DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**BETTER CARE YEAR END REPORT**		
DATE OF DECISION:		**20 JUNE 2018**		
REPORT OF:		**DIRECTOR OF QUALITY AND INTEGRATION**		
CONTACT DETAILS				
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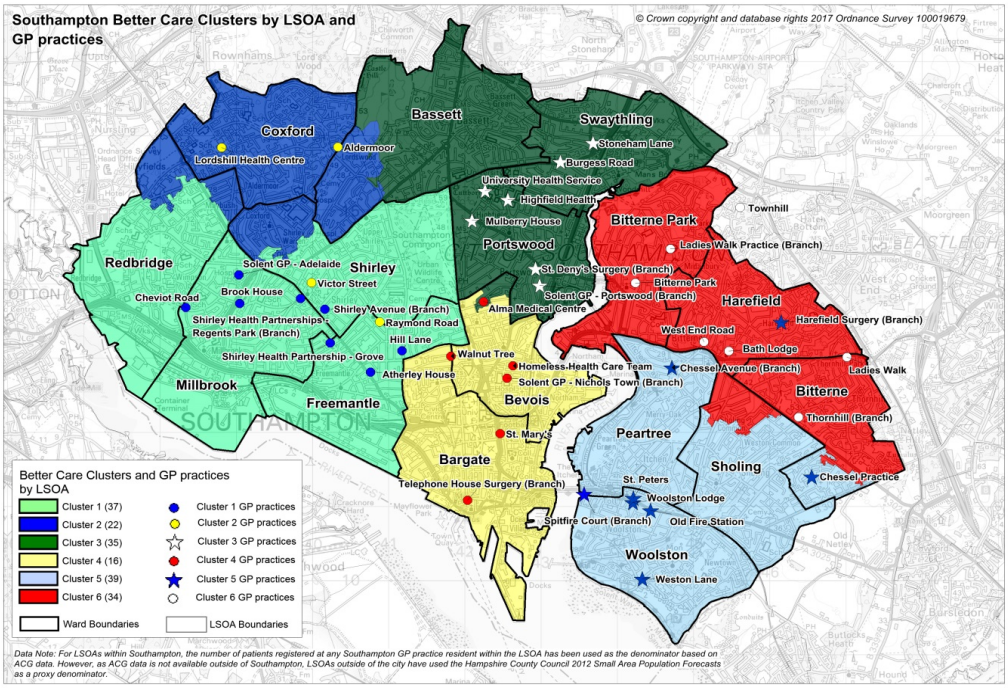
STATEMENT OF CONFIDENTIALITY		
NOT APPLICABLE		
BRIEF SUMMARY		
This report provides an end of year overview of Southampton City's Better Care programme in 2017/18.		
RECOMMENDATIONS:		
	(i)	To note the end of year 2017/18 report for Better Care.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Health and Wellbeing Board is accountable for the delivery of the Better Care Plan in Southampton. On a day to day basis responsibility for overseeing financial and quality performance of each of the Better Care schemes included in the Better Care pooled fund has been delegated to the Joint Commissioning Board (JCB).	
2.	It should be noted that 2017/18 is year one of a two year Better Care plan. No changes to the schemes are envisaged for 2018/19.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	NOT APPLICABLE	
DETAIL (Including consultation carried out)		
1.	**Overview** Southampton's Better Care Plan aims to achieve the following vision: • to put **individuals and families at the centre of their care and support**, meeting needs in a holistic way • To provide the **right care and support, in the right place, at the right time** • To make **optimum use of the health and care resources** available in the community • To **intervene earlier** and build resilience in order to secure better outcomes by providing more coordinated, proactive services. • To **focus on prevention and early intervention** to support people to retain and regain their independence	

It is a programme of whole system transformational change which is based around 3 key building blocks:

- **Implementing person centred, local, integrated health and social care through the city's six cluster teams** (shown in the map below). This includes harnessing the assets within communities and the power of individuals in improving their own health and wellbeing. It also includes health, social care, housing and voluntary sector teams in each cluster coming together to proactively identify those people most in need in the local area and plan and deliver care and support in a more joined up and personalised way.



- **Joining up Rehab and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams** that in turn link with each of the six clusters.
- **Building capacity** across the system to promote and support people to maintain their independence for as long as possible. This includes promoting self management approaches and supporting the role of carers. It also includes developing the capacity of the voluntary and community sector to meet lower level needs in local communities, as well as investing in the home care sector to enable more people to continue living in their own homes.

At the heart of the Better Care Programme is the focus on **prevention and early intervention**, encouraging local people and the health and care workforce to promote positive health and wellbeing at every opportunity and to identify problems as early as possible, taking proactive action to address them.

