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.

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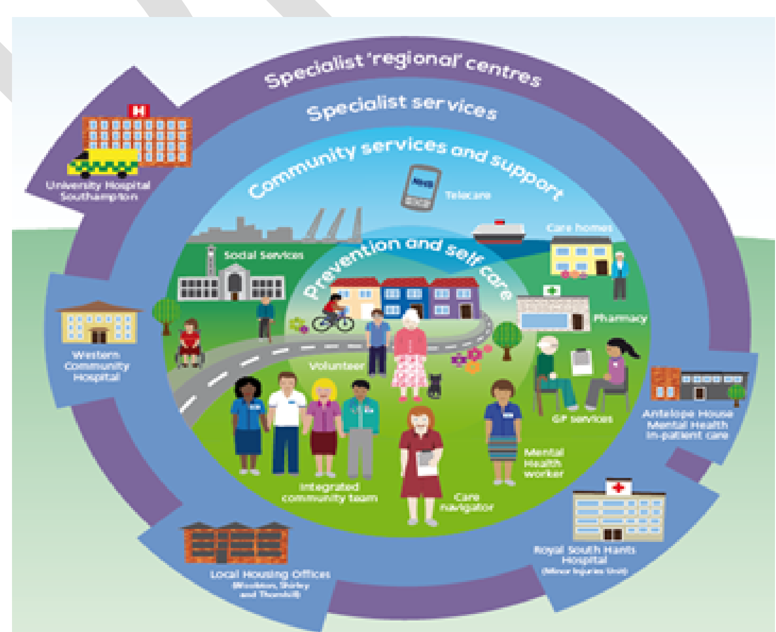
2. Vision and Strategy

"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

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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:

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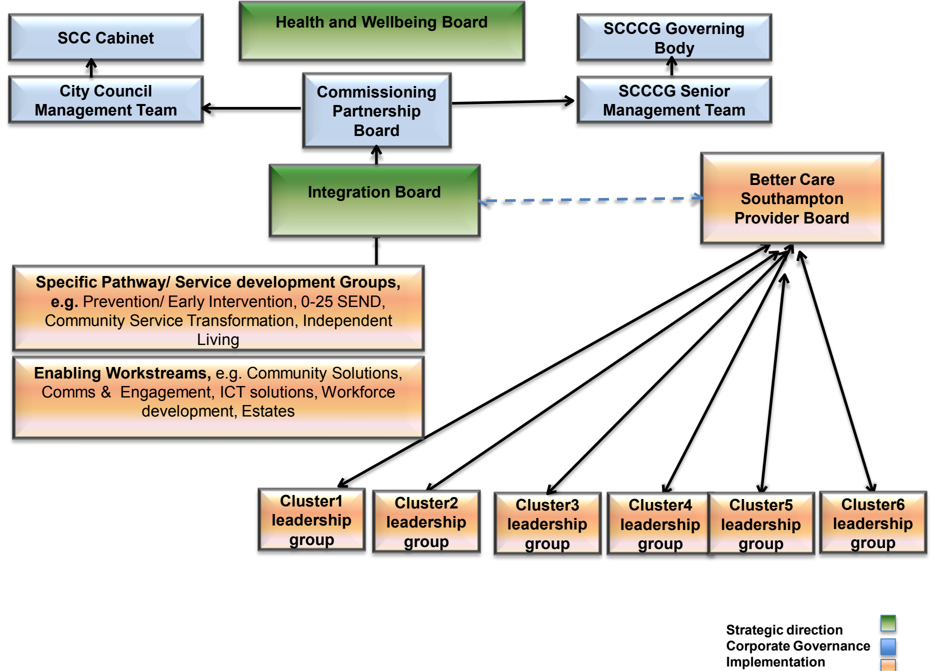
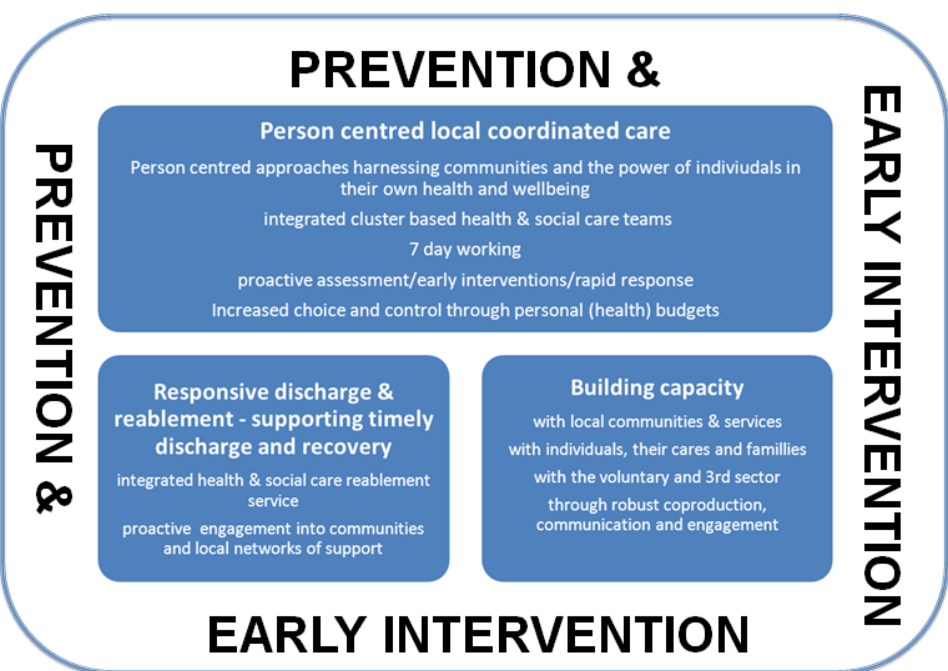


