DECISION-MAKER:		**Cabinet**		
SUBJECT:		Consultation on proposals for an Integrated Service for Crisis Response, Rehabilitation, Reablement and Hospital Discharge. (Phase One and Phase Two)		
DATE OF DECISION:		August 18th 2015		
REPORT OF:		Cabinet Member for Health and Adult Social Care		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY:
Appendix 1 of this Report is not for publication by virtue of category 3: Information relating to the financial or business affairs of any particular person (including the Authority holding that information) taken from paragraph 10.4 of the Council's Access to Information procedure Rules as contained in the Council's Constitution.

BRIEF SUMMARY

A key element of the Better Care Plan approved by Cabinet in January 2014 was to achieve a re-designed integrated health and social care crisis response, rehabilitation/ reablement and hospital discharge service for Southampton. The vision is to achieve significant benefits across the system including:

- An improved client experience that is person-centred, seamless and integrated
- A clear and effective pathway for clients to promote recovery and independence
- Improved efficiencies by reducing service duplication, providing co-ordinated care and a more tailored use of bed-based resources
- Reducing spend across the health and social care system by reducing the future demand for services as the population gets older e.g. spend on avoidable hospital admission rates, length of hospital stay and need for on-going complex packages of care.

Following aseries of Stakeholder Workshops a Business Case has been produced on a potential preferred Option for a new, integrated service model. (Appendix 1)

This report seeks Cabinet approval for the preferred Option and to initiate a process of consultation on the re-provision of these services, including the potential preferred Option, which comprises two separate Phases.

Phase One: A proposed service model which will bring together those functions associated with crisis response, rehabilitation, reablement and, at a later date

hospital discharge, delivered by the City Council and Solent NHS Trust to provide a seamless response for the service user. This will be achieved through a single integrated team approach, with a single integrated management structure that better supports people in their communities and maximises their potential for independence. This preferred Option has the potential to impact on staff in terms of line management, roles and location of staff base. Although a small number of management posts (9 Full Time Equivalents (FTE) across the City Council and Solent NHS Trust) have been identified as potentially impacted by this preferred Option, the number of posts potentially at risk may be fewer. The preferred Option will not change the employer or terms and conditions (i.e. City Council staff will remain employed by the Council on the same terms and conditions). This Phase One is a re-structure of staffing resources and does not impact on the type, service delivery location or total range of services available to clients.

Phase Two: A reconfiguration of rehabilitation and reablement beds, to achieve a more appropriate and cost effective balance of bed based and domiciliary care services that meets needs of clients and would deliver better outcomes, and represents a better value use of resources. This preferred Option will have implications for the future locations of staff employed by Southampton City Council rehab/reablement and respite in-house services, and has the potential to impact on a larger number of City Council posts (potentially 41 FTE) and on how services are delivered.

These rehab/reablement and respite in-house services are currently provided by the City Council at Brownhill House. It is proposed this unit would close if the preferred Option for Phase Two, subject to consultation, were to be approved. Clients will still receive rehab, reablement and respite services, but they will be provided in an integrated and flexible way, with a tailored use of bed-based resources other than at Brownhill House.

In addition, Southampton Care Association (SCA) currently utilise Brownhill House for provision of a commissioned Day Service for Older People. The implication of progressing Phase Two will mean a likely re-location for the Day Service, which would be facilitated by City Council.

RECOMMENDATIONS:

	(i)	To approve that within the consultations the preferred Option is Option 4 which will deliver an integrated service.
	(ii)	To approve a formal consultation with relevant staff in the City Council and Solent NHS Trust on Phase One.
	(iii)	To delegate authority to the Acting Director of Adult Social Care and Head of Legal and Democratic Services, following consultation with the lead Cabinet Member for Health and Adult Social Care to do anything necessary to give effect to the Phase One proposals incorporating any changes resulting from the staff consultation.
	(iv)	Subsequent to consultation, and as a part of the actions in (iii) to facilitate integrated working between Health and Social Care, to approve establishing a Section 113/Section 75 agreement under the National Health Service Act 2006 as appropriate.
	(v)	To approve a formal consultation with relevant staff (City Council and Solent NHS Trust), with stakeholders and with service users, carers and family members on proposals for Phase Two, including the potential preferred Option - a reconfiguration of rehab and reablement beds to achieve the most appropriate balance of bed

