Developing supportive communities Developing responsive community services to support greater levels of acuity in community Enhanced health in care homes
Rate per 100,000		**13/14 – 1617: NHS delays = 400** **S/Care delays = 450**		13/14 – 16/17: NHS Delays = 390 S/Care delays = 240						
DTOC % of all beds		**5.2%**						4.0% - Sept 17 3.5% - June18	3.5%	

Metric	15/16 Actual	16/17 Actual	National Average	Stat Neighbour Average	2017/19 Ambition	17/18 projected FOT based on 16/17 + growth	18/19 projected FOT based on 16/17 + growth	Proposed targets		Action to achieve proposed targets
								17/18	18/19	
Total delayed days per day per 100,000 18+ population		25.4			To work towards achieving the national expectation for Southampton of 11.1			16.781	11.644	

7.2 Further detail on DTOC performance, along with benchmarking, and setting of 17/18 and 18/19 targets can be found in the DTOC Self Assessment available on request.

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8. Risks

8.1 The following risk log has been agreed by the Integration Board for 2017/18, with risks assigned to members of that Board. It reflects the main risks to Southampton's Better Care programme of achieving the key national and local metrics.

		Impact				
		1	2	3	4	5
Likelihood	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Risk		Description	Risk Lead	Impacts	Probability	Impact	Criticality Rating	Risk Action Plan
1	**NEL Activity and XBDs**	1.1 Risk of failure to reduce NEL activity, XBDs and admissions to nursing and residential care whilst investing in community alternatives	**DC (ICU)**	Double funding of activity in inpatient and out of hospital settings will not be sustainable. Savings will not be released from inpatient settings to fund out of hospital activity. CCG and LA will overspend.	*5 - Very High*	*4 - High*	**20**	Robust tracking of NEL, XBD and residential and nursing care activity - reported monthly to integration board Clear business cases in place for each new Scheme to be signed off between commissioners and providers Consider risk and benefit share arrangements going forward between commissioners and providers Robust monitoring of Schemes and continuous impact assessment to enable in year adjustments to be made if schemes not delivering required impact Enhanced access hubs Improved primary care and community care of long term conditions (e.g. COPD)

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Risk		Description	Risk Lead	Impacts	Probability	Impact	Criticality Rating	Risk Action Plan
2	**Domiciliary Care**	2.1 There are significant pressures in the domiciliary care market currently: there has been a 24% increase in double up packages compared to last year and we are seeing higher numbers of patients with more complex needs coming through the system at a time when the local dom care market is experiencing increasing difficulties in sourcing dom care.	**CB (ICU)**	Increasing pressure on domiciliary care Increase in length of hospital stays and delayed transfers of care	*5 - Very High*	*5 - Very High*	**25**	Continue to work with the market to develop onward care capacity to support timely discharge and flow. STP New Models of Care Programme will focus on development of a recovery focussed model, de-escalating care intervention at the earliest possible juncture, right-sizing support around individual patient need. Look at the current Domiciliary Care market provision and seek to reinvigorate interest in the Care sector through a range of incentives and recruitment initiatives including the development of an enhance university recruitment programme in collaboration with local academic leaders. In 2018/19, work with Southampton City Council to implement further improvements in onward care to support timely discharge, capitalising on opportunities linked to recommissioning of the domiciliary care framework.
3	**Contractual**	3.1 Risk that current contractual and payment mechanisms, e.g. acute PBR, will incentivise the wrong behaviours in the system and disincentivise the behaviours required	**DC/SR (ICU)**	Community providers will disengage from the vision if funding does not follow increased community activity. Providers will be dis-incentivised from working together on shared outcomes	*3 - Medium*	*4 - High*	**12**	Actively explore alternative contractual and payment mechanisms - to include alliance contracts, outcome based commissioning and payment mechanisms that follow pathways and patients as opposed to units of activity Develop clear outcomes framework and embed in all contracts Use of CQUIN to incentivise system wide approaches

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Risk		Description	Risk Lead	Impacts	Probability	Impact	Criticality Rating	Risk Action Plan
4	System Capacity	4.1 Risk that we will not be able to develop the required level of prevention and early intervention services to support the programme and to underpin changes due to - financial challenges in all agencies, the capacity of local voluntary sector agencies, ability to recruit volunteers/competing demand for volunteers	**CB (ICU)**	Unable to put in place the required level of prevention and early intervention services required to halt increasing demand. Inpatient and residential activity and associated spend continues to be high. Failure to achieve the vision of Better Care	*4 - High*	*4 - High*	**16**	Establishment of scheme specifically on prevention and early intervention to provide the necessary focus and visibility, realignment of resources to increase priority on this approach Development of infrastructure to support sourcing of external funding streams e.g. Big Lottery - continuous horizon scanning and bid writing Work with businesses to explore alternative sources of funding Making Every Contact Count (MECC)
		4.2 Risk that providers are destabilised through system change, e.g. smaller voluntary sector providers may be destabilised if larger voluntary sector providers win business; acute hospital providers could be destabilised by shift of activity into community. Risk that community and voluntary sector providers do not have capacity to engage or are unable to recruit an adequate pool of people wanting to volunteer	**SR (ICU)**	Continued reliance on public sector services / failure to achieve more preventative proactive models of support Lack of resource capacity to support people in community and inability to manage & prevent escalation of need to specialist services Variety and mix of providers is reduced thereby restricting the potential for future market development	*4 - High*	*4 - High*	**16**	Early and continuous engagement of the market at all stages of the programme Robust impact assessments for any changes throughout the programme Good representation on Integration Board to continuously monitor this risk Partnership group established to share learning and development SVS supporting voluntary sector input to the clusters and leadership group Vol sector capacity issues included in SVS input to vanguard bid. Community development commissioning plan to support development of infrastructure and coordination of effort Ensuring that procurement processes are proportionate to the size of the investment and that grants and contracts are applied appropriately Work with economic development team to

Risk	Description	Risk Lead	Impacts	Probability	Impact	Criticality Rating	Risk Action Plan
							engage employers/businesses Use Connect to target employers, e.g. universities in relation to growing the pool of volunteers
	4.3 Risk that local community market (health and social care, public sector and independent providers) does not have capacity to deliver change and there is no ability to attract alternative providers	**SR** **(ICU)**	Inability to achieve community based model. In patient and residential activity and associated spend continues to be high. Failure to achieve the vision of Better Care	*4 - High*	*4 - High*	**16**	Develop market position statements in priority areas to give early heads up and engage market in planning; regular communication with market about priorities and business opportunities Develop market development plan in key areas, e.g. domiciliary care. Identify levers and rewards. Community development commissioning plan to support development of infrastructure to support CVS
	4.4 Risk that providers and primary care are unable to recruit to key posts, e.g. dom carers, nurses, social workers, community paediatricians and geriatricians	**JH/LM/ SRob/ AR/ PJ/SO** **(UHS/ Solent/ CCG/ SPCL/ SCC/**	Inability to achieve community based model. Inpatient and residential activity and associated spend continues to be high. Failure to achieve the vision of Better Care.	*4 - High*	*4 - High*	**16**	Develop system wide workforce plan identifying the roles required to deliver the Better Care vision and ensure that this is embedded in organisational workforce plans through the Integration Board Develop system wide recruitment campaigns in key areas Explore joint appointments to make posts more attractive

Risk		Description	Risk Lead	Impacts	Probability	Impact	Criticality Rating	Risk Action Plan
			SHFT)					Engage health and social care training providers to ensure that sufficient numbers of students with the right skills/behaviours are coming through the system
		4.5 Risk that Primary care does not have capacity to engage and deliver high quality care because of workload	**SRob/ AR (CCG/ SPCL)**	Inability to achieve community based model. Inpatient and residential activity and associated spend continues to be high. Failure to achieve the vision of Better Care.	*4 - High*	*4 - High*	**16**	Local GP Federation represented on Integration Board Strong GP input / leadership into the programme Primary care Local Improvement Scheme targeted at supporting practices to engage in Better Care clusters Strong engagement in MCP which is linked to Better Care Primary Care Strategy to develop model for sustainable primary care embedded in MDT consistent with BCF model. GP Forward View national funding
5	**Cultural Change within system**	5.1 Risk of not being able to achieve the cultural change required amongst the workforce (Solent, UHS, Southern Health, SCC, Primary Care) - e.g. person centred care and self management, partnership working, management of risk in a community setting, use of technology like telehealthcare	**JH/LM/ SO/PJ/ AR (UHS/ Solent/ SHFT/ SCC/ SPCL)**	New ways of working will not embed Inpatient and residential activity and associated spend continues to be high. Local people do not have confidence in new ways of working if health and social care staff who work with them don't Failure to achieve the vision of Better Care	*4 - High*	*4 - High*	**16**	Cluster leadership development and workforce development System leadership event Add MECCs and multispecialty provider principles into job descriptions Ensure that organisational workforce development plans reflect Better Care working practices and values - through Integration Board Investment in multiagency Organisation Development in each cluster Better Care communication plan and branding

