DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**BETTER CARE END OF YEAR REPORT**		
DATE OF DECISION:		**19 JUNE 2019**		
REPORT OF:		**DIRECTOR OF QUALITY AND INTEGRATION**		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
Not Applicable.

BRIEF SUMMARY
This report provides an overview of performance in 2018/19 against Southampton's Better Care programme and pooled fund, including the iBCF (improved Better Care Fund), and highlights priorities for 2019/20.

RECOMMENDATIONS:		
	(i)	To note 2018/19 performance against Southampton's Better Care programme and spend against the pooled budget, including the iBCF.
	(ii)	To note the priorities for 2019/20.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Health and Wellbeing Board (HWBB) is responsible for overseeing the Better Care pooled fund in each Local Authority area. In Southampton, this responsibility has been delegated to the Joint Commissioning Board (JCB) from the Health and Wellbeing Board (HWBB). The JCB reviews progress against the Better Care programme and pooled budget on a quarterly basis and an end of year report is presented to the HWBB.
2.	At the point of writing this report, national planning guidance for 2019/20 is still outstanding following publication of the national Policy Framework on 10 April 2019. However verbal intelligence from the LGA and NHSE is that 2019/20 will be seen as a transitional year whilst the national review of the Better Care Fund is concluded and the current spending period comes to an end. Changes to the planning guidance in 2019/20 are expected to be limited. There will be no change to the four national conditions: (i) Plans to be jointly agreed (ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution (iii) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care (iv) Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care. As part of this all Health and Wellbeing Boards adopt the centrally-set expectations for reducing or maintaining rates of DToC during 2019-20 into their BCF plans.

	The main changes are expected to be: • A one year plan (as opposed to two years) • A requirement to include the Adult Social Care Winter pressure funding in the Better Care pooled fund • A stronger emphasis on integrating housing, housing adaptations and equipment services into the plans for integration.
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**. 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 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**. • **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 5 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, along with 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 totalled £111.5M (£74.5M from the CCG and £37M from the Council), making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which was £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. Local integrated services (clusters)
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. **2018/19 Performance**

The table below provides the year end position for the key Better Care national metrics.

Metric	Year End Performance against Plan	Year End Performance against previous year
Non Elective Hospital Admissions	8% above plan	3% increase
• Children	-	6% increase
• Working age adults	-	2% increase
• Older People	-	4% increase
• Non Elective Hospital Admissions resulting from Falls Injuries	20% above plan	9% increase
Delayed Transfers of Care (DTOC)		
• Rate (this is the % beds occupied by a delayed discharge as a % of all available beds for Southampton. The national NHSE target is 3.5%)	4.8% against a target of 3.5%. Split by provider Trust: - UHS: 5.5% - Solent: 2.3% - Southern Health: 3.6%	4.8% compared to 5.4% in 17/18
• Average Daily Delays (this is the average number of patients delayed each day across Southampton LA area. Southampton's daily target is 26.6)	38.6 against target of 26.6	Not available
• Rate of Average Daily Delays per 100,000 over 18 population (Southampton's target is 13.2 per 100,000)	16.2 compared to target of 13.2	Not available
Permanent Admissions to Care Homes	8% above plan	6% increase

3. **Performance Commentary**

- **Permanent admissions to residential and nursing homes:** A high number of people whose capital has depleted, and so are no longer self funding, in the first 6 months of the year has resulted in an increase in the proportion of Council funded permanent admissions. This has contributed to the increase in the figures as has an increase in nursing home admissions.
- **Delayed transfers of care (DTOC):** There are two key national measures for DTOC – the national 3.5% target (% beds occupied by a delayed discharge as a % of total

beds available) which is the NHS England measure reported at Acute Hospital Trust level; and the rate of average daily delays which is used by Local Government (Southampton's expected rate for 18/19 being 13.2 per 100,000 over 18 population which equates to 26.6 average daily delays). DTOC is measured across the whole system and so locally the daily target has been split as follows:

- UHS – 19.98 average daily delays
- Solent – 2.66 average daily delays
- Southern Health – 4.0 average daily delays

The national target is split by responsibility as follows:

- NHS – 11.3 daily delays
- Adult Social care – 11.0 daily delays
- Both (joint NHS and social care responsibility) – 4.4 daily delays

The beginning of 2018/19 saw an increase in the DTOC rate. Although the DTOC rate has been reducing since September, it still remains significantly above where it should be and above that of our comparator authorities. Figure 1 at Appendix 1 shows performance against the 26.6 daily target for Southampton as a whole and split by NHS, Social Care and "Both" delays.