		based and domiciliary care to support the integrated service model.
	(vi)	To note that there is an indicative **net** saving in the region of £210,000 to £825,380 to be realised by 2020 if Phase Two of the re-design of services is taken forward. This saving is associated with a predicted reduction in hospital admissions and permanent admissions to residential and nursing homes by investing more into reablement and domiciliary care, and is predicated on re-investment of some of the resources freed up by Phase Two.
	(vii)	To note, subsequent to consultation, the final recommended proposal in respect of Phase Two, will be brought back to a Cabinet meeting in 2016 for approval and agreement to implement.
REASONS FOR REPORT RECOMMENDATIONS		
1	There is a strong case for change. The outcomes for clients and their experience can be improved as the city has: • A higher proportion of older people who rely on input from Adult Social Care services than is the case nationally (5.2% compared with 3.8%) • A significantly growing number of Delayed Transfers Of Care (DTOC) • A much higher rate of admissions of older people aged 65 and over to residential and nursing care homes when compared to other Health and Wellbeing Boards in our comparator areas and nationally.	
2	There are also significant pressures on City Council resources and pressures on the health system: • Rates of unplanned admissions and delayed transfers are above the national average, pressure on beds is unsustainable and unsafe and there are high rates of admission to residential and nursing homes • Current community rehabilitation, reablement and hospital discharge services are provided by Southampton City Council Adult Social Care and Solent NHS Trust, working with Southern Healthcare and University Hospital Services (UHS) • While the different teams work hard to provide quality services, current service configuration makes it difficult to work effectively together in a co-ordinated way. The Business Case (Appendix 1) has evidenced the impact of having separately provided hospital discharge, crisis response, rehabilitation and reablement functions.	
3	The recommendations in this report for an integrated service contribute to a key element of the Better Care Plan approved by Cabinet in January 2014, which was to achieve a re-designed integrated health and social care rehabilitation/ reablement service for Southampton. This requires a new service that can deliver an improved client experience that is: • Person-centred, seamless and integrated, (e.g. care planning and assessment may be undertaken by any agency using a common trusted tool) Provides a clear and effective pathway to promote recovery and independence.	
ALTERNATIVE OPTIONS CONSIDERED		

	The options considered were:
4	Option1: **Do Nothing** - this is considered not to be a viable option as it will not achieve the overall aims and ethos of the Better Care Plan and the issues identified in paragraph 13 will continue.
5	Option 2: **Improved Partnership working only** (i.e. Adult Social Care and Health Teams working across organisational boundaries to streamline referrals and capacity through joint working protocols and processes, without any integration of staff teams). This would deliver some improvement but not the overall system change required to deliver the outcomes needed and reduce the increasing spend on acute hospital and social care. Each service would still be driven by its own organisational aims and priorities as opposed to shared city wide vision and priorities. Potential efficiencies in streamlining management structures and removing duplication of roles would also be lost, as would the ability to flex the totality of staff resources to meet needs in an holistic way.
6	Option 3: **Partial Integration** of Southampton City Council's Reablement team and Solent NHS Trust's existing Locality Community teams only. Once again this will not fully deliver the economies of scale and benefits as identified in the Business Case. (Appendix 1)
7	Option 5: **Full integration as at Option 4 but not to progress to Phase Two**. This option is not considered a preferred Option because: • It maintains a heavy reliance on hospital beds, which does not support the ethos of reablement and independence the city aspires to • It does not offer the flexibility required to meet clients' needs • Business Case data (based on 3 separate Bed Audits) evidenced up to 50% of all clients in community beds are medically fit and could, with appropriate support, be managed in the community/own home with better outcomes • Efficiencies and savings across the pathway would not be realised • Resources would not be transferred to positively promote new ways of working to deliver Better Care Plan principles.
DETAIL (Including consultation carried out)	
	Background
8	The Better Care Plan approved by Cabinet in January 2014 aims to achieve a re-designed integrated health and social care rehabilitation/ reablement service for Southampton. This requires a new service that delivers an improved client experience that is person-centred, seamless and integrated, and provides a clear and effective pathway to promote recovery and independence.
9	There is a strong case for change. A higher proportion of older people in Southampton rely on input from social services than is the case nationally (5.2% compared with 3.8%) and the demand for services is rising. This is characterised by a significantly growing number of Delayed Transfers Of Care (DTOC). Each day on average there are reported to be around 30-40 Southampton City patients in acute hospital beds who are assessed as medically fit for discharge, resulting in delayed discharges. About 12-15 of these delays in any given week can be attributed to Adult Social Care services; the remainder to health services. Excess bed days for 65+ year olds cost the Southampton City Clinical Commissioning Group (SCCCG) approximately £3.1m each year.

