DECISION-MAKER:		**Joint Commissioning Board**		
SUBJECT:		**Better Care Quarter 2 2018/19 Report**		
DATE OF DECISION:		**8 November 2018**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY

NOT APPLICABLE

BRIEF SUMMARY

This report provides a review of performance for Quarter Two 2018/19 against Southampton's Better Care programme and pooled fund.

An overview of each of the individual schemes can be found at Appendix 1.

RECOMMENDATIONS:

	(i)	To note Quarter Two performance for Better Care.

REASONS FOR REPORT RECOMMENDATIONS

1.	The Joint Commissioning Board (JCB) is responsible for oversight of the Better Care pooled fund. This responsibility has been delegated to JCB from the Health and Wellbeing Board (HWBB).
2.	National Better Care Fund Operating guidance was published on 19 July 2018 for 2018/19 along with revised targets for delayed transfers of care (DTOC). The guidance reiterates the previous guidance published for 2017-19 and does not require local areas to revise their plans for 2018-19. The DTOC metric set for Southampton in 2018/19 has been reset based on the Quarter 3 2017/18 position and requires Southampton to reduce average daily delays to 26.6 (comprising 11.3 NHS delays, 11 Adult Social Care delays and 4.4 Joint delays) by September 2018 and then to maintain this position to year end. The Quarter 3 position was 38.8 average daily delays (16.2 NHS delays, 18.3 Adult Social Care delays and 4.4 joint delays). The new 18/19 target represents a slightly less ambitious trajectory than that of 2017/18 and a much more equal split of NHS and Adult Social Care delays. The targets in Southampton's Better Care performance report have been updated to reflect this revised trajectory.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3.	**NOT APPLICABLE**

DETAIL (Including consultation carried out)

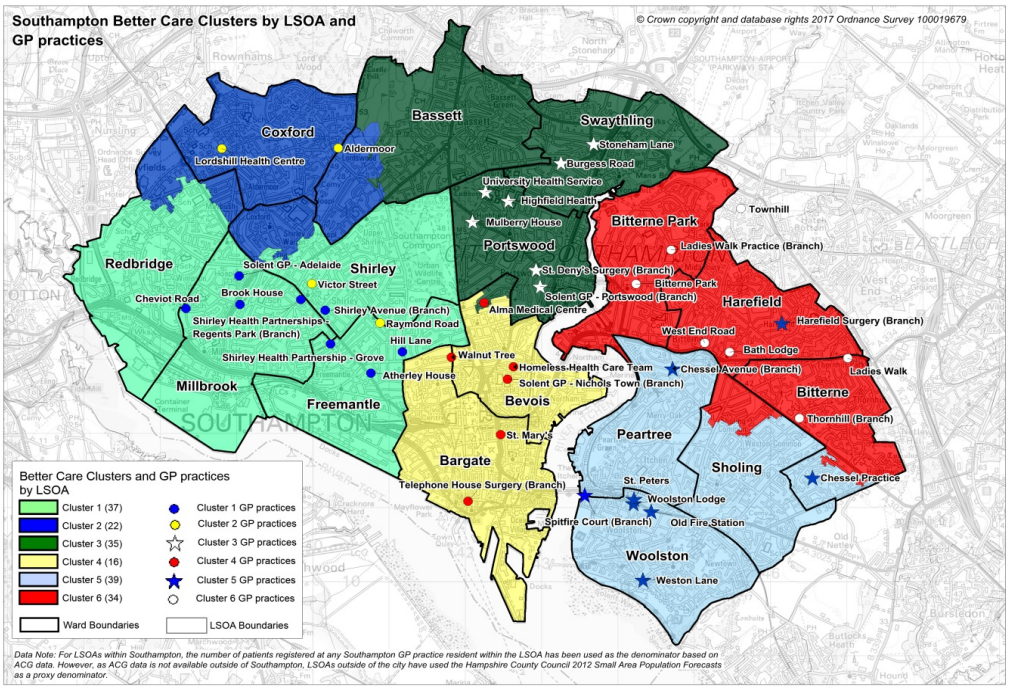
4.	**Overview**

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 Rehabilitation 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. Southampton's 6 key priorities as identified in the 2017-19 Better Care Plan are set out below: • 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 The **Better Care Fund** pools resources from both the CCG and Local Authority to support the delivery of the Better Care Programme. In 2018/19 this totals £110.5M (£73.4M from the CCG and £37.1M from the Council), making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which is £16.2M, 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
5.	**Performance as at Q2 2018/19** The table below provides the Performance against the key Better Care national indicators. Owing to monthly reporting time lags, it is only possible to provide activity data up to Month 5, i.e. 31 August 2018 (September 2018 activity data will be available in November 2018).