Figure 2 at Appendix 1 shows the rate for the daily average delays per 100,000 over 18 population and how Southampton compares to the national average and other Local Authorities.

Performance against the 3.5% target by year end was 4.8% for the system as a whole (5.5% for UHS; 2.3% for Solent and 3.6% for Southern Health).

- The main challenges resulting in delays are:
  - Increasing levels of complexity amongst patients being discharged.
  - Sourcing complex "double up" care packages.
  - Sourcing care home placements particularly for patients with dementia but also in relation to response times for assessment by the homes
  - Sourcing care for patients with low level health needs such as collar care
  - Flow in NHS rehabilitation beds whereby difficulties in sourcing home care prevent patients from moving on and thereby create a bottleneck in the pathway
- However, despite the DTOC rate being higher than plan in 2018/19, the number of delayed days this year to date are at a very similar level to the number this time last year (1% lower) and overall, there has been a steady reduction in DTOC over the past 2 years. In order to understand what more it needs to do in order to improve, the CCG and SCC therefore requested a peer review of DTOC which took place on 30 April 2019, coordinated by the LGA. Key feedback from this review is currently being implemented and includes:
  - Strengthening senior oversight and leadership by ensuring that there is a regular focus on DTOC performance at the monthly Better Care Steering Board meetings
  - Strengthening reporting processes and accountability so that on any one day performance can be tracked against each of the 3 discharge pathways ("simple" which is the responsibility of the hospital; "supported" which is the responsibility of Rehab and Reablement and "enhanced/complex" which is the responsibility of the Integrated Discharge Bureau)
  - Organisation of a system wide workshop for 21 June with Hampshire colleagues to take a fresh look at the 8 High Impact Change Model (using the latest reviewed guidance from the LGA) for improving discharge and flow and identify key improvement areas for focus

- Refresh of the DTOC action plan to include priorities identified from above workshop plus:
    - Continuing to mainstream discharge to assess and home first principles.
    - Improving planning at the hospital front door to assess needs, direct people to the most appropriate setting, avoid admission where possible, commence early discharge planning.
    - Continuing to increase the supply of home care to meet greater levels of complexity and address gaps e.g. people with low level health needs whilst engaging the social care market and voluntary sector more in our transformation work.
    - Improving hospital processes for organising discharge/"getting the basics right" – 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.
    - Working towards 7 day discharge.

- **Non Elective (NEL) admissions:** For 2018/19 NEL admissions were 8% above target and, despite holding growth for the majority of the year, ended the year 3% higher than 17/18. This was due to high rates of admissions in the last 3 months of the year coupled with unprecedented increases in Emergency Department (ED) attendances, particularly amongst children and over 65s. The majority of the increase has been in short stay admissions (less than one day) – 13% increase compared to previous year for children and 12% for over 65s. This is shown in Figure 3 of Appendix 1.
- In comparison longer admissions of one day or more only increased by 2% for both children and over 65s.
- Growth in short stay admissions (less than one day) remains a particular challenge. Work is ongoing with UHS, Solent and Adult Social Care to develop rapid pathways from the hospital front door back into the community where hospital stay is avoidable; however under current coding rules, any stay in hospital (be it only for a few hours) will be counted as an admission.
- Short stay NEL admissions in the working age population on the other hand were 1% lower than the previous year; the following have helped to reduce admissions for this age group:
    - Changes to the pathway for low risk chest pain patients.
    - Reductions in admissions amongst high intensity users - this has included the introduction of an ambulance demand practitioner targeting cohorts of patients with frequent urgent care activity (which is demonstrating reductions in ambulance call outs) and the implementation of an intensive support scheme focussed on people in the inner city with very complex health and social care needs.
- With regard to falls related admissions amongst older people which were 20% above target and 9% higher than last year, a detailed review of activity has been undertaken in 18/19 to identify areas on which to focus improvement. The following developments have been agreed for 2019/20 funded by the CCG:
    - Implementation of a telecare pilot specifically targeting people identified as being at high risk of falling in their own homes (which is where the majority of falls occur) to provide falls prevention equipment as well as a 24 hour responder service to prevent people remaining on the floor for long periods of time (identified as a key reason for admission)
    - Introduction of a clinician from the Urgent Response Service into the South Central Ambulance Service call centre with knowledge of the local pathways and services in order to support the call handlers with identifying alternatives to hospital conveyance (identified as a missed opportunity).