10	The city has a much higher rate of admissions of older people aged 65 and over to residential and nursing care homes when compared to Health and Wellbeing Boards in our comparator areas and nationally. In 2013/14, there were 487 admissions in Southampton costing the City Council £8.98m per annum.
11	Current community rehabilitation, reablement and hospital discharge services are provided by Southampton City Council Adult Social Care and Solent NHS Trust, working with Southern Healthcare and University Hospital Services (UHS). These includes: • Community Emergency Department Team (CEDT) – managed by Solent NHS Trust and provides rapid assessment and triage to avoid unnecessary hospital admission • Hospital Discharge Team (HDT) – managed by the City Council and undertake hospital based assessment and discharge planning. Part of the team also works in the Emergency Department, intervening early to avoid unnecessary hospital admissions, working closely with CEDT • Brownhill House (BH) - A residential unit, managed by the City Council, where Health (the SCCCG) fund 25 rehabilitation beds (6 week maximum stay) for patients that do not need medical care and the City Council funds 12 respite beds. Therapy input is provided by staff from Solent NHS Trust. • Solent NHS Trust Royal South Hants Rehabilitation Wards - Fanshawe Ward (19 beds) and Lower Brambles Ward (24 beds) are health operated "step up and step down" wards that offer inpatient rehabilitation to patients who have medical care needs • SCC City Care First Support (CCFS and CCFS 24) and Reablement Teams - this service offers practical support and encouragement to clients in their own home focussing on goal orientated plans that promote independence. This includes sensory services, occupational therapy and care management services • Solent NHS Trust Community Rehabilitation Teams - are locality based and multi-professional, comprising of Occupational Therapists, Physiotherapists, Associate Practitioners, Community Support Workers, Older Persons Mental Health Support Workers and Consultants in Integrated Medicine for Older People. They support people with complex rehabilitation needs in the community, and specialise in the assessment and treatment of falls • Solent NHS Trust Rapid Response and Out of Hours Nursing Service - is a multidisciplinary health and social care team working in Southampton City caring for vulnerable adults who have a medical, nursing or social crisis and can be cared for safely at home for up to seven days.
12	A total of 365.66 Full Time Equivalent (FTE) posts are involved in these services across the two organisations, 56% of whom (205.29 FTE) are City Council staff.
13	While the different teams work hard to provide quality services, the current service configuration makes it difficult to work effectively together in a co-ordinated way. The Business Case (Appendix 1) has evidenced the impact of having separately provided hospital discharge, crisis response, rehabilitation and reablement functions as: • Hospital discharge processes are unnecessarily complex • Some community and bed based resources cannot respond rapidly and flexibly enough to meet the demands of the system and ensure that, where