Better Care Performance

Month 5

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

Metric	Year to Date vs. Target	Year to Date vs. Last Year	Commentary
Urgent Care Demand			
A&E Attendances (Type 1, Main ED)	No Target set	Better (1% lower than last year)	• Children & Young People: 5% decrease year on year • Working Age Adults: 3% decrease year on year • Older People: 6% increase year on year.
Non Elective Admissions	Slightly Off Track (4% higher than target)	Better (3% lower than last year)	• It is assumed that NEL admissions are lower than last year because this time last year, **GP front door streaming** wasn't in place and the **coding changes** for NEL short stays into CDU chairs hadn't been implemented.
Non Elective Short Stay Admissions (Length of stay 0 days)	No Target set	Better (7% lower than last year)	• Children & Young People: 5% increase year on year • Working Age Adults: 14% decrease year on year • Older People: 4% increase year on year.
Non Elective Super Stranded Admissions (Length of stay ≥21 days)	No Target set	Better (5% lower than last year)	• Working Age Adults: 7% increase year on year • Older People: 6% decrease year on year.
Discharge & Out of Hospital Model			

DTOC rate (August snapshot)	Off Track (5.8% vs. 4.0% target)	Better (DTOC rate was 6.2% in August last year)	• August 2018 had a total of 1,242 delayed days, equivalent to a **DTOC rate of 5.8%.**
			• Provider DTOC rates in August:
			  • UHS: **5.8%** vs. 4.1% target
			  • Solent: **5.3%** vs. 2.6% target
			  • Southern Health: **6.9%** vs. 5.9% target

Delayed days	Off Track* (58% higher than target)	Better* (20% lower than last year)	• *Note, Southern Health did not submit DTOC data for Southampton in May, so the numbers are skewed.
Permanent admissions into residential care	On Track (1% lower than target)	Slightly worse (5% higher than last year)	
Prevention			
Injuries due to falls	Off Track (16% higher than target)	Slightly worse (5% higher than last year)	

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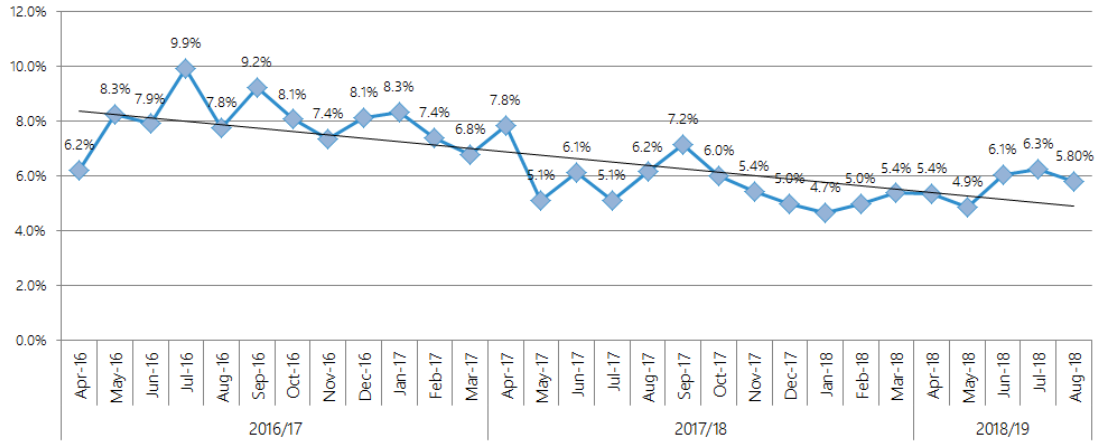
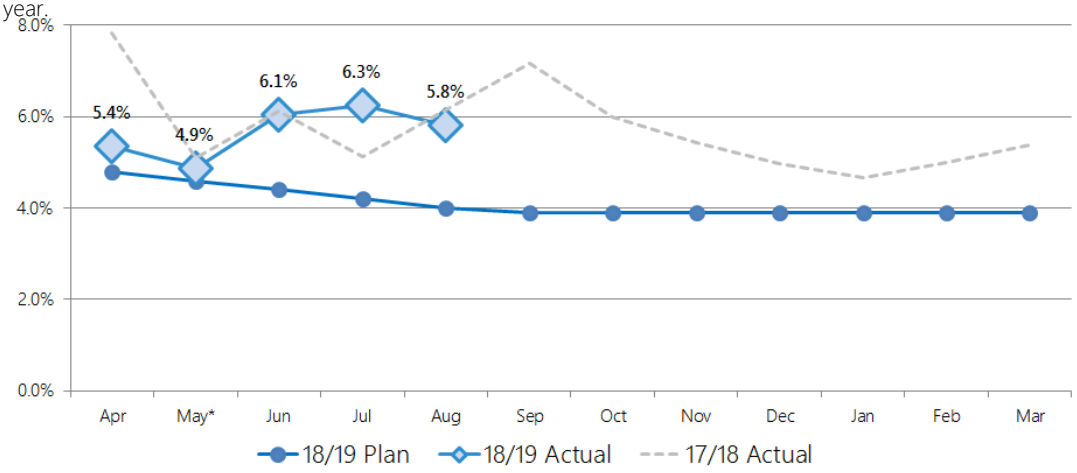
6. **Performance Headlines**