Risk		Description	Risk Lead	Impacts	Probability	Impact	Criticality Rating	Risk Action Plan
6	**Changing the expectations and ownership of the public and service users**	6.1 Risk that public and service users do not change their expectations and do not want to take more responsibility for their own health and wellbeing, or more control over their own care and support.	**CB (ICU)**	New ways of working will not embed. Continued over-reliance on health and care system. Failure to achieve the vision of Better Care	*4 - High*	*4 - High*	**16**	Better Care communication plan in place and branding Ongoing work using National Voices I Statements to raise awareness and prompt discussion Use of workforce to deliver the key messages - Making Every Contact Count
7	**Change in Leadership**	7.1 Risk that changes in leadership (managers as well as political leadership) could result in different priorities/direction of travel thereby destabilising work programme	**SRob (CCG)**	Work programme becomes destabilised. Staff and service users become disengaged through changes in direction of travel. Slippage/delay in delivering change required. Failure to achieve the vision of Better Care	*5 - Very High*	*4 - High*	**20**	Ensure that there is broad consultation with all stakeholders including the opposition party Ensure that there is strong evidence base for the programme Ensure robust business plans in place
8	**IT**	8.1 Risk that IT/ interoperability workstreams do not deliver quick enough to support the new ways of working, e.g. sharing of information, shared care plans, mobile working	**LM/AR (Solent/ SPCL)**	Delay in health & care staff being able to share information and view care plans Duplication of assessments; inefficient working practices; key information not available to staff	*4 - High*	*3 - Medium*	**12**	HHR in place System wide IT management group in place to oversee work programme Work already underway to ensure that GP systems link to HHR – TPP Systmone GP record upload to HHR is technically working and being tested currently. Work planned to ensure social care link to HHR National support available through GPFV to build resilience and sustainability

8.2 Under the terms and conditions of the BCF S75, arrangements are in place for sharing over and under-spends against some of the key schemes.

9. **Finance**

9.1 In 2017/18 and 2018/19, Southampton will continue to pool far beyond its BCF minimum requirement which is £16.176M and £16.484M for each of the two years respectively. This is shown in the table below:

	2017/18	2018/19
CCG contribution (minimum)	16,176,000	16,484,000
CCG contribution (additional)	53,325,000	53,325,000
SCC contribution	30,713,349	30,713,349
SCC Contribution (iBCF)	4,981,651	3,161,704
Total	105,196,000	103,684,040

9.2 The above funding is split across the following pooled fund schemes for 2017/18 as follows:

Scheme	**CCG £000**	**SCC £000**	**Total £000**
Carers	1,240	134	**1,374**
Clusters	47,026	2,212	**49,238**
Rehab & Reablement	10,543	4,551	**15,094**
DFG (Capital)		1,882	**1,882**
Joint Equipment Store	798	803	**1,601**
Telecare		250	**250**
Direct Payments		500	**500**
Long Term Care		2,750	**2,750**
Integrated Care Teams – LD	9,894	16,414	**26,308**
Prevention & Early Intervention		6,199	**6,199**
Total	**69,501**	**35,695**	**105,196**

10. National Conditions

10.1This BCF Plan supports the national 4 conditions for Better Care as follows:

1. A BCF Plan, covering a minimum of the pooled fund specified in the Spending Review, should be signed off by the HWBB and by the Council and CCG
This 2017-19 Better Care plan has been developed through the city's Integration Board, Commissioning Partnership Board and the Health and Wellbeing Board. Progress against 2016/17 plans and priorities for 2017-19 have been signed off by all these Boards (HWBB 29 March 2017).. There is joint agreement across commissioners and providers within the Southampton Local Delivery System as to how our Better Care programme contributes to Southampton's longer term strategy. This is reflected in the broad ownership of our Better Care Programme, our commitment to bringing our plans for Better Care and provider development (e.g. MCP, Primary Care strategy) together as well as in the CCG's Operating Plan, the Council's Plan and the City Strategy. All key stakeholders are represented on the Integration Board which reports to the HWBB and provides more

focussed leadership for Southampton Better Care. Membership includes University Hospital Southampton Foundation Trust, Solent NHS Trust, Southern Health Care Foundation Trust, South Central Ambulance Service, Southampton Primary Care Ltd (the local GP Federation), Hampshire Constabulary, Primary and Secondary School Sectors, the Voluntary Sector and Southampton City Council Adult Social Care and Housing and Children's Services.

Southampton City is already pooling an amount significantly greater than its minimum requirement – approx. £100M in 16/17 against a minimum requirement of £15.9M– and has plans to further increase this in 17/18. Plans for allocation of the additional ASC investment in line with the grant conditions have been agreed and will become part of the BCF S75 in 2017/18.

All partners are committed to their contributions in line with inflation to the agreed BCF Schemes:

- Integrated health and social care cluster teams (existing scheme with additional CCG STP investment agreed for 17/18)
- Integrated Rehab, Reablement and Supported Discharge (existing scheme with additional funding from ASC additional allocation/ improved BCF and additional CCG STP investment agreed for 17/18)
- Support for carers (existing scheme)
- Care technology (existing scheme with additional funding from ASC additional allocation/improved BCF for 17/18)
- Prevention and early intervention (existing scheme)
- Integrated adult learning disability services (existing scheme)
- Promotion of Direct Payments/Personal Budgets (new scheme for 17/18 with additional funding from ASC additional investment)
- Transforming Long Term Care capacity (additional scheme being worked up for 17/18 with additional funding from ASC additional allocation/improved BCF)
- DFG (existing scheme)
- Integrated provision for children and families with complex needs (new scheme being worked up for 17/18)

2. To maintain provision of social care services

Southampton has defined "maintaining the provision of social care services" as "ensuring that resources are available to provide appropriate support for those who meet the current eligibility criteria and effective signposting for those who do not (ref. Better Care Plan September 2014)".

Eligibility criteria remains as those who need 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,

DRAFT

based on Department of Heath Guidance 2010.

The key focus for maintaining this provision 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.

Local Schemes and spending will support this commitment to maintain eligibility, including responding to increasing demographic demand, through delivering the following objectives:

- maximise independence through improved integrated re-ablement and rehabilitation and responsive discharge
- developments to increase use of extra care housing
- access to telecare/telehealth services, to help people regain their independence and reduce the need for ongoing care
- ensuring carers have access to appropriate resources and feel supported
- widen peer and community/voluntary sector support availability
- strengthen the focus on prevention, supporting people to keep themselves healthy and independent, linked to their local communities, and by intervening early when people need help
- 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

The total value attributable to social care services in the 2017/18 pooled fund is £XX. This is the total funding spent on social care functions and mainly sits within the Carers, Clusters, LD joint commissioning, transforming long term care and Rehab and Reablement Schemes. A significant element of this funding reflects current Council investment but a sizeable element also reflects the CCG's contribution to reablement.

3. A proportion of the area's allocation to be invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement

A significant number of our schemes include ongoing investment in NHS commissioned out of hospital services (just over £Xm). This includes the Cluster Scheme which brings together over £48M to deliver integrated person centred care and the rehab and reablement scheme which has over £15 ½M invested in community out of hospital services.

This includes additional investment the CCG is making this year in expanding case management to focus on those people most at risk of deterioration and therefore use of emergency and hospital services, and in supporting discharge through rolling out discharge to assess at scale.

In 2016/17 our non-elective admissions grew by around 4% compared to the previous year, primarily in the very short stay (less than 24 hour) admissions amongst adults (ED and GP referrals remained virtually static) which suggests this increase relates to people being admitted mainly from ED for short periods of assessment and observation. We have instigated a number of additional schemes to address short stay admissions this year - some within our Better Care Programme (e.g. development of Southampton's frailty model, expanding case management, developing community services to manage

greater levels of acuity, implementation of enhanced health in care homes, fracture liaison and falls prevention) - and some outside (e.g. reducing admissions for chest pain, abdominal pain, heart failure, alcohol and respiratory related conditions and working with the ambulance service to increase see and treat and non conveyance rates). We are also in discussion with UHS regarding coding of very short stay admissions.

We have taken the decision not to hold back any of the investment as a local risk fund. A risk share was fully discussed by the CCG and the Council and rather than holding back money for non delivery around non electives, it was felt that we should invest in community services to mitigate NEL demand.