	appropriate, hospital admissions are avoided or/and that discharge systems are responsive • Some services are under-utilised • Organisational boundaries place unnecessary “hand offs” in the process and patient pathway • Inpatient provision is deployed over several sites • Assessments that could take place in the community are undertaken in an acute setting • Bed based and community resources do not work collectively to make maximum use of available resources
14	The current system does not deliver a fully responsive integrated pathway for clients, residents and patients. Delays in referrals and acceptance into different elements of the pathway are common.
15	There are also significant pressures on City Council resources and pressures on the health system. Rates of unplanned admissions and delayed transfers are above the national average, pressure on beds is unsustainable and unsafe and there are high rates of admission to residential and nursing homes.
16	It is necessary to consider providing a seamless integrated service in order to improve the experiences and outcomes for clients. This will also result in reducing costs and improve effectiveness and therefore 5 potential options were considered through a process of stakeholder engagement. The preferred Option 4 is recommended for the reasons detailed earlier in this report.
	Option 4: Full Integration
	<u>Phase One:</u>
17	The preferred Option is a proposal to bring together all the functions associated with crisis response, rehabilitation, reablement and at a later date hospital discharge, into a seamless process with clear outcomes achieved through a single integrated team approach, with a single integrated management structure that better supports people in their communities and maximises their potential for independence. The proposed preferred model has been developed through a series of consultation workshops and meetings as follows: • Senior Managers’ Stakeholder Workshop (Integrated Commissioning Board) on 21st August 2014 • Stakeholder workshops held on 11th September 2014 and 17th September 2014 • Dedicated Task and Finish groups • Interviews with operational managers, clinicians and finance officers • Ongoing project work stream groups • Provider Project Board meetings • Integrated Commissioning Board (Nov, Dec 2014, Jan 2015)
18	Further work has been undertaken to identify patient pathways and scope opportunities for joint working through project work streams. The outline model and work streams to deliver the model have been detailed in the Business Case – attached at Appendix 1. This Phase One is a re-structure of staffing resources and does not impact on the type, service delivery location or total range of services available to clients.

19	The anticipated benefits of this preferred Option 4 are:- • Improved efficiencies by reducing service duplication and providing co-ordinated care e.g. planning and assessment may be undertaken by any agency using a common trusted tool • Increased integration of staff working across the service pathway, supporting improved training and development opportunities, and improved care for clients • Increased effectiveness of care delivered through different ways of working which are person-centred, holistic and promote recovery and independence • Greater opportunities to target resources flexibly to meet need • Improved access for clients across the service pathway on a 24/7 basis • Reduced spend across the health and social care system e.g. by reducing avoidable hospital admission rates, improving through-put through the system and reducing average length of stay in hospital, and reducing need for on-going complex packages of care.
20	As identified in paragraphs 5 and 6 of this report, improved partnership working, or partial integration will not achieve the required overall system change, or realise better client outcomes and potential financial benefits of full integration. A fully integrated service will deliver a shared city wide vision and will better able to target resources to deliver this vision.
21	The potential impacts on staff of this preferred Option are: • A small number of management posts (9 Full Time Equivalents (FTE) across the City Council and Solent NHS Trust) have been identified as potentially impacted by this preferred Option, the number of posts potentially at risk in the option may be fewer • Some staff may be re-located to other existing City Council /Health facilities to enable co-location • Some staff may have a change in line management • Some staff may have a change in role and carry out functions on behalf of both organisations.
22	The proposals associated with this report were discussed at an informal meeting between the Acting Director of Adult Social Care and Trade Union representatives which was held on 29th July 2015. Formal Consultation on the preferred model is proposed with all relevant City Council staff in the Teams listed in paragraph 11. The consultation period will be for a 45 day period from 26th August to 9th October 2015. The consultation methods will include written particulars ,meetings with relevant, recognised unions, teams meetings and 1:1 sessions and will follow agreed Council policies and procedures.
23	Cabinet is requested to approve delegated authority to the Acting Director of Adult Social Care and Head of Legal and Democratic Services, following consultation with the lead Cabinet Member for Health and Adult Social Care to do anything necessary to give effect to the Phase One proposals incorporating any changes resulting from the staff consultation.
24	Formal consultation with relevant staff at Solent NHS Trust will be conducted by them during the same period 26th August to 9th October 2015, and will be in line with the Trust's policy and procedures.
25	The target date for a new Integrated Service to be fully operational is by 1st April 2016. However incremental implementation could commence as soon as possible (subject to consultation), which could mean that many of the proposed changes e.g. co-location and