- **Permanent admissions to residential and nursing homes:** After an apparent worsening of the position in Quarter 1which was caused by a higher than usual number of admissions in April 2018, the Q2 position is showing this metric to be on target, 1% below the plan for Month 5.
- **Delayed transfers of care** Whilst significantly improved from last year (Apr - August 18 data showing 20% reduction in Delayed days compared to the same 5 months in the previous year) and a continued steady reduction over the last 2 years, a number of key challenges continue to make the target difficult to achieve.

The graph shows Southampton City's DTOC rate from April 2016 to the most recently available data, August 2018.



The graph shows Southampton City's DTOC rate performance for 2018/19 versus plan, and a comparison to the previous year.



The first 5 months of this year, whilst the number of discharges have been high, have seen high rates of delay, the main challenges being:

- increasing levels of complexity amongst patients being discharged. There has been a strong push within the hospital (through initiatives like SAFER and Red to Green days) to discharge patients earlier which is evidenced through reduced lengths of stay. However patients coming out of hospital tend to be more complex with higher levels of need which are more difficult to meet. One way that the ICU is looking to address this is by asking the Community Independence Team to target patients who have been discharged with large home care packages to see if, several weeks after discharge, this level of care could be reduced through re-ablement or different types of equipment. The Community Independence Team is also aiming to allocate therapists to in-reach into the hospital to assess patients alongside the hospital team. The Community Independence Team therapists will have a greater knowledge of what is available in the community.
- workforce capacity in the domiciliary care market particularly to support higher levels of need for more complex clients e.g. requiring calls at specific times or double up calls 3 or 4 times a day. To address this pressure, additional investment was made in the Home Care retainer to bring on line additional hours over the Summer holidays and further investment is being made this winter. In addition the ICU and Adult Social Care are exploring whether double up packages could be converted to single hand packages through different types of equipment. The ICU has also made links with the Department of Work and Pensions to explore ways of better attracting staff into the home care workforce.
- nursing home capacity to take more complex clients. To address this, the ICU is working with a number of providers to increase capacity for dementia clients, including investment of capital, although this is reliant on building work and so benefits will not be seen until next year.
- increased requirement for housing adaptations and equipment to enable people to return home, which is resulting in increased spend on the Joint Equipment Service budget (£170k cost pressure forecast for this year). There have also been some problems with hospital based therapists following the correct processes for requesting equipment

which have resulted in delays but these have now been resolved.

- increased delays related to public funding decisions as increasing complexity is driving more bespoke requests which do not necessarily meet continuing health care criteria. Whilst these requests have been addressed on a case by case basis, there may be some merit going forward in considering a pooled budget, perhaps linked to the pooled budget proposed for Pathway 3 Discharge to Assess placements.
- people with low level health needs which are not specialist but require care staff to administer basic clinical tasks e.g. PEG feeds, collar care, eye drops. Finding home care providers able to take on such clients has proven a challenge. In response, the ICU is working with a small number of providers on the home care framework to enable them to access training to undertake this work. The ICU is also working with Solent NHS Trust to commission the Urgent Response Service to provide low level health care on an interim basis to enable people to leave hospital and be supported whilst they are waiting for a home care package to be sourced.

For the remainder of this year, the following system wide priorities have been agreed:

I. Continue to mainstream discharge to assess which for the majority of patients will be in their own home.

II. Improve planning at the hospital front door to assess needs, direct people to the most appropriate setting, avoid admission where possible, commence early discharge planning and early conversations about discharge.

III. Strengthen community services to provide person centred, proactive, coordinated care and support, 7 days a week capable of managing greater levels of acuity outside of hospital.

IV. Increase the supply of home care to meet greater levels of complexity and address gaps e.g. people with low level health needs.