	➢ Re-procurement of a city wide falls exercise service ➢ Additional investment into the Community Independence Service to increase the capacity for falls assessments to ensure that people are compliant with their medication, exercising appropriately and making other lifestyle changes that could prevent a fall
4.	**Key Developments in 2018/19** Below is a summary of some of the key developments in 2018/19 against each of the 18/19 Better Care priorities. • **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** ➢ Implementation of an **integrated 0-19 Early Help Service**, bringing together NHS employed public health nurses (Health Visitors and School Nurses), the Council's Children's Centres and Family Matters teams to form an integrated offer delivered across three localities. Work has commenced to further strengthen and extend the teams by devolving some city wide services down to localities, including social workers. The Council has been successful in a bid to become a research partner with the national What Works Centre for Children's Social Care which is funding 6 **social workers to work in 3 school clusters** across the city from February 2019 which will test the benefit of bringing social work closer to schools and children and families. ➢ A Better Care Programme Manager was appointed in May 2018 to support integration at an operational level and a number of key building blocks are now in place including: - Detailed population profiles to inform each locality's understanding of their local population and setting of local priorities. - Local Solution Groups which bring together community and voluntary sector partners with statutory services to map the wider community provision and work together to identify future creative solutions to meeting local need. - Commenced pilot of social work hubs • **Priority 2: A much stronger focus on prevention and early intervention** ➢ Implementation of the new **Southampton Living Well Service** which commenced in April 2018 and is transforming the way we provide older people's day care into a more person centred, community focussed model. The provider of this service is co-producing an activity offer with service users and will establish an affiliate scheme with local activity groups/organisations which will significantly increase the number and range of activities being offered outside of the traditional day care setting. ➢ Establishment of an integrated **Information, Advice and Guidance** Service. In the first year of the contract for every £1 invested into the service approximately £4 is returned in benefit to the clients who use the service (e.g. through savings in bills, increased access to benefits, consumer advice etc) ➢ Development of the **Falls Exercise** offer which is now operating across the whole city. • **Priority 3: A more radical shift in the balance of care away from bed based provisions and into the community** ➢ Implementation of the national **High Impact Change Model for hospital discharge and flow**. Discharge to Assess (D2A) for discharge pathway 2 (people requiring reablement or some level of additional support in their own homes) is now mainstreamed for all people leaving hospital (UHS as well as the

community hospitals RSH and Snowden). There is evidence that discharge to assess and reablement for this group is reducing the need for ongoing care. Between January 2018 and January 2019, 947 people left the service having been on the reablement pathway of whom 500 had no further care needs at the end of their reablement period (53%). Specific data for patients discharged from the RSH shows that of those requiring ongoing care, 20% had reduced needs.

A D2A pilot for the more complex group of people leaving hospital on Discharge Pathway 3 has also been piloted in 2018/19. An evaluation of this pilot has shown that those patients/clients who have accessed the D2A scheme have shorter lengths of hospital stay (on average the D2A group had an average length of stay 27 days less than those patients/clients who were offered D2A but declined).