2.11 Governance for the Section 75 BCF Partnership Agreement sits with the Commissioning Partnership board (CPB). Meeting monthly, CPB comprises the Chief Executives of the Council and CCG, Director of Public Health, CCG Governing Board clinical lead, Cabinet member and Chair of the Health and Wellbeing 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

Further development of clusters

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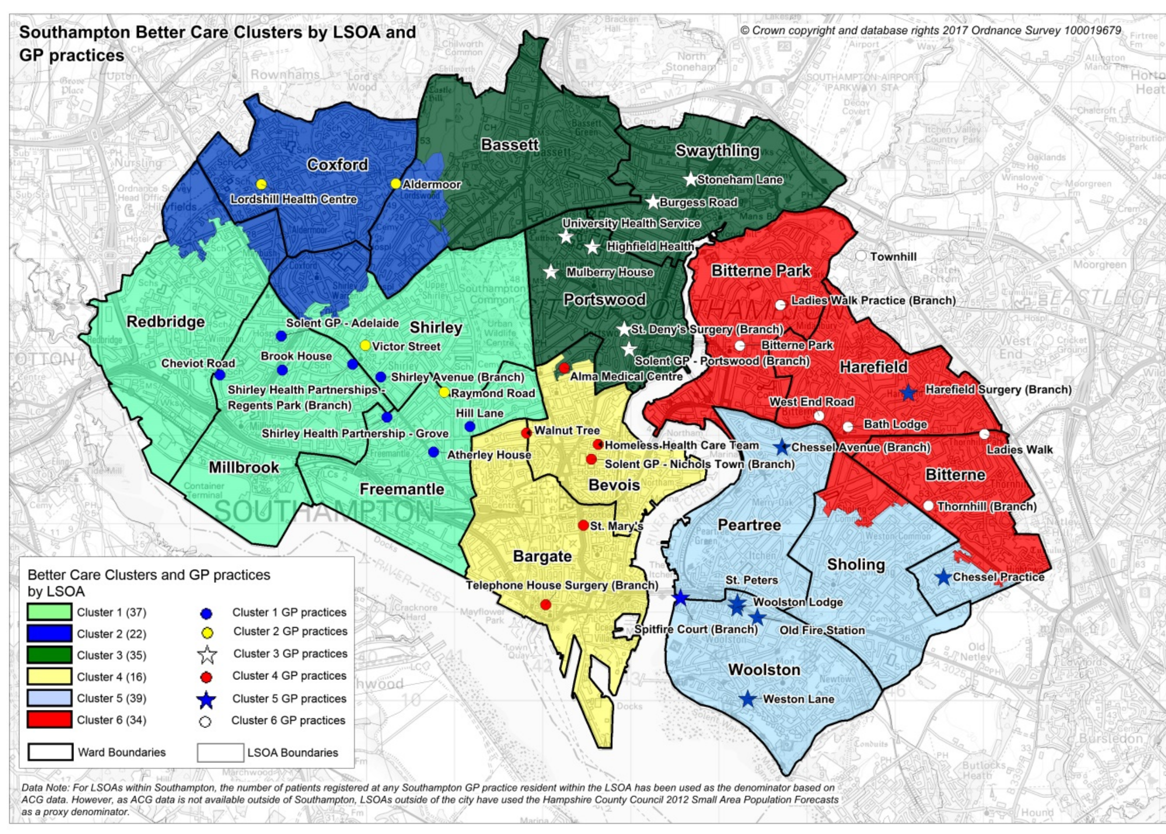
workers, voluntary sector, and social care to focus on the needs of a single geographical area, using joint assessment and planning approaches, including risk stratification, to identify needs early and intervene in a coordinated person centred way. Each cluster covers a population of approximately 30,000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