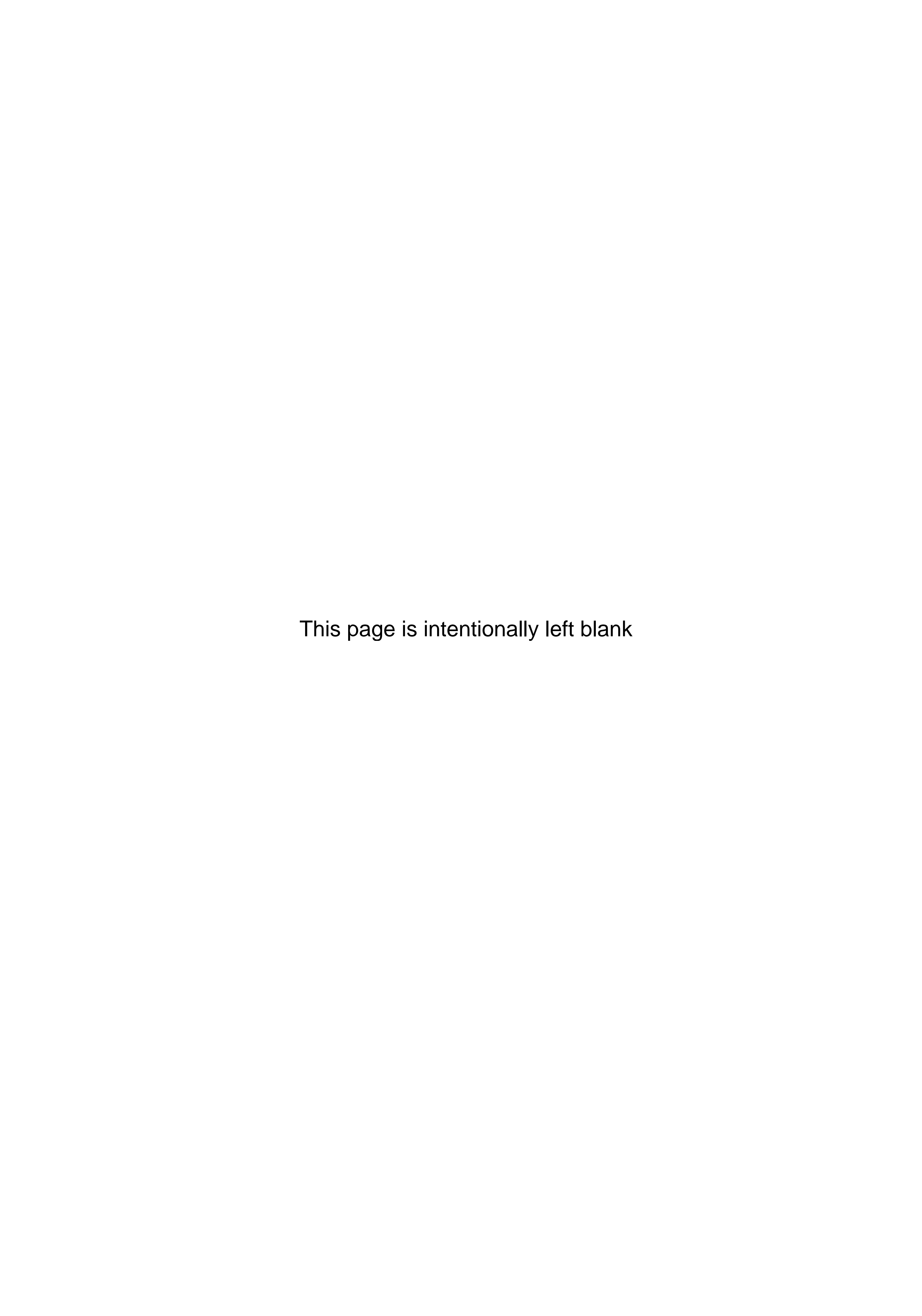
We have risk sharing arrangements in place for each of our schemes that are set out in the terms and conditions of our Section 75 Partnership Agreement. Monthly financial reviews are held to go through each scheme in detail in terms of spend and forecast expenditure and report to the Commissioning Partnership Board.

4. Managing Transfers of Care

Reducing delayed transfers of care is an important target for Southampton's Better Care Plan and an area in which both the CCG and Council are making significant additional investment in 2017/19. This includes CCG investment to roll out discharge to assess across pathway 2 and into the Council's hospital discharge team to sustain 7 day working in support of pathway 3; and Council investment of some of its additional adult social care allocation (ref. improved BCF) into a discharge to assess scheme for the community hospitals, additional replacement care to support patients who cannot return immediately to their own homes and the remodelling of the hospital discharge team. We are also using a significant part of the additional social care allocation to transform long term care (residential and domiciliary care), in acknowledgement of the significant pressures within our long term care market which are impacting on our DTOC rates.

The CCG and Council have undertaken a joint self assessment of Southampton's DTOC rates (available on request) and agreed a revised trajectory for 2017/19 towards achieving the 3.5% national target. The Southampton Local Delivery System works in close partnership with Hampshire partners as part of the SW Hampshire System to address DTOC at our main acute hospital provider UHSFT and has jointly agreed the following 3 key priorities for tackling DTOC in 2017/19 (described in detail in Section 3.15 above):

- *To continue to embed at pace the 3 pathways across the whole system (simple, supported and enhanced)*
- *To continue to support and develop the long term care market*
- *To turn our focus also onto improving discharge processes in Southampton's community hospitals, in particular Solent and SHFT.*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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		ADULT SOCIAL CARE GRANT		
DATE OF DECISION:		26 JULY 2017		
REPORT OF:		SERVICE DIRECTOR, ADULTS, HOUSING AND COMMUNITIES		
CONTACT DETAILS				
AUTHOR:	Name:	Paul Juan	Tel:	023 8083 2530
	E-mail:	paul.juan@southampton.gov.uk		
Director	Name:	Paul Juan	Tel:	023 8083 2530
	E-mail:	paul.juan@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY

NOT APPLICABLE

BRIEF SUMMARY

The Board is requested to ratify proposals for spending a one-off Government grant of £4.98M in 2017/18 for the purpose of meeting adult social care needs, reducing pressures on the NHS and stabilising the social care provider market.

RECOMMENDATIONS:

	(i)	To ratify expenditure of £4,981,651 in 2017/18 on schemes (set out in Appendix 1) that will meet adult social care needs, reduce pressures on the NHS and stabilise the social care provider market, in accordance with the grant conditions, Financial Procedure Rules and the governance arrangements for Southampton's Better Care Fund.

REASONS FOR REPORT RECOMMENDATIONS

1.	The Departments of Health and Department for Communities and Local Government have encouraged engagement with Health and Wellbeing Boards to agree spending plans.
2.	The grant will be pooled into the Better Care Fund, to support a continuing agreement with the local NHS.
3.	Subject to Cabinet approval, Full Council will consider a recommendation at its meeting on 19 July 2017 to accept a one-off Government grant of £9,710,902 over three years from 2017/18 to 2019/20 (including an allocation of £4,981,651 for 2017/18).

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4.	No other options have been considered and rejected.

DETAIL (Including consultation carried out)	
5.	Additional funding for adult social care was announced in the Spring Budget 2017 and the council's allocation is set out in figure 1 below. | Year | Amount £ | | 2017/18 | 4,981,651 | | 2018/19 | 3,161,704 | | 2019/20 | 1,567,547 | | Total | 9,710,902 | *Figure 1*: Southampton City Council's grant allocation
6.	Conditions are attached to the grant to ensure that the money is spent on adult social care services and supports improved performance at the health and social care interface.
7.	Proposals for schemes to be funded from this grant during 2017/18 are set out in Appendix 1. These proposals have been agreed in principle at the Integration Board and the Commissioning Partnership Board. They are scheduled to be considered at a meeting of the council's Cabinet on 18 July 2017 and at Full Council on 19 July 2017.
8.	These schemes will help the council to meet eligible adult social care needs; support the NHS and, in particular, the progress being made across the local health and social care system to reduce delayed transfers of care from acute and community hospitals; and to help maintain a diverse and sustainable social care provider market locally.
9.	The Department of Health and Department for Communities and Local Government have announced the development of new performance measures to assess how effectively this grant is being used. The Care Quality Commission (CQC) is scheduled to carry out 20 targeted inspections later this year with a focus on the interface between health and social care services.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
10.	The new funding, totalling £9.71M, will be paid as a Department of Communities and Local Government grant.
11.	Funding for the schemes proposed in Appendix 1 is additional to the budget for 2017/18 approved by Council on 15 February 2017.
12.	Guidance has not been issued at this stage on whether any unspent funding can be carried forward to future years. Appendix 1 details how the first year's funding of £4.98M will be allocated, subject to ratification by the Health and Wellbeing Board, while the remaining grant will be incorporated into the General Fund budgets for 2018/19 (£3.16M) and 2019/20 (£1.57m) scheduled to come before the Health and Wellbeing Board in due course and to Full Council in February 2018 and 2019 respectively.

Property/Other	
13.	Any provision of nursing care at Holcroft House is likely to require building work, which will require scoping by the council's Capital Assets Team prior to approval by the Council Capital Board. The budget for this work may be transferred to the General Fund Capital Programme at this stage, funded by Direct Revenue Financing.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
14.	The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund.
Other Legal Implications:	
15.	There are no other legal implications arising from this report.
RISK MANAGEMENT IMPLICATIONS	
16.	Acceptance of the grant and implementing the proposals set out in Appendix 1 would reduce the risk of the council failing to ensure an effective and sustainable adult social care system, which is identified as a risk in the council's strategic risk register.
POLICY FRAMEWORK IMPLICATIONS	
17.	Accepting the grant would support delivery of the Southampton City Council Strategy 2016-2020 and, in particular, the key outcome of supporting people in Southampton to live safe, healthy and independent lives.
18.	Accepting the grant will also support delivery of the Health and Wellbeing Strategy 2017-2025 and the Southampton Better Care Plan.