- Implementation of the **Crisis Lounge** to provide a safe space in the community for people in mental health crisis, diverting unnecessary ED attendances. This is now operating 24/7.
- Further roll out of **IAPT** (Improving Access to Psychological Therapies) in the community to support more people with lower level mental health needs.
- Successful piloting of the **Enhanced Health in Care Homes** model with 15 residential care homes across the city has demonstrated a significant impact on reducing Emergency Department (ED) attendances and Non elective hospital admissions (NEL). Overall it would appear that ED attendances have reduced by 48%, Ambulance Call outs by 57% and NEL hospital admissions by 38% across the 15 targeted homes over a 16 month period. The pilot has also helped to build positive relations between commissioners, health services and these homes. As a result, the CCG are now rolling this out city wide.
- Continued **work with the care home market to develop capacity to meet increasing levels of complexity.** This has included encouraging care homes to increase complexity of care by identifying current capabilities, and the training and skills development required to meet future needs. SCC and CCG are also looking into options to contract for capital investment in nursing homes in return for bed spaces at a reduced rate.
- Successful re-procurement of the **Home Care Framework** and continued expansion throughout the year of the hours available to respond to increasing demand. The new framework which went live in April 2019 builds on the lessons and challenges of the previous framework. A key feature of the new Home Care model is to have appointed lead providers for each of the city's Better Care clusters to better coordinate care on the ground, model the new ways of person centred, strengths based working and ensure strong linkages with other services as part of our overall integrated model. The lead providers will have a greater responsibility in working in partnership with other health care providers in their cluster, including acute and community hospitals, GP surgeries and social care teams.

- **Priority 4: Significant growth in the community and voluntary sector**
  - Development of plans for a new **Community Solutions Service** which will provide an infrastructure to support Community Development and roll out Community Navigation across the city. This is now being procured and will be in place by the Autumn of 2019/20.
- **Priority 5: Develop new models of care which better support and develop new contractual and commissioning models which enable and incentivise the new ways of working**
  - Embedding the use of **care technology in Adult Social Care;** although there is still some way to go, referrals have increased over 2018/19 and referral routes have been opened up to promote greater usage, e.g. to the Lifeskills team and

Homegroup to allow for more supported living clients with learning disabilities to be referred for Connected Care assessment.

- Development of an **integrated team for adults with learning disabilities**, which brings together Council, Southern Health and CCG staff. An integrated Service Manager commenced in post in September.
- Establishment of the **Joint Commissioning Board** which brings together senior decision makers from across the CCG and Council to determine commissioning strategy

5. **Impact of the iBCF**

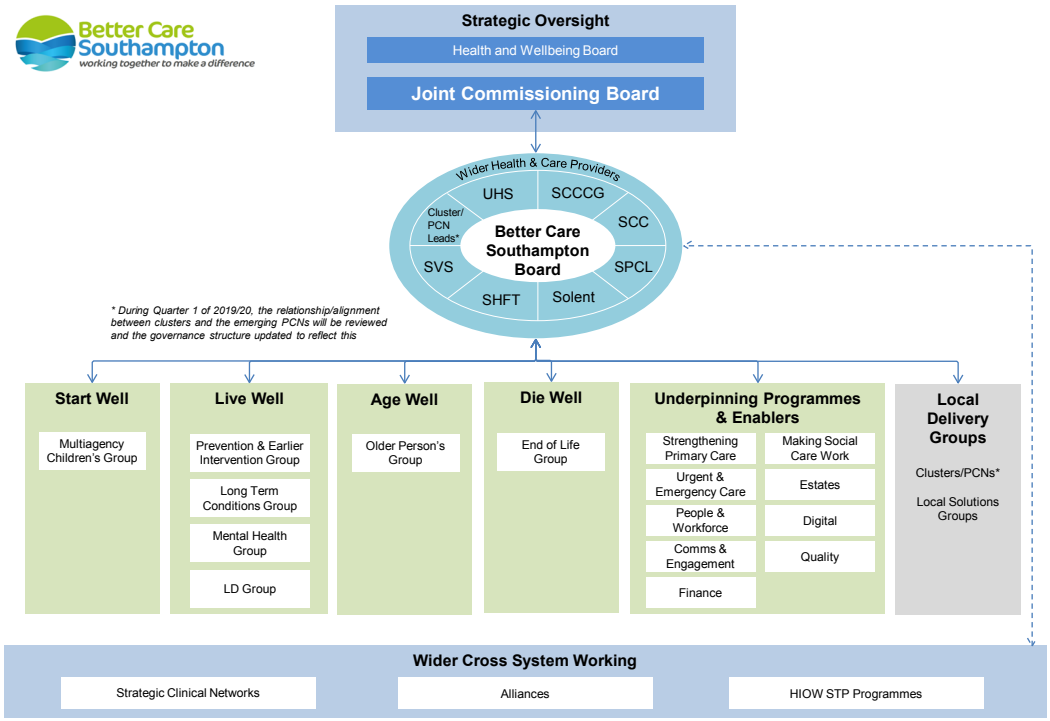
A number of the achievements outlined above have been supported by the iBCF national fixed term (April 2017 – March 2020) grant funding which is part of the overall pooled fund. In 2018/19 the total value of the iBCF was £4.85M, which included a carry forward from 2017/18 of £1.68M. This has been allocated as follows:

