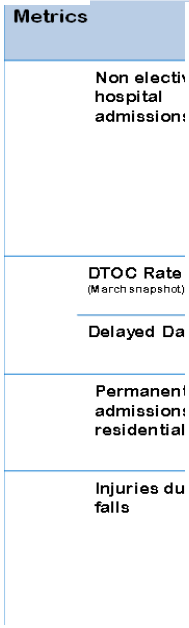
Performance Report – 2017/18 Year End Highlight Report

Key Achievements:



- **Permanent admissions to care homes** lower than target and 12% lower than last year
- **Delayed Discharges** significantly better than last year (29% reduction)
- No increase in **unplanned hospital admissions** , despite 1.6% increase in population
- Integrated **Rehab/ Reablement** reducing long term packages of care - 40% reablement clients leave the service independent, requiring no further care; of those remaining 23% saw a 13% reduction in their care - Saving of 129.5 care hours a week
- Significant savings achieved since opening of **Erskine Court** - £286K full-year effect
- Dedicated professional leads in place for each of the 6 **clusters** and city wide Programme Manager appointed to accelerate implementation of person centred integrated care across all clusters.
- **Enhanced Health in Care Home** model pilot started in September 2017 - for evaluation June 2018
- **Discharge to assess now standardised for pathway 2** across both acute and community hospitals.
- Procurement of a range of prevention and early intervention services: new Integrated Advice, Information and Guidance service, new Southampton Living Well Service

Key Risks and Issues:

- Capacity of care market to meet increasing needs and support additional schemes
- Resilience in the voluntary sector

Year End Financial Position

Overall position:	£1.167m forecast overspend 1% (£109.3m budget)

Priorities for 2018/19:

2018/19 Work Programme

Person centred local coordinated care

- Strengthen cluster leadership and embed integrated working practices
- Embed new strengths based model of adult social care and housing into clusters.
- Develop integrated models of care and support, including Frailty model, Learning Disability Services and prevention and early help provision for children and families.
- Develop community services to manage greater levels of acuity outside hospital.
- Implement the new service model for end of life care

Responsive Discharge and Reablement

- Embed the three discharge pathways (simple, supported and enhanced), including Discharge to Assess with a particular focus this year on Pathway 3
- 7 day services to support seven day discharge, including improving quality of discharge and relationships with care homes
- Develop the role of the clusters in supporting timely discharge.
- Roll out of the Enhanced Health in Care Homes model

Building Capacity

- Embed the new Southampton Living Well Service, Community Navigation and new integrated Information and Advice Service.
- Full implementation of online carer support services.
- Continue to seek development partner(s) to increase the supply of extra care housing.
- Re-procure home care and stimulate growth in the local supply of nursing care for people with complex needs and challenging behaviour.
- Procure and implement the care technology strategy in Southampton.