SUPPORTING DOCUMENTATION

Appendices	
1.	Proposals for spending the additional funding in 2017/18

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**~~Yes~~/No**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**~~Yes~~/No**

Other Background Documents

Other Background documents available for inspection at: Civic Centre, Southampton, SO14 7LY

	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.	Letter from Department of Health and Department for Communities and Local Government to Chief Executive dated 22/3/17	Not applicable

APPENDIX 1

Proposals for spending the grant in 2017/18

Scheme	Detail	Funding in 2017/18 £ ,000	Grant conditions		
			Meeting needs	NHS/ hospital discharge	Market
Extra nursing home capacity for complex needs	Conversion of all or part of Holcroft House residential care home to offer nursing in addition to residential care (subject to feasibility and registration); and/or commission additional capacity in private sector. This would not involve moving any existing clients from the premises	1,500	✓	✓	
Meeting increased demand and complexity	Additional investment to meet an increase in demand and complexity over and above original forecasts	1,000	✓		
Stabilising the provider market – workforce, home care and nursing	Additional investment to provide extra training and career development for carers; to consolidate increased domiciliary care capacity; and to support financial stability in the nursing home sector	850			✓
Speeding up hospital discharges for people with complex needs	Investment to support the complex discharge pathway, a discharge to assess scheme for Continuing Health Care (CHC) and an assess at home scheme covering the Royal South Hants (RSH) hospital	500	✓	✓	
Establish a dedicated Direct Payments Team	A new dedicated team working across the Council and Integrated teams to increase direct payment uptake, increasing choice and control and improving outcomes, including people leaving hospital	350	✓	✓	
Weston Court replacement care/short stay scheme	Working with a domiciliary care agency to provide support required to utilise existing facilities for replacement care, short stays, including for people with a learning disability, and to support hospital discharge	250	✓	✓	
Accelerating the extra care housing programme	A pump prime fund to accelerate plans for increasing the local supply of extra care housing, which leads to better outcomes in a more cost effective way when compared with residential and nursing care	250	✓		

Scheme	Detail	Funding in 2017/18 £ ,000	Grant conditions		
			Meeting needs	NHS/ hospital discharge	Market
Expanded 7 day social care operation in the hospital discharge team	To support discharge of individuals with complex needs from University Hospitals Southampton at the weekend	130		✓	
Enhanced social care out of hours service	To help prevent hospital admissions and support hospital discharges	100	✓	✓	
Care Technology Coordinator post	A dedicated Care Technology Coordinator working across Council and Integrated Teams to sustain an increase in referrals, supporting independence, preventing admissions & supporting timely discharges	50	✓	✓	
TOTAL		4,980			

DECISION-MAKER:		Health and Wellbeing Board		
SUBJECT:		SHARED COMMISSIONING BETWEEN SOUTHAMPTON CITY COUNCIL AND SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
DATE OF DECISION:		26th JULY 2017		
REPORT OF:		Director Quality and Integrated Commissioning		
CONTACT DETAILS				
AUTHOR:	Name:	Stephanie Ramsey	Tel:	023 80 296941
	E-mail:	stephanie.ramsey1@nhs.net		
Director	Name:	Stephanie Ramsey	Tel:	023 80 296941
	E-mail:	stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY
The attached report regarding shared commissioning between Southampton City Council and Southampton City Clinical Commissioning Group (CCG) is being considered by Cabinet 18 July 2017 and Full Council 19 July 2017. The Health and Wellbeing Board will be provided an update on the Cabinet report at their next meeting.

RECOMMENDATIONS:		
	(i)	That the Health and Wellbeing Board notes the report.

REASONS FOR REPORT RECOMMENDATIONS	
1.	For information.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None.
DETAIL (Including consultation carried out)	
3.	See attached report for detail.
RESOURCE IMPLICATIONS	
Capital/Revenue	
4.	None
Property/Other	
5.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
6.	See report.

Other Legal Implications:		
7.	**Legal implications of the proposals put forward in the attached report are outlined in sections 26 and 27 of the report.**	
RISK MANAGEMENT IMPLICATIONS		
8.	**See report.**	
POLICY FRAMEWORK IMPLICATIONS		
9.	**Policy framework implications of the proposals put forward in the attached report are outlined in sections 29-31 of the report.**	

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION

Appendices	
1.	**Shared commissioning between SCC and Southampton City CCG report to Cabinet 18 July 2017 / Full Council 19 July 2017**
2.	**DRAFT Terms of Reference for the Joint Commissioning Board**

Documents In Members' Rooms

1.	**None.**

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**

Other Background Documents
Other Background documents available for inspection at:

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

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COUNCIL</td></tr>
<tr><td colspan="2">SUBJECT:</td><td colspan="3">SHARED COMMISSIONING BETWEEN SOUTHAMPTON CITY COUNCIL AND SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP</td></tr>
<tr><td colspan="2">DATE OF DECISION:</td><td colspan="3">18 JULY 2017
19 JULY 2017</td></tr>
<tr><td colspan="2">REPORT OF:</td><td colspan="3">THE LEADER OF THE COUNCIL</td></tr>
<tr><td colspan="5"><u>CONTACT DETAILS</u></td></tr>
<tr><td>AUTHOR:</td><td>Name:</td><td>Sarita Riley, Service Lead, Legal Services
Stephanie Ramsey, Director Quality and Integration</td><td>Tel:</td><td>023 80833218

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</table>

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY
This report recommends further integration between health and social care in the city through the establishment of a Joint Commissioning Board to make joint decisions on behalf of the Council and CCG on certain agreed functions related to health and care. This will be in line with best practice and give Southampton a leading edge as there is an emerging consensus, both nationally and locally, about the opportunity to improve outcomes through a unified approach to health and care planning and funding (commissioning). To contribute towards this it is proposed to build on the existing integrated commissioning arrangements by establishing a new Joint Commissioning Board which would have delegated powers from Council/Cabinet and the CCG General Assembly/ Governing Body to make joint decisions on behalf of the Council and CCG on certain functions related to health and care. It is proposed that the scope of the integrated commissioning arrangements will broadly mirror those areas of health and care commissioning covered by the Better Care Fund S75 plus other existing partnership agreements/shared funding arrangements.

RECOMMENDATIONS:		
	CABINET:	
	(i)	To approve the establishment of a Joint Commissioning Board between the Council and Southampton City Clinical Commissioning Group to undertake Executive functions within the Boards proposed Terms of Reference.
	(ii)	To delegate authority to undertake joint commissioning functions that are executive functions within agreed budgets to individual members of the Board (Officers and Members as appropriate) acting at Board meetings within the procedures set out in the terms of reference.
	COUNCIL:	
	(i)	To approve the establishment of a Joint Commissioning Board between the Council and Southampton City Clinical Commissioning Group to undertake non-executive functions within the Boards proposed Terms of Reference.
	(ii)	To delegate authority to undertake joint commissioning functions that are non-executive functions within agreed budgets to individual members of the Board (Officers and Members as appropriate) acting at Board meetings within the procedures set out in the terms of reference.
	(iii)	To authorise the Service Director: Legal and Governance following consultation with the Leader, Group Leaders, the Chief Strategy Officer and the Director: Quality and Integration to make all necessary changes to the Council's Constitution to give effect to the establishment of the Board and decision making arrangements, including but not limited to changes to the Executive Scheme of Delegation, Officer Scheme of Delegation, Member and Officer Codes of Conduct, Partnership Protocols, Financial and Contract Procedure Rules, decision making protocols and standards and the creation of an Inter Authority Agreement, information sharing and information governance protocols, conflict resolution procedures and protocols as well as terms of reference for any new Board established.

REASONS FOR REPORT RECOMMENDATIONS	
1.	There is an opportunity to strengthen existing joint commissioning arrangements to achieve the level and pace of service change and integration needed to meet current and future challenges. This will enable both organisations to provide the seamless health and care which residents need and to meet quality and sustainability challenges. The current governance structures require changes for both organisations to be able to implement the necessary changes jointly and at pace.
2.	National direction, such as Integration and Better Care Fund Policy Framework 2017, requires integration between health and care services. Success measures for such are being developed nationally and the Care Quality Commission has the remit to carry out targeted reviews.
3.	Nationally there is an expectation that full integration of health and social care will be implemented by 2020. Southampton is ideally placed to increase the pace and depth of integrated commissioning, with its asset of co-terminosity between health and local government; its track record of delivering benefits through integration, its existing integrated commissioning functions and good working relationships. A shared

	ambition for change has been agreed between SCC Cabinet and the Clinical Commissioning Group (CCG) Governing Body: ‘*Commissioning together for health and wellbeing will allow us to push further and faster towards our aim of completely transforming the delivery of health and care in Southampton so that it is better integrated, delivered as locally as possible, person centred and with an emphasis on prevention and intervening early to prevent escalation’.*
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
4.	Eight options were rigorously tested against a range of (weighted) financial and non-financial assessment criteria. They included: • Resident and patient outcomes: increasing resident and patient benefits through maximising new commissioning possibilities • System efficiency and sustainability :financial benefit through making savings for both organisations; effective decision making; ease of deliverability • Accountability: democratic accountability; strategic alignment of priorities for both organisations; legal and regulatory compliance.
5.	The options considered and rejected during this first stage were to: • do nothing • continue with or reverse current arrangements • joint commissioning by a Combined Authority. These were rejected on the basis of an agreed scoring criteria which comprised ranking the weighted benefit criteria; through this process it was ascertained that these options did not deliver the same benefits as other options.
6.	Four shortlisted options were analysed further to assess their benefits in terms of : • Strategy (i.e. which option has the greatest potential to drive service innovation, provider integration and ultimately maximise benefits for citizens and patients) • Governance (i.e. which option has the structures, powers and duties to maximise integration, whilst minimising complexity and the possibility of legal challenge) • Financial (i.e. balance of pooled and aligned budgets for each option).
7.	As a result of further assessment an additional three options were rejected at this stage: • Joint commissioning hosted by either the CCG or Council • Commissioning overseen by the Health and Wellbeing Board (H&WB). This was rejected as the Health and Wellbeing Board is a sub-committee of Council, not the Executive and as such cannot legally exercise Executive powers. The H&WB has statutory functions wider than the scope of shared commissioning as well as statutory membership which would impact on the balance of the proposed new board as the members have particular voting rights in law. The current H&WB advisory / scrutiny role could also be lost from the system. • Establishing a Regulation 10 committee as allowed within a Section 75 agreement (an agreement made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England). This was rejected as it would limit decision making to pooled budget items only and not areas where budgets are aligned rather than formally pooled.
DETAIL (Including consultation carried out)	
8.	The proposal is to establish a Joint Commissioning Board to be accountable for

	effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements for health and care between Southampton City Council and Southampton City CCG. This would demonstrate a commitment to genuine joint working and provide a body constituted with executive powers jointly accountable to Cabinet/Council and the CCG Governing Body/General Assembly. This change will enable greater transparency as meetings will be held in public and reduce complexity in decision making,
9.	The Board will approve and monitor the development and implementation of a publicly available, annual Integrated Commissioning Plan; ensure objectives and targets are met, outcomes achieved for residents and patients and that commissioning arrangements align with the partners' financial and business planning cycles.
10.	This Board would replace the Commissioning Partnership Board which oversees the work of integrated commissioning. The Commissioning Partnership Board make recommendations for key decisions to the Council's Cabinet and CCG Governing Body. It has no delegated decision making power and its role is to ensure effective collaboration, alignment and assurance across the integrated commissioning arrangements between Southampton City Council and Southampton City CCG. The Board also ensures that priorities identified by the Health and Wellbeing Board are met. The proposal in this report is to further strengthen integrated commissioning by delegating some decision making to the members of a Joint Commissioning Board, once strategic direction has been set by Council and CCG Governing Body. This will include the delegation of some of the responsibilities for Better Care currently within the remit of the Health and Wellbeing Board.
	Scope
11.	The proposed scope of the integrated commissioning arrangements will be limited to agreed elements of health and care commissioning. A large majority will be areas already included in the well-established Better Care Fund Section 75 agreement between the council and the CCG. It will also include other existing partnership agreements and shared funding arrangements. This includes services such as integrated rehabilitation, reablement and discharge services, support services for carers, care technology, joint equipment service, mental health and integrated services for children with complex health needs. A detailed breakdown is attached at Appendix 1. At the start, it is proposed that the Joint Commissioning Board will be responsible for an initial budget of at least £105M. The services included within this budget will form part of the budget process for both organisations and still be required to contribute to the efficiency and savings programmes. The remit of this Board will be to recommend savings to contribute to these programmes. The Joint Commissioning Board will be responsible for delivering agreed savings, many of which will be inter related across social care and health, such as with integrated rehabilitation and reablement.
12.	There will also be services in scope for consideration by the Board where the commissioning responsibility/ decision making remains solely with the City Council or the CCG but the use of funding is aligned to deliver a jointly agreed strategy. This could include Respite and short breaks or transformation of Children and Adolescent Mental Health Services (CAMHS). In addition there will be other areas to consider together that help both organisations achieve agreed outcomes, such as bids for funding.
13.	It would be the responsibility of the Board to: • assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes

	• monitor financial contributions of the Council and the CCG and make recommendations regarding future financial contributions • receive and sign off all Better Care Fund performance reports for approval and submission to NHS England • provide the Council/Cabinet and CCG Governing Body with an annual review of the S75 Better Care Partnership Agreement arrangements.
	Governance
14.	The council's representation on the Joint Commissioning Board will be made through executive appointments of 3 Cabinet Members, similar to the membership of the Health and Wellbeing Board. The CCG will similarly nominate 3 members from the CCG Governing Body. The proposal is that there will be delegated decision making to individual members of the Board with appropriate safeguards limiting the exercise of their delegations to circumstances in which consensus can be achieved at the Board meetings. The Council's Cabinet and the CCG Governing Body may grant delegated authority (with any appropriate caveats) to those of its members or officers participating in the Board to make decisions on their behalf, whilst retaining overall responsibility for the decision made by those members or officers. It would therefore be the individual member or officer who had the delegated authority to make a decision rather than the Joint Commissioning Board itself (unless under S75 lead commissioning arrangements).
15.	As the Board will, through its member's delegated decisions, be exercising Executive functions, the following requirements would apply: • set published meeting dates, to provide advance information on the Council's Forward Plan (28 days before any decision)) and CCG's governance arrangements • written reports containing specified information that must be published a set period in advance (5 working days before meeting date) • hold meetings in public (proposed to commence from April 2018) • restrictions on taking confidential decisions unless a period of notice (28 days) has been given • requirements around recording and publishing decisions • 'standstill period' following decisions during which 'Call In' can be exercised by the council's Overview and Scrutiny arrangements.
16.	The council's legal advice is that this is a tried and tested method of governance that is legally the most robust to achieve. It also requires less change constitutionally and will be easier to manage administratively.
17.	Under this proposal Executive Members or Officers attending the Board would require delegated powers to enable them to make decisions following consultation with the collective Board. This could be achieved by amending the Executive Procedure Rules and Officer Scheme of delegation in the Council's constitution together with consequential amendments to Financial Procedure Rules and Access to Information Procedure Rules. Such changes would need to go through the constitutional change process and be approved by Full Council.
18.	The draft Terms of Reference is attached at Appendix 1 and includes the scope. The Board would require a consensus between the two organisations prior to any delegated decisions being taken. Consensus will be demonstrated by a show of hands. It is important that given the nature of the decisions, securing the support of both partners will be critical to the success of this Board. In those circumstances where consensus cannot be reached, it is proposed that the matter would be deferred for further consideration by the parties to be reconsidered after discussions between the Chair

	and respective partner lead. Functions outside the decision making scope of the Board, but related to health and social care will be discussed for information only at the Board, with the considerations and any recommendations of the Board formally minuted. Items will then be referred to the relevant decision maker (e.g. CCG Governing Body, Council).
	Benefits
19.	Shared commissioning enables achievement of a shared vision e.g. a shared focus on prevention and early intervention and community solutions to promote independence & a shared commitment to realise it. This is alongside the ability to share risks and benefits associated with implementation of the shared vision, enabling us to do the "right thing" without unfairly disadvantaging or advantaging one organisation and to commission against a single agreed set of common outcomes and priorities – making best use of resources. The opportunity to share data on needs and good practice evidence leads to more intelligent commissioning and to develop more innovative solutions to meet people's needs in the round (as opposed to commissioning in silos for people's "health" versus "social" needs) which leads to improved outcomes for people. Bringing together health, public health and social care resources and stripping out duplication had already led to savings and efficiencies. A stronger governance process will facilitate the commissioning of a more joined up health and care system,
20.	Integrated commissioning has already achieved savings across both organisations covering a range of services which include in 2016/17, Adult Social Care - £2.4M, Public Health - £1M and the CCG - £3M. Integrated commissioning arrangements have been highlighted as a particular strength in recent inspections, e.g. SEND and delivered improved outcomes and made positive benefits such as: • redesign of an integrated Rehabilitation and Reablement Service which has reduced admissions to residential and nursing homes (16% lower than the plan in 2016/17) • collaborative work with the home care market promoting an increase in over 1,500 hours per week • focus on quality in care home provision limiting the need for lengthy cautions or suspensions from placement; • 50% increase in carers identified, engaged and in receipt of services • complete redesign of all age mental health services undertaken – Mental Health matters – and additional investment identified for CAMHS and adult mental health services • six new supported living schemes have been created providing 28 new tenancies for people with learning disabilities
21.	Ten benefit criteria of integrating commissioning were identified to be used as part of the options analysis including: • Using integrated commissioning to drive provider integration and service innovation. It is through these innovations that integrated commissioning has the greatest potential to benefit citizens and patients. • Improving the efficiency of commissioned services. This includes both streamlining process and reducing duplication and variation. This is particularly relevant for services / providers working across both commissioning organisations. • Increasing the effectiveness of commissioning – across the whole of the commissioning cycle. Combining the knowledge, expertise and (importantly) authority and leaderships of both organisations (clinical and democratic) has the potential to significantly increase the effectiveness of commissioning across the city.

22.	Financial benefits from integrated commissioning will be delivered in a number of ways including: • Economies of scale and benefits accruing from integrated services • Enhanced market and local economic development arising from more opportunities to invest at scale in health and care private, social enterprise and voluntary and community provision. • Agreed efficiency savings arise from better understanding of activity, unit costs and reduced variation.
	Consultation and engagement
23.	A Steering Group with representatives from the council's Cabinet and lead officers and executive officers from the CCG Governing body reviewed the outcomes from the options appraisal as well as feedback from one to one interview discussions with Members, clinicians and stakeholders. Feedback which has been reflected in the final proposal in this report, included: • do not want to move backwards and undo progress made by integrated commissioning (ICU) • agreed further integration is the correct direction of travel, to deliver better outcomes for citizens and financial stability • current governance structures constrain the pace and quality of decisions. • enabling cultural differences between the organisations to be narrowed through mutual trust whilst retaining control within each organisation. • define 'red lines' – the areas of control that would need to remain for the council and the CCG. • need to define clear metrics for further integration – the measures of success and the degree to which each option can achieve these and selection by Parliament for Southampton to be one of a handful of councils to test this.

