Better Care Update

Health & Wellbeing Board
20 June 2018

NHS
Southampton City
Clinical Commissioning Group

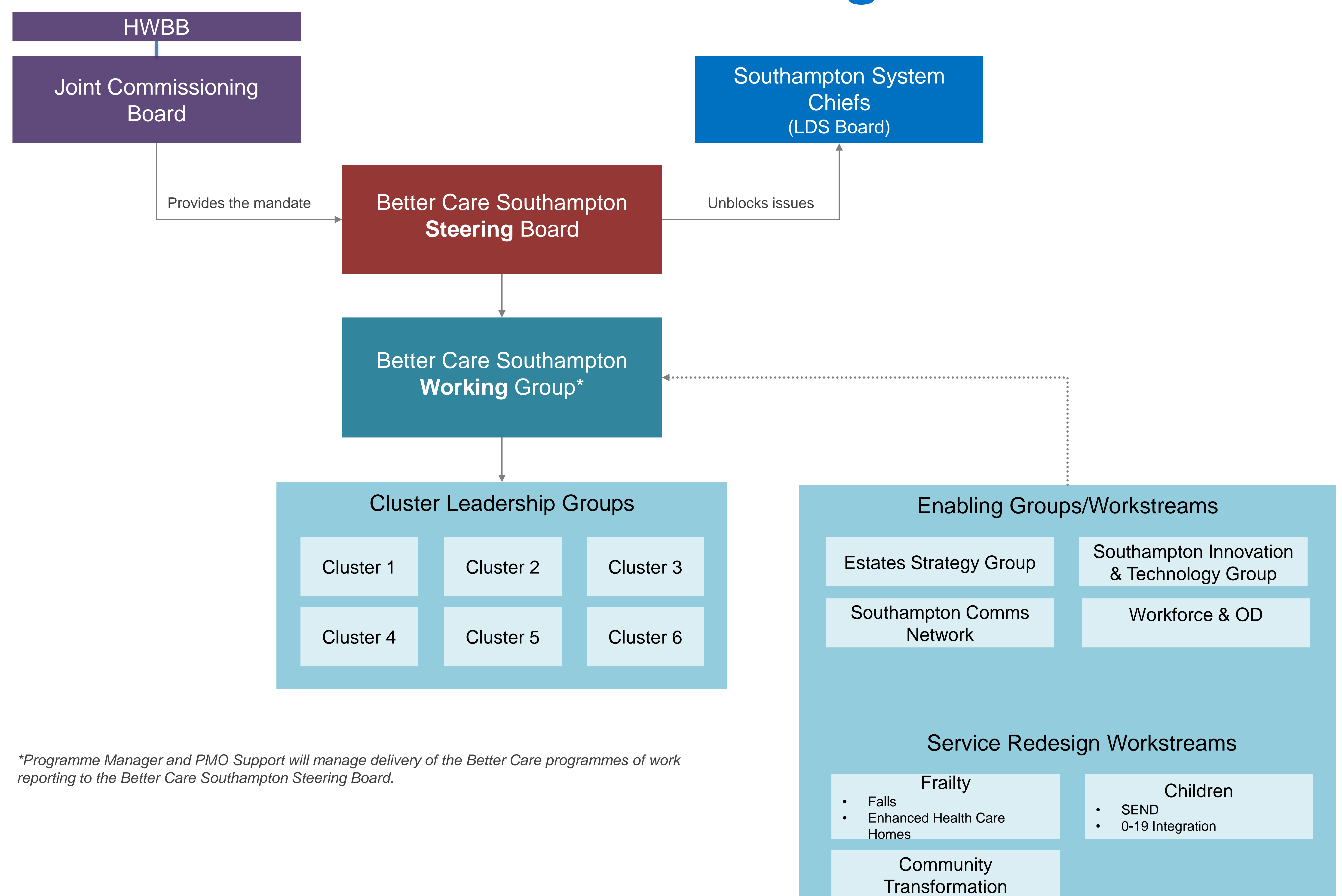
What we will cover

- Our Vision for Better Care Southampton
- Our Approach
- Progress to date
- Impact
- 2018/19 Priorities and key enablers