The **Better Care Fund** pools resources from both the CCG and Local Authority to support the delivery of the Better Care Programme. In 2017/18 this totalled just over £109M (£71.5M from the CCG and £37.8M from the Council), making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which is £16.177M, demonstrating its commitment to integrating health and social care at scale.

Southampton's Better Care Fund is made up of the following schemes:

1. Supporting Carers
2. Cluster working
3. Integrated Rehabilitation and Reablement and Hospital Discharge
4. Promoting Care Technology
5. Prevention and Early Intervention
6. Learning Disability Integration
7. Promoting uptake of Direct Payments
8. Transforming Long Term Care
9. Integrated provision for children with SEND
10. Integrated health and social care provision for children with complex behavioural & emotional needs

2. **Performance in 2017/18**

The table below provides the Performance against the key Better Care national indicators at 2017/18 year end.

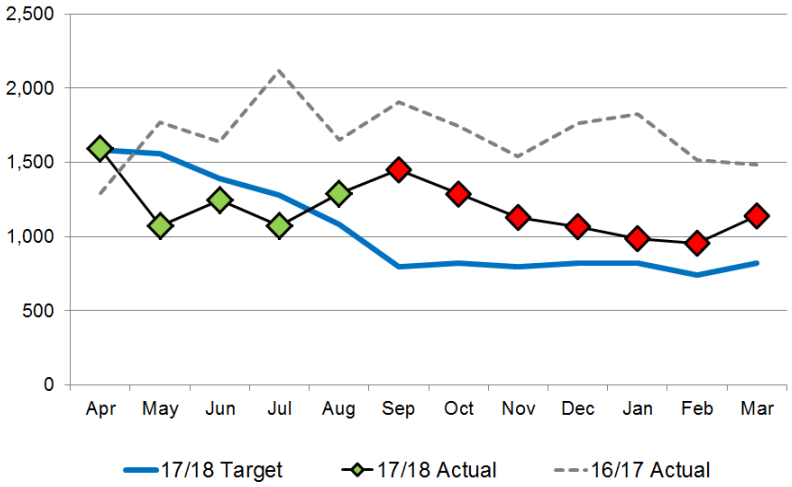
2017/18 End of Year Performance Summary

Green	≤0% difference — On Track
Amber	>0% and <10% difference — Slightly Off Track
Red	≥10% difference — Off Track

Metrics	End of Year Performance vs. Target	End of Year Performance vs. Previous Year	Commentary
Non elective hospital admissions	Target Achieved (0% variance to target)	Flat (0% change to last year)	• It is likely that the following initiatives helped with delivery: 1. **Changes to coding/counting of very short stay NEL admissions** where a patient is admitted into a CDU chair. From August 2017, these are now only counted as an A&E attendance. 2. **Introduction of GP front door streaming in ED**, from October 2017. 3. **Case Management** in primary care and with care homes
DTOC Rate (March snapshot)	Target Not Achieved (5.4% vs. 3.9% target)	Better (2.2% lower than last year)	• Provider DTOC rates at the end of the year – UHS, 5.9%; Solent, 4.1%; Southern Health: 3.6%. • Strong focus this year on community hospital DTOC as well as acute hospital
Delayed Days	Target Not Achieved (14% higher than target)	Better (29% lower than last year)	
Permanent admissions into residential care	Target Achieved (6% lower than target)	Better (12% lower than last year)	• Success in this area is believed to be the result of focus on "home first" principles supported by developments in domiciliary and extra care and discharge to assess schemes focussing on supporting clients to maintain their independence
Injuries due to falls	Slightly Missed Target (7% higher than target)	Slightly Higher than Last Year (3% higher than last year)	• Reducing admissions related to falls continues to be a challenge although the numbers are small exaggerating percentage variance • A number of initiatives are in place to reduce falls, some only starting in Quarter 3, e.g. the Fracture Liaison Pathway and the expansion of falls exercise across the city. It is known that it can take a while for interventions to embed and have an impact