RESOURCE IMPLICATIONS

Capital/Revenue

24. The current 2017/18 value of the Better Care Section 75 pooled budget resources is:

Scheme	CCG £'000	SCC £'000	Total £'000
Carers	1,240	134	**1,374**
Clusters	47,026	2,212	**49,238**
Rehab & Reablement	10,543	4,551	**15,094**
Capital		1,882	**1,882**
Joint Equipment Store	798	803	**1,601**
Telecare		250	**250**
Direct Payments		500	**500**
Long Term Care		2,750	**2,750**
Integrated Care Teams	9,894	16,414	**26,308**
Prevention & Early Intervention		6,199	**6,199**
Total	**69,501**	**35,695**	**105,196**

CCG Savings (QIPP) schemes impacted by Integrated Commissioning:

Scheme	CCG £'000
Working Age Adults Non-Elective Admissions	548
Older people falls and Ambulatory Care Sensitive admiss	61
Rehab/Supported discharge	702
Case Management	1,013
	2,324

Property/Other

25. Not applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

26. Children and Families Act 2014 – emphasises that a local authority in England and its partner commissioning bodies must make arrangements ("joint commissioning arrangements") about the education, health and care provision to be secured

27. Care Act 2014 establishes requirement for integration of care and health by 2020

NHS Five Year Forward View 2014 which outlines the future direction for the NHS which requires new partnerships in how care is delivered breaking down barriers between health and social care with more integrated approaches and with patients having far greater control over their own care

Other Legal Implications:

28. Changes will be required to the Executive Scheme of Delegation, Officer Scheme of Delegation, Member and Officer Codes of Conduct, Partnership Protocols, Financial and contract procedure Rules, Decision making protocols and standards and the creation of an Inter Authority Agreement, information sharing and information governance protocols, conflict resolution procedures and protocols as well as terms of reference for any new Board established. Changes will only be made following consultation with the Leader and Group Leaders. Changes to Financial Procedure

	Rules will at this time be limited to authorising an increase in individual Cabinet Member authority to spend up to £2M and only when all 3 Cabinet Members on the Board are in agreement.
POLICY FRAMEWORK IMPLICATIONS	
29.	The scope of integrated commissioning fully supports the achievement of priorities in the Council Strategy, and in particular, children and young people in Southampton get a good start in life, people in Southampton to live safe, healthy, independent lives. These are also the basis of the Southampton Better Care plan. They also form the core of the CCG operating plan and Southampton City Local Delivery System Plan 2017-19 where key priorities include: • Prevention and Earlier intervention – deliver a radical upgrade in prevention, early intervention and self-care • Better Care Southampton • Mental health – improve the quality, capacity and access to mental health services • Children and maternity – improve local services for children, young people and women.
30.	Integration and Better Care Fund Policy Framework 2017 – local areas have to set out in Better Care Fund returns for 2017-19 how they expect to progress to further integration by 2020. Policy Framework has been developed by the Department of Health (DH), Department for Communities and Local Government (DCLG), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and NHS England.
31.	The proposals above help the city to realise the Local Government Association's eight principles for effective health and care commissioning.

KEY DECISION?	Yes
WARDS/COMMUNITIES AFFECTED:	All
<u>SUPPORTING DOCUMENTATION</u>	
Appendices	
1.	Draft terms of Reference including the scope
Documents In Members' Rooms	
1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?	No
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	Yes/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.		
2.		

Appendix 1

DRAFT Terms of Reference for the Joint Commissioning Board

1. Introduction

1.1. Southampton City Council and Southampton City Clinical Commissioning Group have developed a shared ambition for change *'Integrated Health and Wellbeing Commissioning allows the city to push further and faster towards our aim of completely transforming the delivery of care in Southampton, so that it is better integrated, delivered as locally as possible, person centred and with an emphasis on prevention and intervening early to prevent escalation'.* For the purpose of these Terms of Reference, Health and Wellbeing is defined as Health and Care services outlined in the scope Annex A.

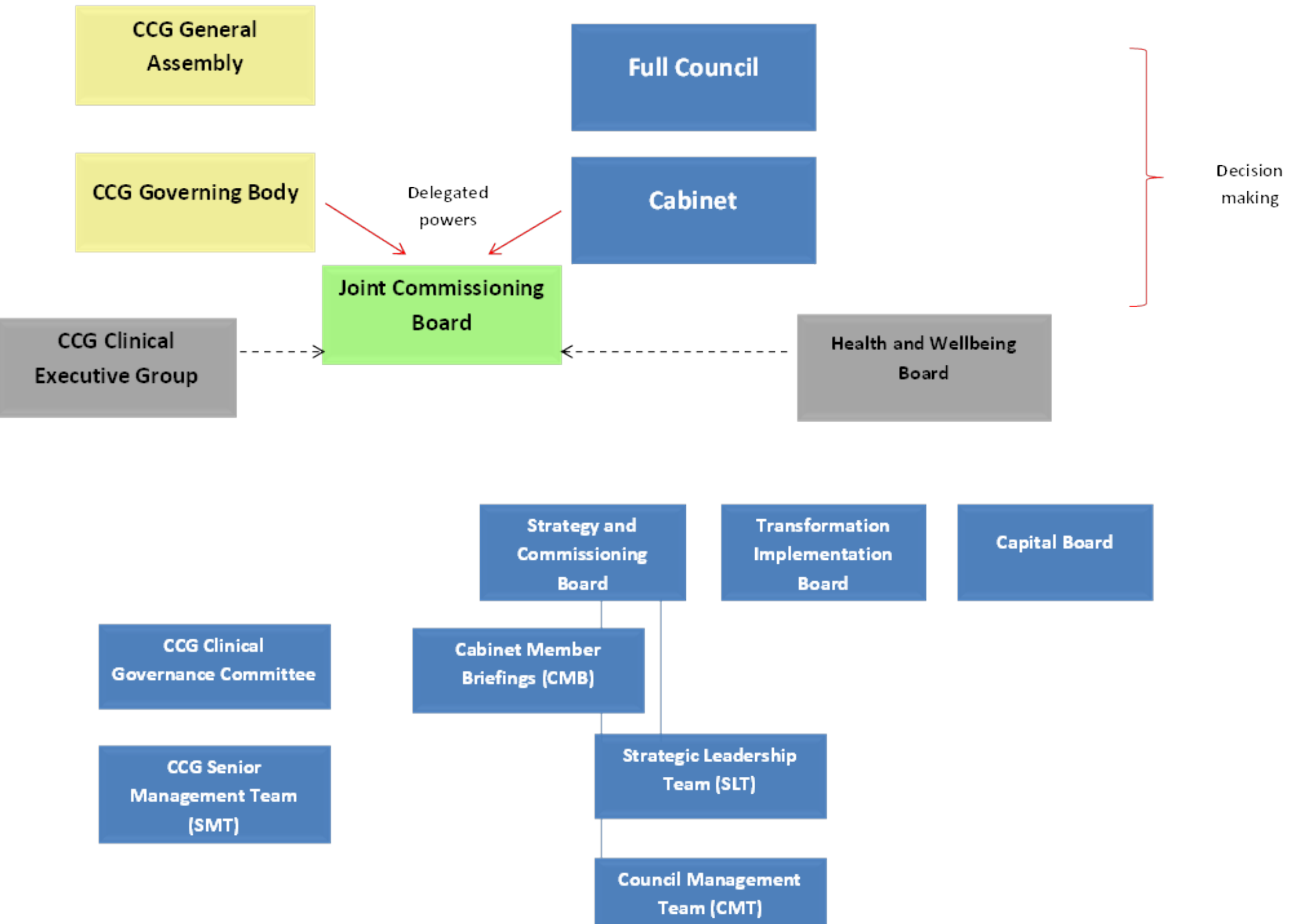
If we are to realise this vision and meet the challenges we face then we will need to

- Act as one for the city by
  - developing and delivery a single view of the city's needs and how we can ensure they are best met
  - aligning and allocating our collective resources to achieve prioritised outcomes
  - working for the whole population
- Support people to become more independent and do things for themselves by changing the relationship between citizens and services
- Be innovative and have an appetite for risk to make the change
- Make the most of new opportunities and powers
- Build on our existing good work
- Ensure that the system is financially sustainable and flexible enough to meet current and future challenges.

1.2. There are a number of benefits from integrated commissioning that have been grouped under three broad headings

1. **Using integrated commissioning to drive provider integration and service innovation**. It is through these innovations that integrated commissioning has the greatest potential to benefit citizens and patients.
2. **Improving the efficiency of commissioned services**. This includes both streamlining process and reducing duplication and variation. This is particularly relevant for services/providers working across both commissioning organisations.
3. **Increasing the effectiveness of commissioning – across the whole of the commissioning cycle.** Combining the knowledge, expertise and importantly authority and leaderships of both organisation (clinical and democratic) has the potential to significantly increase the effectiveness of commissioning across the City.