	joint processes could be in place before that date. Integration of the hospital discharge functions would follow at a later stage.
	Phase Two:
26	The potential preferred Option involves a reconfiguration and overall reduction of rehab and reablement beds, whilst offering a more flexible range of suitable alternative provision that meets clients' outcomes, and represents a better value use of resources. The anticipated benefits of this preferred Option are: • Supporting the preferred service model (Phase One) with the most appropriate balance of bed-based and domiciliary care provision. • Meeting client needs and improving outcomes for them whilst promoting an ethos of reablement, recovery and independence • Supporting reduced re-admission to hospital or a reduced level of on-going care packages • Making more effective and efficient use of resources. • Achieving efficiency savings through gradually increasing the use of the Domiciliary Care contractual framework.
27	It has been developed via: (i) the same range of consultation workshops and meetings as identified in paragraph 17, (ii) an initial review of clients' needs and bed usage, and (iii) a consideration of a range of suitable alternative provisions for both rehab/reablement and respite beds. These alternatives include the reablement element of the new Domiciliary Care contractual framework, generic Domiciliary Care, short-term accommodation in Residential Care, and Extra Care Housing.
28	This preferred Option will mean the likely closure of Brownhill House and therefore has potential implications for staff, Southampton Care Association, other stakeholders, service users, carers and family members and the public and will therefore involve full consultation with all parties.
29	The general occupancy rate of Brownhill House is evidenced in the Business Case at around 71%, however there have been periods over the last year when this has dropped to 43% occupancy. The average length of stay within the Rehabilitation beds in the unit is 36 days; and the majority of clients are older people recovering from a range of conditions including most commonly, injuries due to a fall, or health conditions such as influenza, pneumonia or Chronic Obstructive Pulmonary Disease.
30	The average length of stay in the respite beds is 28 days (when one exceptional case of a prolonged stay is removed from the calculation), the majority of clients are also older people, and approximately one third of the clients are repeat respite users.
31	The welfare of current users will be taken into account at all stages and individual assessments will be carried out so that all individual risks of any closure are considered and minimised. From an agreed date, new clients would be provided with suitable alternative care settings/packages rather than be admitted to Brownhill House, should Phase Two be approved. Therefore the unit beds will be vacant at point of closure.
	Staff
32	The Phase 2 preferred Option will have implications for the future locations of City Council rehab/reablement and respite in-house services which are currently

	provided at Brownhill House. It has the potential to put a number of SCC staff associated with Brownhill House at risk (potentially 41 FTE) and involves commissioning an increasing proportion of reablement domiciliary care from the independent sector via the Domiciliary Care contractual framework and, over time, as vacancies in CCFS occur, a smaller proportion from in-house services. The savings associated with this shift to the independent sector, where the unit costs are significantly lower, have been factored into the savings model on this basis. It should be noted however, that greater savings could be realised quicker through a more pro-active approach to externalisation, but this is not being proposed.
33	Officers from the City Council, Solent NHS Trust, University Hospital Services and SCCCG are working together to identify opportunities for redeployment / ring-fenced employment opportunities across the system to mitigate the risk of staff redundancies. The consultation with staff on Phase Two will involve the same staff teams as identified in paragraph 11 (or as amended subsequent to Phase One consultation), and will follow the Council's approved policies and processes. The formal Phase 2 staff consultation period will be for a 45 day period from 26th October to 9th December 2015 and will include meetings with relevant, recognised unions.
	Southampton Care Association (SCA)
34	The implication of progressing Phase Two of the preferred Option will be a re-location for the Day Service at Brownhill House, provided by SCA. The Council has a contract with SCA to provide Day Services (and associated transport) for older people in a range of venues across the city, including at Brownhill House. The Day Service at Brownhill House has a capacity of 18 places per day and operates for 5 days per week (Monday – Friday) for 48 weeks of the year. The service has a discrete client grouping of older people (High Level Physical Dependency), and currently supports 70 people across the week.
35	A Day Service for a different discrete client grouping, (Older People with Dementia), was also previously provided by SCA at Woodside Lodge under this contract. Subsequent to the consultation on SCC services at Woodside Lodge, SCC and SCA worked together to successfully facilitate a re-location of the Day Service to another facility in May 2015. Therefore, subject to consultation, the City Council will work closely with SCA to facilitate a re-location of the Brownhill House Day Service to a suitable alternative building; and specifically consider two key mitigating factors:- (i) enabling clients to retain existing friendship groups; (ii) ensuring transportation time is retained at the existing level i.e. completed in fifty minutes (maximum).
36	The consultation with SCA, service users, carers and their families will be for 12 weeks, and the proposed period is from 26th August to 20th November 2015. The consultation methods will include a mixture of written consultation, group meetings, and some 1:1 consultation as appropriate. The Equality and Safety Impact Assessment will be revised as appropriate following consultation feedback. The City Council will also provide sufficient advocacy services to enable Day Services users to fully participate in the consultation process, if required.
	Other stakeholders, service users and the public