3. **Performance Headlines**

- **Permanent admissions to residential and nursing homes** have reduced significantly compared to 2016/17, exceeding the 2017/18 target. This is believed to be the result of a relentless focus on "home first" principles supported by developments in home care and extra care and discharge to assess schemes focussing on supporting clients to maintain their independence.
- **Delayed transfers of care** have reduced significantly compared to 2016/17 (29% reduction of 4913 bed days), albeit not achieving the national 3.5% target (delayed bed days as a % of total available bed capacity). The position

	for UHS at year end was 5.9% against the 3.5% target. Good progress has been made at the community hospitals with a year end position of 4.1% for Solent and 3.6% for Southern Health. The chart below shows the significant reduction made in 2017/18 compared to 2016/17:  The reduction has been significantly noticeable in delays related to completion of assessment - these reduced by 2308 in 2017/18 compared to 2016/17 (a reduction of 76%). • **Non Elective admissions** remained the same in 2017/18 as in 2016/17, despite a 1.9% increase in population. • **Falls** were 7% above target at year end and 3% higher than in 2016/17. A number of initiatives have been put in place to reduce falls, although some only starting in Quarter 3, e.g. the Fracture Liaison Pathway which commenced 1 October 2017 to identify patients with fragility fracture following attendance in A&E or hospital admission and ensure they are appropriately referred to community support services. It is known that, as with many prevention programmes, it can take a while for interventions to embed and have an impact.
4.	**Key highlights in relation to the Better Care Schemes in 2017/18** Below is a summary of the key developments in 2017/18 against each of the three "building blocks" identified in section 1. • **Implementing person centred, local, integrated health and social care through the city's six cluster teams** o Cluster Development: six clusters are embedding across the city. Cluster leadership has been strengthened with the appointment of dedicated professional leads for each cluster from December 2017. o A Better Care programme manager has also been appointed (started May 2018) to provide additional support and capacity for cluster development, the initial task being a stock take of progress made in each cluster towards integrated person centred working with a view to putting in place a development plan for each cluster. o Local Solutions Groups bringing together voluntary, community, faith organisations and the business sector have now been established in each cluster. The initial focus of the groups will be to map

neighbourhood resources to aid signposting to community alternatives. The Itchen to Bridge the Gap group (Cluster 5) has already been established and has completed this mapping exercise (to be uploaded to the Southampton Information Directory (SID)) and developed Dementia Friends with local businesses in the Bitterne area.

- Additional investment from the CCG has been made available to Solent NHS Trust to provide enhanced End of Life support – recruitment of additional palliative care support workers commenced in Quarter 3; the enhanced provision will support more people to die in their place of choice.
- A model of Enhanced Health in Care Homes has been piloted since September 2017 to provide additional support to care homes. This includes a city wide team providing training and development and support with implementation of best practice, e.g. early warning signs tool; and case management and enhanced primary care support delivered respectively by Solent NHS Trust and Southampton Primary Care Ltd focussing on the 15 homes with the highest number of hospital admissions. This model will be evaluated in June 2018 with a view to further roll out across the city.

- **Joining up Rehab and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams**
  - The Integrated Rehabilitation and Reablement and Hospital Discharge service continues to embed and achieve key performance targets (92% of referrals for crisis response responded to within 2 hours, 88% reablement clients achieving their goals).
  - Data from the Urgent Response Team (within the Rehab and Reablement Service) continues to show that the service is reducing long term care needs. In Q3 there were 42 users of rehab and reablement. 40% of these left independent, requiring no further care; of those remaining 23% saw a 13% reduction in their care. This resulted in a saving of 129.5 home care hours a week.
  - The Hospital Discharge Team is now providing a service across the community hospitals as well as the acute hospital in line with the city's ambition to improve hospital discharge across the system as a whole.
  - Discharge to assess is now standardised for pathway 2 (clients requiring additional support, including rehab and reablement) and the numbers of discharges to this pathway are exceeding target levels. A similar model has been piloted for pathway 3 and the results are currently being evaluated.
  - The work undertaken on integrating and strengthening rehab and reablement has also achieved the intended refocus from bed based reablement to reablement in a person's own home, and, as a result, we have seen a drop in demand for the five reablement beds commissioned from the residential care sector over the last 6 months and have subsequently reduced this to 3 beds for 2018/19.
- **Building capacity** across the system to promote and support people to maintain their independence for as long as possible

- The Carers in Southampton Service has increased the numbers of carers identified. Between 98% and 100% of carers assessed and awarded a personal budget have taken this as a Direct Payment.
- There have been a number of developments with the voluntary and community sector which have resulted in new services being procured during 2017/18, including:
  - The Integrated Advice, Information and Guidance service which went live in February 2018
  - The Southampton Living Well Service which went live in April 2018 and will transform the current older person's day services into a more community focussed model.
  - The roll out of Community Navigation across all clusters. A number of different providers are currently delivering this service and work is currently underway with them to develop a more integrated model of provision.
  - Falls exercise classes are now operating in all parts of the city and their impact is currently being evaluated.
  - The new Behaviour Change Service went live 1 April 2017.
- The additional iBCF funding (which is part of the Better Care pooled fund) has been used to increase capacity within the care market particularly over the winter period. This has included the following developments:
  - The development of extra care; new placements have been made, including individuals moving from nursing care settings to extra care. Significant savings have been achieved following the opening of Erskine Court in 2016/17 - £272K full-year effect. The ICU is working with the care provider to continue to increase complexity levels that can be met within Erskine Court. This includes additional training for staff to meet greater needs, payment for covering call alarms in schemes, activities, and planning for additional capacity overnight to support individuals with night-time care needs. Learning from Erskine Court is being utilised in the development of Potters Court to maximise positive outcomes.
  - Consolidation of increased home care (5,829 additional home care hours purchased for 17/18), promotion of 7 day working and extension of an existing retainer for 6 months to provide additional capacity over the winter to support hospital discharge.
  - Promotion of community based resources as an alternative to social care - temporary resource put in place to update Southampton Information Directory (SID) so that people are aware of the services available.
  - Development of prevention, early intervention and return to home initiatives to help people keep well and maintain their independence thereby reducing future pressure on the care market. Grants for agencies were provided to go live from April