Our vision for Better Care

- Putting **individuals and families at the centre of their care and support**, meeting needs in a holistic way
- Providing the **right care and support, in the right place, at the right time**
- 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

Better Care Governance Arrangements



**Programme Manager and PMO Support will manage delivery of the Better Care programmes of work reporting to the Better Care Southampton Steering Board.*

Our Approach

PREVENTION &

PREVENTION &

EARLY INTERVENTION

Person centred local coordinated care

Person centred approaches harnessing communities and the power of indiviudals in their own health and wellbeing

integrated cluster based health & social care teams

7 day working

proactive assessment/early interventions/rapid response

Increased choice and control through personal (health) budgets

Responsive discharge & reablement - supporting timely discharge and recovery

integrated health & social care reablement service

proactive engagement into communities and local networks of support

Building capacity

with local communities & services

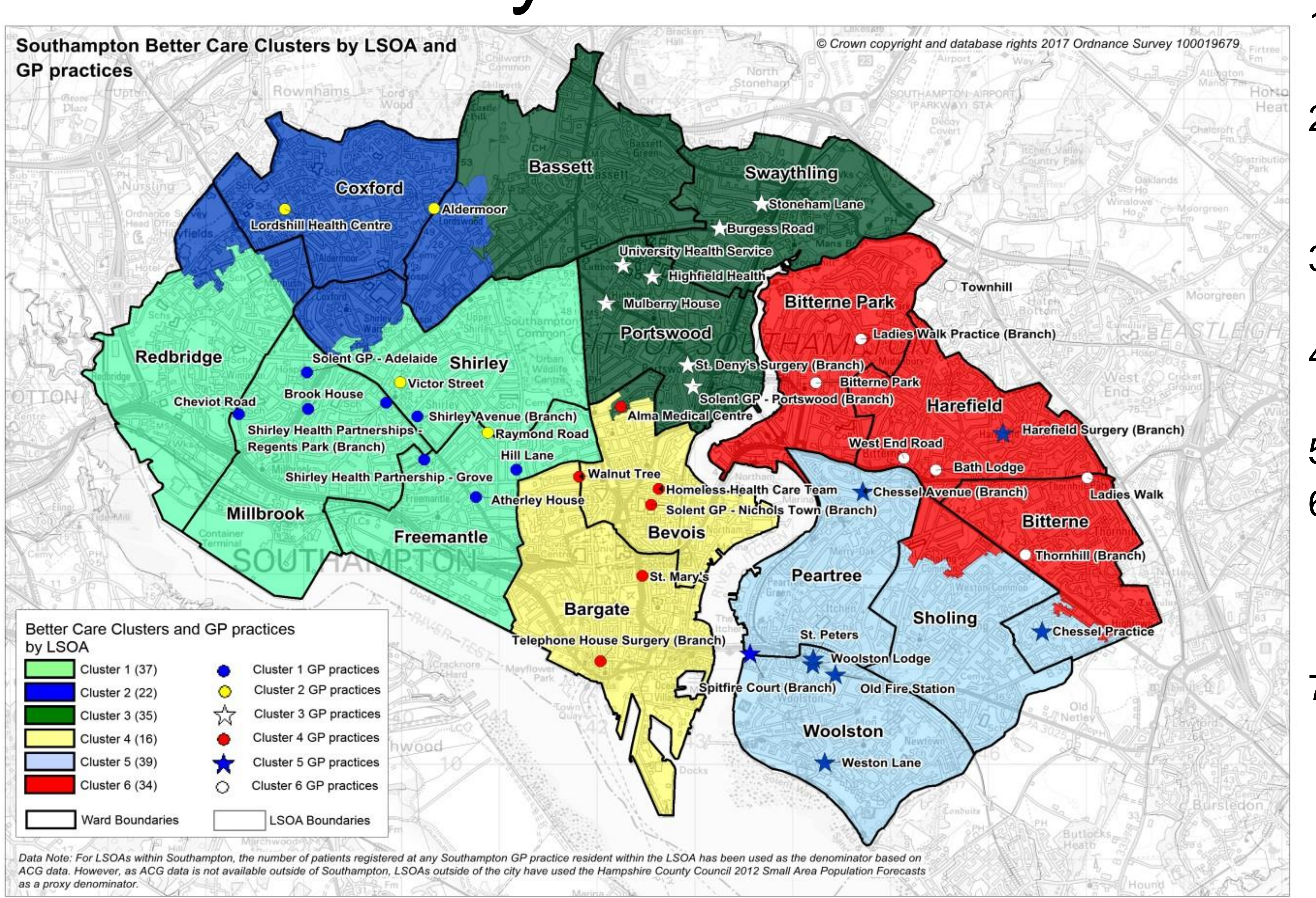
with individuals, their cares and famillies