V. Improve hospital processes for organising discharge – e.g. timely and reliable transport and provision of medication and equipment, timely transfer of patient notes and consistent application of the Complex Discharge policy, particularly in relation to early discharge planning.

VI. Work towards 7 day discharge.

At an individual organisational level the following areas of focus have been identified:

For Commissioners (CCG and SCC)

- Commission a pathway for people with low level health needs to leave hospital in a timely way and be supported at home.
- Continuously review demand and capacity to target additional resource in the right place and work with Care Homes and Home Care providers towards making 7 day discharge a reality.

For UHS and Southern Health

- Improve the quality of discharge processes with a particular focus on timely provision of transport, medications, equipment, patient records and 7 day working.

	• Embed the message that "discharge is everyone's business", ensuring that all staff receive regular updates on discharge processes and that this is evidenced through auditing practice, with a particular focus on having early conversations with patients about their discharge arrangements. **For Solent** • Continue to develop the Urgent Response Service to respond to need by supporting people with increased levels of acuity in the community. • Strengthen the palliative care support worker offer to enable more people to die at home as opposed to in hospital or in a care home. **For Southampton City Council** • To ensure robust provision to prevent delay for pathway 3 and ensure statutory responsibility under safeguarding and mental capacity are adhered to. • Continue to support 7 day working across the system to help maintain timely patient flow. • To support community hospitals and Urgent response to prevent delays and maintain flow. • **Non Elective admissions:** at month 5, whilst NEL admissions are 4% higher than plan, they are 3% lower compared to this time last year (9% lower amongst the working age adult population) against a backdrop of population growth. Particular schemes believed to be impacting on reducing non elective admissions include: o Extension of the Adult Mental Health Crisis Lounge opening hours - now open 24 hours a day, 7 days a week. o Primary Care Streaming in the Emergency Department. o Changes to the pathway for low risk chest pain patients. o Reductions in admissions amongst high intensity users - this has included the ambulance demand practitioner scheme which targets cohorts of patients with frequent urgent care activity and is demonstrating reductions in ambulance call outs as well as the implementation of an intensive support scheme focussed on people in the inner city with high end health and social care needs.
7.	**Key highlights for Quarter Two 2018/19** • **Priority 1: More rapid expansion of the integration agenda across the full life-course, building on the city's model of person centred integrated care based around 6 geographical clusters** ➢ Work has continued on the development of our 6 clusters. At the end of Q2, all clusters have dedicated clinical and professional leadership, have arrangements in place to facilitate local decision making and planning and have begun to agree priorities informed by cluster level population data aligned to city wide priorities. Performance reports are now being presented at cluster level. A number have also begun to map cluster assets to understand the opportunities for social prescribing and work is commencing on the utilisation of risk stratification tools to support better targeting of need. ➢ Work is progressing between commissioners and managers across the

Council, Southern Health and Solent to explore a more integrated model of delivery encompassing the following services: Community Independence Team, Community Nursing, Older Person's Mental Health teams and Social Care locality teams.

- In addition, we have been reviewing our Early Help offer to children and families in Q2 and have plans in place which we will be rolling out over Quarters 3 and 4 to strengthen prevention and early intervention in localities. This includes deploying more specialist resource into our locality teams, e.g. social workers and CAMHS, as well as working with adult services to improve access to support for Adult Mental Health and Substance Misuse. This is being supported through a bid for additional investment to the "What Works for Children's Social Care Centre", the outcome of which will be known in mid November 2018.

- **Priority 2: A much stronger focus on prevention and early intervention**
  - A pilot to reduce frequent ED attendances and emergency admissions amongst some of the most vulnerable people in the city centre working with a voluntary sector provider went live in June 2018 and during Q2 we have successfully recruited our first 8 clients to the scheme and are already seeing positive results in reducing pressure on health services.
- **Priority 3: A more radical shift in the balance of care away from bed based provisions and into the community**
  - Work has continued to embed the High Impact Change Model for hospital discharge. D2A for Pathway 2 is now mainstreamed for all patients and the D2A pilot for Pathway 3 has been extended to year end. Further evaluation is taking place to support the case for mainstreaming this in 2019/2020. A report will be brought back to JCB in January 2019.
  - The Enhanced Health in Care Home pilot focussing on 15 residential care homes in the city came to an end in Quarter 1 and the evaluation has shown a significant impact on reducing Emergency Dept attendances and Non elective admissions. It has also helped to build positive relations between commissioners, health services and these homes. Agreement has been given by the CCG (who funds this pilot) in Q2 to roll this approach out city wide from April 2019, whilst continuing the existing pilot to year end.
  - During Q2, the ICU has signed a number of agreements with care homes to reduce access fees for some clients in line with a strategy agreed by the Joint Commissioning Board. Work is continuing to add to these and to enter into long-term arrangements to secure cost reductions for many new care placements. This will support our overall strategy of strengthening community provision. We are also encouraging care homes to increase complexity of care by identifying current capabilities, and the training and skills development required to meet future needs.
  - Planning permission has been granted this Quarter for a new 44-bed nursing home in Rownhams, on the outskirts of the city. The home has secured a majority of funding, but requires additional investment. The Council has been reviewing options to contract for capital investment in the home. This is subject to budget pressures generally and the council is looking at short-term funding against long-term return. The home would help to expand the supply of nursing home placements available to the