1.3. The Council and CCG have therefore established a Joint Commissioning Board to commission health and social care in the City of Southampton. It will encourage collaborative planning, ensure achievement of strategic objectives and provide assurance to the governing bodies of the partners of the integrated commissioning fund on the progress and outcomes of the work of the integrated commissioning function. The Joint Commissioning Board hereafter will be referred to as the Board



1.4. The Board will act as the single health and wellbeing commissioning body for the City of Southampton and a single point for decision makers. The Board will convene and exercise their functions following consensus / consultation with each other on those functions as defined in Annex A. This includes those areas of health and social care commissioning covered by the Better Care Fund Section 75.

1.5. The CCG Governing Body and SCC Cabinet may grant delegated authority (with any appropriate caveats) to those of its members or officers participating in the Board to make decisions on their behalf, whilst retaining overall responsibility for the decision made by those members or officers. It is therefore the individual member or officer who has the delegated authority to make a decision rather than the Joint Commissioning Board itself.

1.6. It is proposed that the scope of the integrated commissioning arrangements overseen by the new Board will be broadly as described below.

1.7. The Board will have oversight of all schemes established under the Better Care Section 75 and other remaining Partnership Agreements which in some cases may have their own specific Partnership Board, under the NHS Health Act 2006 flexibilities, and Local Government Act 1972 (s.113). This will include shadow monitoring of schemes under development and scrutinising their suitability for future inclusion in the BCF Partnership Agreement or other Partnership Agreements. A list of the schemes

included and planned for the Better Care Section 75 Partnership Agreement can be found at Appendix A.

1.8. The Board has been established to ensure effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements between Southampton City Council and Southampton City CCG.

1.9. As such, the Board will develop and oversee the programme of work to be delivered by the Integrated Commissioning Unit and review and define the integrated commissioning governance arrangements between the two bodies.

1.10. The Board will monitor the performance of the integrated commissioning function and ensure that it delivers the statutory and regulatory obligation of the partners of the Better Care Fund.

1.11. Evidence based commissioning will be key to achieving our vision and the Board will be informed and driven by needs assessment, market analysis, user experiences, consultation and engagement.

2. Scope

2.1. The scope of the Board will cover joint NHS and City Council services commissioned by the Integrated Commissioning Unit. The scope is outlined in Annex A.

2.2. The Board may, where appropriate, develop a wider range of services subject to final approval of the CCG Governing Body and Council

2.3. Subject to the agreement of the CCG Governing Body and the Council, the Board membership may be amended to include any other partner who jointly commissions with the City Council or Southampton City Clinical Commissioning Group and other agency representatives may be co-opted as necessary.

3. Role and Objectives

3.1. To agree shared commissioning priorities for the Council and CCG based on where a partnership approach will improve outcomes and promote greater efficiencies.

3.2. To approve and monitor the development and implementation of the Integrated Commissioning Plan to ensure it meets agreed priorities, objectives, savings and performance targets and aligns commissioning arrangements with partners' financial and business planning cycles.

3.3. To ensure that all commissioning decisions are made in line with the principles set out in the Integrated Commissioning Strategy.

3.4. To monitor the financial plans and financial performance of the integrated commissioning function, including forecasts for the year.

3.5. To ensure compliance with any specific reporting requirements associated with the formal pooled fund described in the Section 75 agreement.

3.6. To ensure compliance with rules and restrictions associated with any other blocks of funding, including specific grant funding.

3.7. To ensure management response to risks identified and the assurances against them regarding the integrated commissioning function.

3.8. To agree, subject to the financial decision making limits of the council and the CCG, all financial planning commitments across areas of integrated commissioning responsibility for pooled or non-pooled budgetary provision.

3.9. To receive and consider reports on service development, budget monitoring, audit and inspection reports in relation to those services which are the subject of formal partnership arrangements.

3.10. To set priorities for and review the performance of the Integrated Commissioning Unit on behalf of Southampton City Council and Southampton City CCG.

3.11. To seek assurance on the quality and safety of commissioned services in relation to key performance indicators and standards. Where performance is outside of expected threshold to receive exception reports.

3.12. To provide system leadership and direction to the staff of the integrated commissioning function.

3.13. To promote quality and identify how the health and wellbeing strategic intentions and priorities of partners will be supported and enabled through integrated commissioning.

3.14. To maintain oversight of the s.113 arrangements between the two organisations.

4. Better Care Section 75 Partnership Agreement

4.1 With specific reference to the Better Care Section 75 Partnership Agreement, the Joint Commissioning Board:

4.2 Shall oversee and review the schemes established under the Better Care S75 Partnership Agreement, ensuring adherence to the relevant legislation and protocols in the development of Partnership Agreements have been followed.

4.3 Shall receive, review and approve Business Cases for new pooled fund schemes to be established under the Better Care Section 75 Partnership Agreement (with reference to the respective Schemes of Delegation).

4.4 Shall receive and review quarterly reports on each Better Care pooled fund scheme on the exercise of the partnership arrangements. These reports shall include details of:

- Annual forward financial plans setting out the projected annual spend
- Review of the operation of each scheme covering:
  - evaluation of performance against agreed performance measures targets and priorities and future targets and priorities;
  - quality of service delivery and how the arrangements benefit and meet the needs of client groups;
  - any service changes proposed;
  - any shared learning and opportunities for joint training;
  - assurance that monitoring and evaluation processes take account of statutory guidance and policy directives pertaining to quality standards, best value and audit arrangements of the Council and the CCG.

4.5 Shall ensure the Services provided under each scheme are meeting the needs of the service users and their carers.

4.6 Shall ensure that commissioning decisions are the result of the wide ranging consultation and discussion with the key people involved in all aspects of the function of delivering joined up health and social care.

4.7 Shall encourage and ensure that service providers work collaboratively with service users, other providers and commissioners and that it is promoted through positive design of payment packages and risk and benefit share arrangements into commissioning contracts.

4.8 Shall ensure that commissioners listen to service users and providers and respond supportively to ideas to make services more effective for the user and more responsive to needs.

4.9 Shall assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes and act upon these at the earliest opportunity and monitor their impact throughout the delivery of the services. This shall include consideration of proposed changes to the services and funding and how these may impact on each organisation.

4.10 Shall monitor financial contributions of the Council and the CCG and make recommendations regarding future financial contributions.

4.11 Shall provide the Council and CCG with an annual review report and forward plan of the S75 Better Care Partnership Agreement arrangements, incorporating financial and activity performance, risks, benefits and evidence of improvements for service users.

5. Risk Sharing principles

5.1. The pooled budget arrangements will be managed in such a way as to avoid destabilising either organisation.

5.2. Each organisation will retain responsibility for dealing with any deficit it has at the start of the pooled budget arrangement.

5.3. Each organisation will strive to achieve a balanced budget within the pooled budget.

5.4. The statutory requirements of each organisation must be maintained.

5.5. The pooled budget will contain a mechanism for dealing with significant changes to the funding or statutory responsibilities of either organisation that effect the areas on scope of the pooled budget arrangement.

5.6. The mechanism should be transparent and as simple as possible.

5.7. Both organisations will develop an appropriate Inter Authority Agreement (IAA) to include a financial management agreement which will feed into the corporate governance arrangements of each partner organisation and provide robust management information.

5.8. Both organisations will agree a mechanism for the early identification of potential in year under or over spends and for remedial actions to be put into place.

6. Governance and Reporting

6.1. The Board will be accountable to the Council's Cabinet and / or Council as appropriate and the CCG Governing Body. It will work in partnership with the Health and Wellbeing Board and the CCG Clinical Executive Group.

6.2. The Board will need to demonstrate contribution to the Health and Wellbeing Strategy outcomes

6.3. The Board will need to be informed by the JSNA, needs assessments, market analysis and feedback from consultation and engagement with residents and patients.

6.4. The Board will meet monthly and be minuted. Where items require decision by a Member or Officer of the Council the requirements of the Local Government Act 2000 in relation to publication of Forward Plans, Agendas, reports and Decision Notices will be fully complied with.

6.5. At least one meeting each quarter will be dedicated to reviewing the performance of the Better Care S75 Partnership Agreement, undertaking those responsibilities as set out in above.

6.6. The Board shall be entitled to call a meeting, at any time, outside of the agreed meetings schedule, for any purpose, subject to compliance with any statutory requirements in relation to decision making under the Local Government Acts and CCG Constitution.

6.7. All minutes and papers from the Board will be reported to the CCG Governing Body and made available to Council's Cabinet.

6.8. Agendas will be jointly agreed in line with the Forward Plan and will need to be circulated at least 5 working days in advance of the meeting. All new agenda items are subject to agreement of the Chair or Vice Chair. Where a decision of the Council (Member or Officer) is required at a Board meeting then the requirements of the Local Government Act 2000 and Access to Information regulations must be adhered to (publication of notice of key decisions 28 days in advance, publication of reports 5 clear working days in advance, formal decision Notice signed by decision maker and Proper Officer (Democratic Services must attend for this purpose for these items). Decisions that are 'key decisions' within the meaning of the Local Government Act 2000 are subject to the Council's 'call-in' procedures and cannot be implemented until the time for call-in has expired or the matter has been dealt with in accordance with Overview & Scrutiny Procedure Rules.