with the voluntary and 3rd sector

through robust coproduction, communication and engagement

EARLY INTERVENTION

Our Six Integrated Primary and Community Care Clusters



Core Components:

1. 30-50,000 populations
2. Based around GP practice registers
3. Local Leadership
4. Local Partnerships
5. Prevention
6. Integrated working/ joined up conversations
7. Shared under-standing of needs and priorities

Local projects

Cluster 2

Supporting people with complex needs out of hospital

Frailty

Prevention

Cluster 3

Connecting Care for Children

Frailty

Cluster 6

Social prescribing

Frailty

Mental health

Cluster 1

Connecting Care for Children

Bowel Cancer

Frailty

Mental Health

Cluster 4

Connecting Care for Children

Frailty

High Intensity Users

Cluster 5

Community nursing

Care planning

Social prescribing

Progress to date – Person Centred local coordinated care

- 6 integrated **cluster teams** – initially focussing on older people (2015/16), now also focussed on working age adults and beginning to translate model to children's services
  - Dedicated professional leads for each cluster and city wide Programme Manager in post.
  - Local Solutions Groups bringing together voluntary, community, faith, business sector coming together in each cluster
  - Enhanced Health in Care Home model went live in September 2017

Progress to date – Responsive Discharge and Reablement

- **Integrated Rehab and Reablement Service** supporting independence and early discharge
  - 98% crisis referrals responded to within 2 hours
  - 40% reablement clients leave the service independent, requiring no further care; of those remaining 23% saw a 13% reduction in their care.
- **Hospital Discharge Team** operating 7 days a week across acute and community hospitals.
- **Discharge to assess now standardised for pathway 2** across both acute and community hospitals.
- **Discharge to assess being piloted for pathway 3**

Progress to date – Building Capacity

- **Carers:** Increasing numbers identified. 98.5% of carers assessed and awarded a personal budget receive a direct payment.
- **Developing the Prevention and Early intervention market**:
  - Mobilisation of Integrated Advice, Information and Guidance service
  - Mobilisation of new Southampton Living Well Service which will transform the current older person's day services.
  - Community Navigation operating in all clusters – more integrated model being developed
  - Falls exercise classes operating in all parts of the city – currently being evaluated
  - New Behaviour Change Service went live 1 April 2017

NHS
Southampton City
Clinical Commissioning Group

Progress to date – Building Capacity (Contd)

- **Transforming Long Term Care:**
  - Negotiations with independent sector nursing home providers underway to improve access for clients with dementia
  - Expansion of Extra Care Housing – 169 units with further increase planned for additional 83 units by 2020/21 - seeing some transfer of residential care clients to extra care
  - Use of IBCF to increase home care capacity and responsiveness (7 day working, additional weekly hours)

Making a difference to local people

2017/18 End of Year Performance Summary

Month 12 (Apr 17 – Mar 18)

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, as with many prevention programmes, it can take a while for interventions to embed and have an impact

Six Key Priorities going forward

- 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 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
- 7 day services to support seven day discharge.
- Develop the role of the clusters in supporting timely discharge.
- Improve communication and quality of discharge across the hospital and care home sector.

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.

Enablers

Cluster leads in place
Better Care programme manager appointed

Strong Leadership and Governance

Pooled/ aligned Resources

£108M Pooled Fund

Local digital roadmap linked to Better Care programme

Digitalisation

Workforce Development

Better Care Workforce Plan being produced with STP

Joint Estates Plan for cluster hubs – supported through One Public Estate Group

Joint Estates Planning

Organisational and Commissioning Development

Link with STP Strategic Commissioning programme