	2018 onwards. ▪ Transport options for care workers increased as part of a broader programme supporting care staff through agencies. This includes car parking passes and access to bicycles for key parts of the city
5.	**Key Areas of Focus for 2018/19** In 2018/19 we will continue to deliver against the 6 key priorities identified in the 2017-19 Better Care Plan: • Further expansion of the integration agenda across the full life-course • Continue to strengthen prevention and early intervention • Further shift the balance of care out of hospital and other bed based settings into the community • Development of the community and voluntary sector • Development of new organisational models which better support the delivery of integrated care and support • New contractual and commissioning models which enable and incentivise the new ways of working 2018/19 will specifically focus on the following key developments: **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.
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	The total value of the pooled fund for 2017/18 is just over £109m. Financial performance against each Scheme is monitored on a monthly basis by the Better Care Finance and Performance Group and reported to the JCB. KRP
Property/Other	
7.	There are no specific property implications arising from the Better Care

	Programme, although work is underway to explore co-location opportunities in each cluster, taking into consideration existing buildings and future development plans.
LEGAL IMPLICATIONS	
<u>Statutory power to undertake proposals in the report</u>:	
8.	The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006, which requires that in each Local Authority area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2017-19, NHS England set the following conditions: • Agreement of a joint plan between the CCG and Local Authority • NHS contribution to social care is maintained in line with inflation • Agreement to invest in NHS-commissioned out-of-hospital services • Implementation of the High Impact Change Model for Managing Transfers of Care. Southampton is compliant with all four of these conditions. As at the time of writing, no updated guidance has been published for the Better Care fund in 2018/19 and beyond.
<u>Other Legal Implications</u>:	
9.	None
CONFLICT OF INTEREST IMPLICATIOINS	
10.	None
RISK MANAGEMENT IMPLICATIONS	
11.	Key risks and issues for the Better Care Programme overall are summarised below: • **Capacity and Capability of leadership within clusters** to embed the new model of person centred integrated working at the pace required - one of the key initial tasks of the Better Care Programme Manager who commenced this month will be to undertake a stocktake of progress within each cluster to identify strengths and weaknesses and work with the Cluster leadership teams to put in place development plans, highlighting any requirements for additional support and resources to the Better Care Steering Board. • **Capacity of the care market** to meet increasing needs and support additional schemes to improve discharge - To mitigate this, the ICU is working proactively with the care market and utilising alternative mechanisms such as retainers and block contracts to provide increased stability • **Resilience in the voluntary sector** - A number of mitigating actions are being taken including: various procurement options being considered to make best use of local market and encourage innovation; support to local agencies also being considered as part of the developments; proactive review of any bidding opportunities.
POLICY FRAMEWORK IMPLICATIONS	
12.	Southampton's Better Care Programme supports the delivery of outcomes in the

	Council Strategy (particularly the priority outcomes that “People in Southampton live safe, healthy and independent lives” and “Children get a good start in life”) and CCG Operating Plan 2017-19, which in turn complement the delivery of the local HIOW STP, NHS 5 Year Forward View, Care Act 2014 and Local System Plan.
13.	Southampton’s Better Care Plan also supports the delivery of Southampton's Health and Wellbeing Strategy 2017 - 2025 which sets out the following 4 priorities: • People in Southampton live active, safe and independent lives and manage their own health and wellbeing • Inequalities in health outcomes and access to health and care services are reduced. • Southampton is a healthy place to live and work with strong, active communities • People in Southampton have improved health experiences as a result of high quality, integrated services

KEY DECISION?	**Not Applicable - No decision required**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1	Appendix 1 - Introduction to Better Care

Documents In Members’ Rooms

1.	**None**
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No -**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**
Other Background Documents **Other Background documents available for inspection at:**	

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