Scheme	2018/19 Spend	Impact
Establish a dedicated Direct Payments Team	£0.24M	• 120 new people in receipt of a direct payment (although this increase is not mirrored in the overall figures as a number of people have ceased their DP)
Care Technology Coordinator Post	£0.05M	• Provision of care technology has become more embedded for Adult Social Care. 1207 referrals in total during 18/19 compared to 854 in 17/18 and 584 in 16/17 and 276 referrals from integrated/health teams in 18/19 compared to 203 in 17/18. Referrals have visibly increased since the appointment of the coordinator in October 2017. • Conversions have remained stable (54.4% in 17/18 and 54.5% in 18/19) • Benefits tracking process implemented • Supported launch of telecare falls pilot
Weston Court replacement / respite care scheme	£0.31M	• Provision of a new respite service at Weston Court since Jan 2018 for adults with learning disabilities • 23 individuals receiving respite at service and 760 nights provided to date (up to March 2019) – which has enabled individuals to remain living in their family home. This has included provision of extended respite stays for five individuals due to family emergencies who might otherwise have ended up in residential provision
Expanded 7 day social care operation in the hospital discharge team	£0.10M	• 7 day working in the Hospital Discharge Team has meant that delays relating to assessment by the social care team have been significantly reduced.
Speeding up hospital discharge for people with complex needs	£0.35M	• This funding has been used to implement D2A for all clients discharged from the community hospitals (RSH and Snowden) with additional support needs in their own homes, mirroring the process at UHS. 809 patients have been discharged onto this pathway between April 2018 and January 2019 (on average 89 a month). Of these approx. 38% go on to require no further care and, of those needing ongoing care, approx. 20% have a reduction in their care needs. • The funding has also been used to pilot a D2A scheme for those more complex patients coming out of UHS on pathway 3 (i.e. those who are likely to need a nursing home placement). As already highlighted above, data from the pilot has shown that there is a reduction in the number of delayed days in

			hospital for those patients/clients receiving D2A.
	Meeting increased demand and complexity	£2.00M	• Reduction of Adult Social care cost pressure
	Stabilising the provider market	£0.32M	• 100 additional home care hours a week purchased from the Retainer • Employment of Service Development Officer and successful re-procurement of city wide Home Care Framework, whilst also managing business as usual
	Extra Nursing Home Capacity for complex needs	£0.11M	• Appointment of a Service Development post which has led on negotiations with the care home sector to increase access to affordable bed spaces (approx. 50 bed spaces) and encourage and support homes to meet increased levels of complexity • Commissioning of a land options appraisal which has identified land available in the city that would be of the size that could support either extra care developments (large plots of land) or supported living developments (smaller units). This work is the first time the city has provided this level and quality of information, and is being used to underpin investment strategies – both for LA money and for private development resources.
	Additional social work capacity in new community based social wellbeing service	£0.10M	• Additional capacity to meet need
	Additional social work capacity in new integrated learning disability service	£0.11M	• Additional capacity to meet need
	Additional social work capacity to review care needs in accordance with the Care Act 2014	£0.03M	• Additional capacity to meet need
	To be carried forward to 19/20	£1.10M	
	TOTAL	£4.85M	