37 Phase 2 of the preferred Option will impact on a range of stakeholders, services users, and the public as potential future service users. The consultation methods will include a mixture of written consultation, group meetings, and some 1:1 consultation as appropriate. The public consultation will involve a wide range of people/stakeholders and include:

- Individual clients, carers and families if relevant, who have utilised rehab and respite beds in SCC services over the period January – June 2015. The intention is to take a cross-section sample of clients that will represent service users over the 6 month period
- All current services users
- SCC staff in Adult Social Care who referred clients to the rehab and respite beds in SCC services over the same period
- Representative Agencies for the main service user client grouping – older people e.g. Age UK, Carers Together In Southampton
- Southampton HealthWatch
- SCC Provider Forum
- People's Panel
- All Elected Members
- Members of Parliament

38 The public consultation will be for 12 weeks, and the proposed period is from 26th August to 20th November 2015, subject to approval of the recommendations in this report by Cabinet. The September/October meetings of the Health and Wellbeing Board, Health Overview and Scrutiny Panel, and the Overview and Scrutiny Management Committee are intended to be incorporated as part of the formal consultation process.

39 Feedback from the consultation, and Equality Impact Assessment will then inform the final recommended proposal in respect of Phase Two, which will be brought to a Cabinet meeting in 2016 for approval and agreement to implement.

RESOURCE IMPLICATIONS

Capital/Revenue

40 Included within the scope of this project, (Phase 1 and Phase 2) there are SCC services that have an aggregated budget of £3.69M and SCCCG funded services that total £9.5M. The table below outlines the **SCC** services, the associated funding and FTE that are proposed to be included within this project.

	FTE	2015/16 Budget £M
Hospital Discharge Team	18.69	0.52
Brownhill House	41.13	0.56
City Care First Support	112.94	1.43
Reablement Team	32.53	1.18
Total	**205.29**	**3.69**

41 In respect of this project a half year saving of £0.40M for 2015/16 and a full year £0.80M for 2016/17 was agreed as part of the Council's approved savings in February 2015. However, this project could potentially be implemented within the last quarter of 2015/16 (Phase One), and from 1st April 2016 (Phase Two), which would consequently adversely impact on the timescale for delivery of these savings. In addition, as the system wide savings only have an estimated maximum