6.9. The agendas, minutes, decision notices and briefing papers of the meetings of this Board are subject to the provisions of the Freedom of Information Act 2000, the Environmental Information Regulations and the Data Protection Act 1998. If the Chair concludes that specific issues are exempt from publication and should not be made available under the terms of the Freedom of Information Act, a Part 2 meeting of the Board shall be convened to consider them.

6.10. Part 2 meetings have to be notified 28 days in advance of the meeting and reasons for excluding the public included on the report / agenda item or the decision cannot be taken. There are limited urgency provisions but these require prior consent from the chair of the Health Overview and Scrutiny Panel.

6.11. Meetings of the Board shall be advertised in advance on the calendar of meetings of the CCG Governing Body and Council and shall, unless notice of consideration of an excluded item has been given, shall be open to the public to attend from April 2018.

6.12. The Chair will invite questions or statements by members of the public on matters pertaining to that agenda at the beginning of the meeting.

6.13. Administrative support for the Board will be a shared responsibility although agenda publication etc. will be undertaken by the Council.

6.14. The Health and Wellbeing Board will delegate responsibility for Better Care to the Board and the Board will be accountable to the Health and Wellbeing Board for this element.

7. Membership

7.1. The council's representation on the Joint Commissioning Board will be 3 Cabinet Members made through executive appointments, similar to the membership of the Health and Wellbeing Board. The CCG will similarly nominate 3 members from the CCG Governing Body. Both partner organisations will agree a scheme for the appointment of substitute members or nominated deputies at the inaugural meeting of the Board.

7.2. **Other attendees**

- Key senior managers from the Council and the CCG as required.
- The relevant commissioning lead for each of the pooled budgets under the S75 Better Care Partnership Agreement will attend as appropriate the quarterly meetings to present the performance report for the S75 Partnership Agreement.

7.3. The Chair will be a politician from the council or a member from the CCG Governing Body who will rotate on an agreed basis. The Vice Chair of the Board will be from the alternate partner organisation.

8. Quorum, Decision Making and Voting

8.1. The Board will require consensus prior to any delegated decisions being taken; consensus will be demonstrated by a show of hands. It is important that given the nature of the decisions, securing the support of both partners will be critical to the success of this Board. The Board will be quorate if there are at least 4 members in attendance with a minimum of 2 from each.

8.2. In those circumstances where consensus cannot be reached, the matter will be deferred for further consideration by the parties and will be reconsidered after discussions between the Chair and respective partner lead.

8.3. Schemes of Delegation to City Council Members and Council Officers shall be amended to reflect that decisions should not be taken under delegation and should stand either deferred to a future meeting or referred back to the parent body where a consensus of those present do not support the decision proposed. The Chair of the Board shall consult those present before deferring the decision or directing that it be referred back to each partner organisation.

8.4. Legally, it is not possible to have a mechanism that requires individual decision makers to exercise their decision making function in accordance with the will of a majority or quorum of a Board. Any individual decision maker must consider any decision on its

merits as a whole in accordance with established decision making principles. The process for seeking the support of the Board prior to exercising any delegation meets a requirement in the Scheme of Delegation to limit the power to exercise that delegation to situations only where the support of the Board is demonstrated.

8.5. Functions outside the decision making scope of the Board, but related to health and social care will be discussed for information only at the Board, with the considerations and any recommendations of the Board formally minuted. Items will then be referred to the relevant decision maker (e.g. CCG Governing Body, Council).

9. Dispute Resolution

9.1. If disputes relating to the Better Care Section 75 Partnership Agreement arise then the Dispute Resolution process within that will be followed. Otherwise any matter of dispute will be referred for further discussion by the Leader of the Council and Chair on behalf of the CCG before referring back to the Board for further consideration. It is recognised that as the desire is to reach agreement on any matter by consensus that if this is not reached that matter may not move forward. There will be no formal and binding external arbitration procedure.

10. Scrutiny

10.1 Decisions of members of the Joint Commissioning Board will be subject to formal scrutiny normally undertaken by the Health Overview and Scrutiny Panel, on behalf of the Council and Call in. Health scrutiny is a fundamental way by which democratically elected councillors are able to voice the views of their constituents, and hold NHS bodies and health service providers to account. In Southampton the Health Overview and Scrutiny Panel undertakes the scrutiny of health and adult social care. The Panel meets every 2 months. However, there may be some major decisions may be considered by the council's Overview and Scrutiny Management Committee.

11. Conflict of Interests

11.1. The Board will be bound by the Standing Orders/Standing Financial instructions and Codes of Conduct of both parent bodies. Declaration of interests will need to be declared annually and at each meeting of the Board in line with the agenda. Depending on the topic under discussion and the nature of the conflict of interest appropriate action will be taken and recorded in the minutes

12. Variation

12.1. The parent bodies may agree from time to time to modify, extend or restrict the remit of the Board.

12.2. The Terms of Reference will be reviewed in March 2018 or sooner at the request of the Chair or Vice Chair.

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Annex A

Integrated Commissioning – Potential scope

1. For the first year, it is proposed that the scope of the integrated commissioning arrangements overseen by the new Board will be broadly mirror those areas of health and social care commissioning covered by the Better Care Fund Section 75.

2. As is currently the case, the assumption is that some of the services in scope will be jointly funded and jointly commissioned under a S75 or S256/76 arrangement (primarily through the Better Care Fund S75 Agreement).

3. However there will also be services in scope for which the commissioning responsibility/ decision making remains solely with the CCG or City Council but the funding is aligned to deliver a jointly agreed strategy.

4. Beyond this, there could be areas of shared commissioning where the Council and CCG will want to discuss and share information about relevant commissioning intentions, budget and spend. The Board could also consider bids that are of joint interest. These 3 categories are described below:
   - Jointly commissioned/funded services
   - Single agency commissioning aligned under a jointly agreed strategy
   - Other areas relevant for the achievement of the outcomes

<u>Jointly commissioned/funded services</u>

5. These will be services currently in scope for the 2017/19 Better Care Fund S75 agreement. In addition, the scope will include other existing partnership agreements/shared funding arrangements:
   - Integrated Services within the established 6 Better Care Clusters: Community health services for adults (Community Nursing, Continence, Podiatry, Community Wellbeing Services, Community specialist services for people with long term conditions, case management, Palliative Care, community navigation, Community Adult Mental Health Services and IAPT (Improving access to psychological therapies) , Adult Long Term Social Care Teams)
   - Support Services for Carers
   - Integrated rehabilitation, reablement and discharge services (including the Hospital Discharge Team, Discharge to Assess, residential reablement and extra care, Falls Assessments)
   - Care Technology
   - Prevention and Early Intervention services – Behaviour Change, Older Person's Offer, Information, Advice and Guidance
   - Integrated Learning Disabilities provision (placements)
   - Direct Payments Support services
   - Transformation of Long Term Care provision (Adult Social Care additional/improved BCF funding to support transformation of Extra Care and conversion of a Residential Unit to Nursing Care as well as stabilising the Domiciliary Care and Care Home market)
   - Joint Equipment Service, Wheelchair Service, Orthotics and Disabled Facilities Grant
   - Integrated services for children with complex health needs (specifically Building Resilience Service and SEND integrated health and social care team).

Single agency commissioning aligned under a jointly agreed strategy

6. This would mean that commissioning responsibility/ decision making remains solely with the CCG or City Council but the funding is aligned to deliver a jointly agreed strategy. This could include:
    - Long Term Care provision (including domiciliary care, nursing and residential CHC and social care packages) – aligned to Better Care strategy
    - 0-19 prevention and Early Help, CAMHS, Community midwifery – aligned to 0-19 prevention and early help strategy/CAMHS Transformation
    - Sexual health (integrated level 3 service, voluntary and primary care prevention services, termination of pregnancies, vasectomies) – aligned to Sexual Health and Reproductive Strategy
    - Substance Misuse Services – aligned to Substance Misuse Strategy
    - Respite and Short Breaks – aligned to Replacement Care Strategy, services for children, e.g. Edge of care, Family Drugs and Alcohol Court, Looked After Children, Safeguarding – aligned to children's strategy
    - Community development (definition to be agreed)

Benefits

7. The scope will increase the ability of both organisations to:
    - Realise a shared vision – e.g. a shared focus on prevention and early intervention and community solutions to promote independence & a shared commitment to realise it
    - Share risks and benefits associated with implementation of the shared vision, enabling us to do the "right thing" without unfairly disadvantaging or advantaging one organisation
    - Commission against a single agreed set of common outcomes and priorities – making best use of resources
    - Share needs data and good practice evidence – leading to more intelligent commissioning
    - Develop more innovative solutions to meet people's needs in the round (as opposed to commissioning in silos for people's "health" versus "social" needs – leading to improved outcomes for people
    - Bring together health, public health and social care resources and strip out duplication – leading to savings and efficiencies
    - Commission a more joined up health and care system, developing together whole pathways from prevention to care - fewer gaps
    - Enable providers to develop more innovative integrated pathways and organisational models – leading to less fragmentation
    - Shape and develop primary medical care as part of the integrated health and social care system
    - Better understand and manage demand through greater influence over assessment and review processes