6. **2019/20 Better Care Programme**

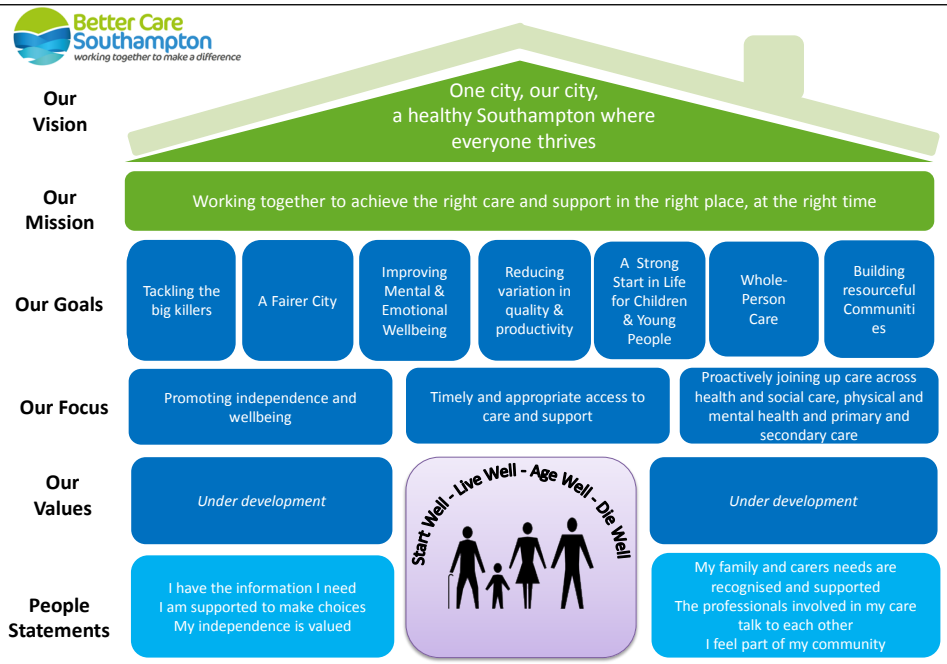
In the light of the city's new 5 Year Health and Care Plan (2019 – 2024), the governance structure for Better Care has been reviewed. The new governance structure will be presented to Joint Commissioning Board on 20 June for approval and is shown below:



The main changes to the governance are:

- A move to 3 localities (as opposed to 6 clusters) to enable better alignment with Primary Care Networks (PCNs) and local health and care delivery structures, where localities of 80,000 – 100,000 populations provide a footprint which offers better economies of scale for organising services around than 6 clusters of 30,000 – 50,000 could offer. This does not preclude working at sub-locality/neighbourhood level where it makes sense to do so.
- Inclusion of the locality leads on the Better Care Steering Board to strengthen connectivity between strategic planning and local service delivery.
- Restructure and rationalisation of the Better Care Steering Board subgroups to align with the life course approach used in the 5 Year Health and Care Plan: start well, live well, age well, die well.

The vision for Better Care has also been refreshed to mirror the 5 Year Health and Care strategy:



Underpinning the delivery of the 5 year plan, 3 key areas of focus have been identified for Better Care:

- Promoting independence and wellbeing
- Timely and appropriate access to care and support as close to home as possible
- Proactively joining up care across health and social care, physical and mental health, primary and secondary care.

The following actions are being taken forward in 2019/20:

Focus	Actions
Promoting independence and wellbeing	• Implement the next stage of the falls prevention strategy. • Further development of strengths based approach in adult social care and wider team • Procurement of the new Community Solutions Service to provide an infrastructure to support growth in the community and voluntary sector and community navigation to better link people into the support that is available in their local communities • Further expansion of Extra Care Housing with the development of 80 new bed spaces at Potters Court which will open in 2020 plus development of further proposals • Development of supported housing options for people with learning disabilities and implementation of new housing related support services for children and adults
Timely and appropriate access to care and support as close to home as possible	• Continuing to embed the High Impact Change Model for Hospital Discharge with a particular focus on strengthening the 3 hospital discharge pathways, work with the care home sector to improve hospital discharge and increasing weekend discharges. • Rolling out the Enhanced Health in Care Homes model city wide • Implementation of the new Home Care framework • Continue to work with the nursing home sector to increase capacity and availability of affordable bed spaces for Southampton clients with increased levels of complexity. • Implementation of Southampton's Frailty model, designed in 2018/19,