- 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:

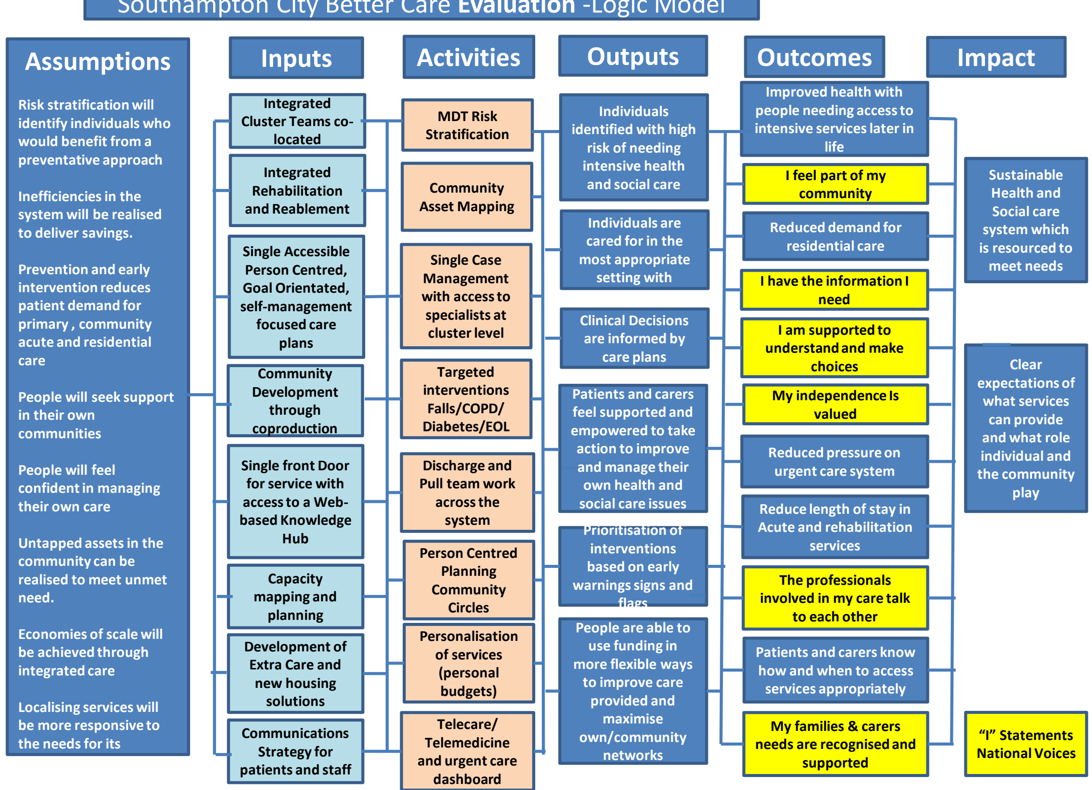
- Development of a clear vision and strategy for telehealthcare in Southampton with 98% of Adult Social Care staff trained and increasing numbers of referrals from 8 in April 2016, 5 in May, 28 in June, 40 in July, 44 in August, 42 in September, and 87 in December 2016. Although a robust process for 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

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.

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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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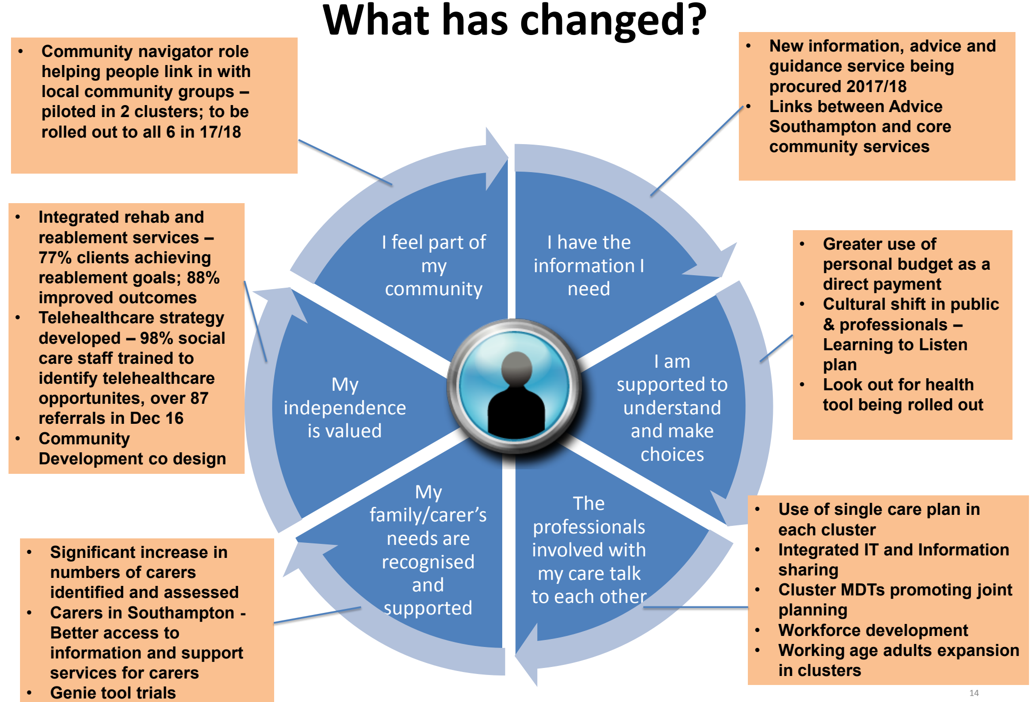