	Council for patients with more complex needs who are more difficult to place. If the home progresses, regardless of council investment or not, the council would look to contract for bed spaces at guaranteed rates. ➢ We have also completed our tender this quarter for the new home care framework and sourced additional home care hours over the summer to respond to the seasonal reduction we see in supply linked to the school holidays. • **Priority 4: Significant growth in the community and voluntary sector** ➢ Work has progressed in Q2 to develop our model for Community Development and a decision has been taken to commission a single service including Community Navigation. During Q3 we will be further engaging with the voluntary and community sector on the design of the model and it is hoped to begin to source this in Quarter 3/4. • **Priority 5: Develop 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** ➢ During Q2, we have continued to see improved uptake of care technology (332 referrals compared to 281 in Q1) and have opened up referrals to the Council's Life Skills team for adults with learning disabilities and Homegroup, a supported housing provider, to enable more clients with learning disabilities to access care technology solutions. The overall conversion rate (from referral to installation) in Q2 has held at 60%. During this quarter we have also continued to develop our business case for vital signs monitoring in care homes, develop a digital app that will allow better coordination of client's care resources, develop an activity monitoring system for use in assessment of high cost supported living clients and scope potential uses for video conferencing in clinical pathways. ➢ During Q2, we have also progressed with the development of an integrated Adult with LD service bringing together Council, Southern Health and CCG staff. An integrated Service Manager commenced in post in September. Other developments have included sourcing accommodation to co-locate staff in two bases and establishing an integrated administrative support. Highlight reports for each of the Better Care Fund schemes can be found at Appendix 1.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	The total value of the pooled fund for 2018/19 is just over £110m. As at Month 5, overall performance against the pooled fund was a projected year end overspend of £0.06M, which represents a percentage variance against budget of 0.05%. This is made up of a £0.39M overspend for the CCG and a £0.33M underspend for the Council. The two main areas of overspend relate to the Clusters and Learning Disabilities Schemes where there is a projected year end overspend of £0.14M and £0.20M respectively. For clusters, this is due to additional costs of £0.05M for locums covering vacant posts in the long term social care teams and additional

	investment in the home oxygen and orthotics service of £0.09M to match need on the CCG contracts included in this scheme. For the Learning Disabilities Scheme, this is due to an increase in complexity of client care, particularly impacting on the CCG which is showing an overspend of £0.30M whilst the Council is projecting an underspend of £0.10M. These overspends are currently being offset by projected underspends on other schemes, primarily: • Integrated Rehab and Reablement and Hospital Discharge where there is a projected underspend of £0.20M on the Council budget, mainly related to staff vacancies (that are now being recruited to). • Prevention and Early Intervention (housing related support schemes) where there is a projected underspend of £0.10M on the Council budget due to a contract saving. Financial performance against each Scheme is monitored on a monthly basis by the Better Care Finance and Performance Group. Appendix 2 details the Better Care Fund finances for month 5.
<u>Property/Other</u>	
9.	There are no specific property implications arising from the Better Care pooled fund.
LEGAL IMPLICATIONS	
<u>Statutory power to undertake proposals in the report</u>:	
10.	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.
<u>Other Legal Implications</u>:	
11.	None
CONFLICT OF INTEREST IMPLICATIOINS	
12.	None
RISK MANAGEMENT IMPLICATIONS	
13.	Risks on specific Better Care Fund Schemes are monitored on a monthly basis. Key risks and issues for the Better Care Programme overall are summarised below: • **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. As mentioned above, it is also working with the Department of Work and Pensions to explore ways of attracting staff to the homecare workforce. • **Resilience in the voluntary sector** and ability to respond to new ways of working - 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	
14.	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.
15.	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.	Quarter 2 Individual Scheme Highlight Reports
2.	Better Care Fund Finances – Month 5

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 - Update only**

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