	to manage higher levels of acuity in the community, e.g. IV medication and strengthen multidisciplinary working at the hospital front door to ensure that people are directed in a timely way to the best setting for supporting their needs, wherever possible in their own homes • Continue to maximise opportunities for using care technology to improve access to health and care and support people's independence. • Continue to increase access to Improving Access to Psychological Therapies (IAPT), including for people with long term conditions • Continue to develop mental health crisis response for adults and children, developing intensive home treatment as an alternative to inpatient care
Proactively joining up care across health and social care, physical and mental health, primary and secondary care.	• Continue to join up health and care across physical and mental health at a locality level with a particular focus on implementing integrated locality health and social care teams for vulnerable adults and continuing to develop the integrated team for adults with learning disabilities. • Continue to implement the extended locality team model for 0-19 Prevention and Early Help Services to manage greater risk in the community, including joint work with Adult Services to ensure a whole family approach - whilst also integrating specialist health, care and education services to better support young people with complex social/emotional/ behavioural needs in the community, reducing numbers entering care or being placed out of area. • Development of a more integrated model of equipment, housing, adaptations and related services • Explore alternative contracting approaches which better support system wide working to a set of common outcomes

RESOURCE IMPLICATIONS

Revenue

7. **2018/19**

The total value of the pooled fund for 2018/19 was £111.50M. Total spend was £111.90M which represents a percentage variance against budget of 0.38%.

The main area of overspend was in the Learning Disabilities Scheme (£0.98M). This is due to an increase in complexity of client care. This overspend was offset to an extent by underspends in other schemes, primarily:

- Integrated Rehab and Reablement and Hospital Discharge where there was an under spend of £0.13M, mainly related to staff vacancies (that are now being recruited to).
- Prevention and Early Intervention where there was an under spend of £0.52M due to contract savings within day care commissioning and housing related support.
- The Children's multiagency Building Resilience Service (BRS) where there was an underspend of £0.12M which is related to staff vacancies (now being recruited to)

Financial performance against each Scheme is monitored on a monthly basis by the Better Care Finance and Performance Group.

8. **2019/20 Spend Plan**

The total Better Care Fund for 2019/20 will be £115.7M, split as follows between the schemes:

Scheme	2019/20 Budget
1. Supporting Carers	£ 1.46M
2. Cluster working	£53.96M
3. Integrated Rehabilitation and Reablement and Hospital Discharge	£17.14M
4. Promoting Care Technology	£ 0.05M
5. Prevention and Early Intervention	£ 7.61M
6. Learning Disability Integration	£28.48M

7.	Promoting uptake of Direct Payments	£ 0.25M
8.	Transforming Long Term Care	£ 0.12M
9.	Integrated provision for children with SEND	£ 1.20M
10.	Integrated health and social care provision for children with complex behavioural & emotional needs	£ 1.27M
11.	Disabled Facilities Capital Grant	£ 2.22M
12.	Additional Social Work Capacity	£ 0.31M
13.	Joint Equipment Store	£ 1.65M

It should be noted that, with the exception of the IBCF, all funding in the Better Care pooled fund is committed to existing service provision.

Property/Other

9. There are no specific property implications arising from the Better Care pooled fund.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

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. For 2019/20, NHS England has set the following conditions:

- Plans to be jointly agreed
- NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care
- Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care. As part of this all Health and Wellbeing Boards adopt the centrally-set expectations for reducing or maintaining rates of DToC during 2019-20 into their BCF plans.

Southampton is compliant with all four of these conditions.

Other Legal Implications:

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.
- **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 the CCG Operating Plan, which in turn complement the delivery of the local HIOW STP, NHS 5 Year Forward View, Care Act 2014 and 5 Year Health and Care 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 – Briefing only**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Performance Charts

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 – EIAs will be conducted as required at an individual project level**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No – PIAs will be conducted as required at an individual project level**
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**	