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Progress against the key metrics 2016/17

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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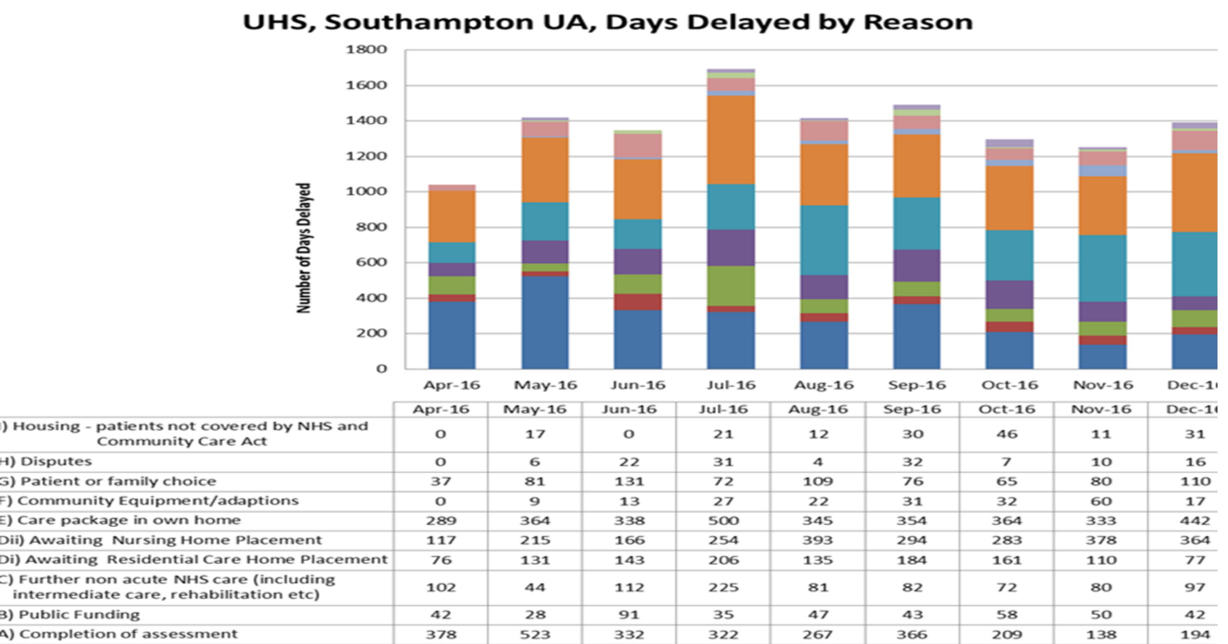

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-1
) Housing - patients not covered by NHS and Community Care Act	0	17	0	21	12	30	46	11	31
H) Disputes	0	6	22	31	4	32	7	10	16
G) Patient or family choice	37	81	131	72	109	76	65	80	110
F) Community Equipment/adaptions	0	9	13	27	22	31	32	60	17
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.

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- 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*

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 13. Implementation of Personal Health budgets and Direct Payments 14. Developing supportive communities/ community capacity 15. Roll out of Community Navigation 16. Procurement of Advice and Guidance 17. Supporting Carers 18. Developing Extra Care 19. Care Home Procurement Strategy 20. Developing Nursing Home Market Capacity to meet need 21. Developing care technology	*Implementation of the older person's offer, promoting independence, health and wellbeing* *Extending the offer of personal health budgets and direct payments, and exploring the alignment between the two* *Develop and procure a community solutions service which builds on community assets to increase local services which people can access easily* *Roll out of community navigation* *Re-commission Advice, Information and Guidance (AIG) services to improve access to accredited information and support self-help* *Agree and implement commissioning intentions for carers support* *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.* *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* *Explore options for levering council assets to stimulate growth in the local supply of nursing care for people with complex needs and challenging behaviour* *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

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%	

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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	
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

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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,

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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

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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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