	savings of £825k, it is likely that the City Council will not achieve the previously agreed savings.
42	The scope of the total annual net savings to be achieved from both Phase One and Phase Two of this project across the whole health and social care system are currently modelled as £210.4k in in the first year, increasing to £825.3k by year 5, the intention is to reinvest some of the gross savings back into community resources. At this time the share of benefits and risk between the partner organisations is still under discussion but will require resolution prior to a subsequent report being presented to Cabinet in respect of Phase 2. An action plan is currently being considered in order to a) provide alternative savings in the short term to mitigate the delay in implementation and b) in the long term to mitigate the likelihood based on current modelling that the SCC saving referred to in paragraph 34 above will not be achieved through this project alone.
43	In financial terms, the activity currently proposed within Phase 1 will be restricted to potentially a small number of management posts. Phase 1 does not include any further changes in volumes of staffing provision across the system. However, it is anticipated that a proportion of the current volume of work undertaken by SCC's Reablement team will transition over to the new Domiciliary Framework providers as the Reablement team reduces through natural staff turnover. The cost difference between Framework providers and SCC Reablement is approximately £16 per hour. A saving of £150,000, based on 10% of provision is expected for the first full year through this approach.
44	Phase 2, which will include significant changes in respect of provision, will form a separate report to Cabinet at a later date. In summary the changes included within the preferred option for Phase 2 include closure of Brownhill House, for which alternative provision will be provided within clients' homes, or suitable alternatives (e.g. Extra Care Housing), at an anticipated lower unit cost by the reorganised and reshaped teams. Furthermore the Phase 2 proposal includes an overall increase in Reablement and Rehab activity volume under the expectation that in reaching a larger group of clients there will be greater savings achieved through a reduction in • Permanent admissions to Residential and Nursing care • Delayed transfers from hospital and • Excess bed days.
45	It is currently proposed that should Phase 2 be agreed, it will be implemented in a gradual way to ensure that resources from the closure of Brownhill House are invested in additional activity only where there is evidence that previous investment has achieved the outcomes to help deliver the long term reductions shown in paragraph 32. This overall project should be seen in the context of an invest to save initiative as without the additional investment in the Rehab and Reablement system (achieved through re-investment of some of the resource freed up by Phase Two), the reduction in long term care activity, would not be possible.
46	At this stage, the savings model is sufficient to provide the scope of any potential savings, but there may be some minor variations as the plan achieves greater clarity. The savings will be system wide and are inter-dependent on actions in both health and SCC, and on achieving the following anticipated benefits: • Reducing avoidable hospital admission rates • Improving through put through the system

	• Reducing average length of stay in hospital • Reducing the need for ongoing complex packages of care The extent to which the anticipated benefits are achieved will have an impact on the actual level of cashable savings delivered. It is currently forecast that all project and implementation costs will be met from within existing budgets held by both organisations.
Property/Other	
47	No property implications have been identified for Phase One of the preferred Option, as any co-location will be within existing estate.
48	In respect of Phase Two, the potential for any property disposal will be covered in a future report, and will be dependent upon the course of action taken following the outcome of this report.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
49	The Care Act 2014 came into force on 1st April 2015 and provides an updated legal framework for care and support and introduces a number of new rights, responsibilities and processes. Of particular note is the new duty under sections 3, 6, and 7 of the Act which requires Local Authorities to: • Carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health-related services • Cooperate generally with relevant partners in performing their functions related to care and support and • In specific individual cases cooperate in performing their respective functions relating to care and support.
50	The recommended option of moving to a more integrated and personalised service approach would support greater compliance with the Care Act 2014. Any re-provision of services, including the integration of these services, must comply with the Care Act and its statutory guidance set out in pages 281-300 and Care Act regulations. Any market re-shaping of services must also take into account the main principles under the Care Act and its statutory guidance including the focus on outcomes and well-being, promoting quality services, including through workforce development and remuneration and ensuring appropriately resourced care and support, supporting sustainability and ensuring choice.
51	Local authorities must ensure their commissioning practices and the services delivered on their behalf comply with the requirements of the Equality Act 2010 and should encourage services that respond to the fluctuations and changes in people's care and support needs. The City Council must also take into consideration the community safety implications of any decisions in line with Section 17 of the Crime and Disorder Act 1998. This will be included in the Equality and Safety Impact Assessment.
52	As this proposal will impact on services provided to individuals, fairness requires consultation to be carried out. Any fair consultation must • take place while the proposals being consulted on are at a "formative stage" • give sufficient reasons for any proposal to allow for intelligent consideration

	and response • allow adequate time for consideration and response; and • ensure that the "product" of the consultation is "conscientiously taken into account" in finalising the proposals.
53	Whilst the decision-maker does not have to consult on options that it does not favour it must not close its mind to other options and must be prepared to change course if persuaded to do so. Fairness may require that interested persons are consulted "not only upon the preferred option, but also upon arguable yet discarded alternative options" .It will be necessary to include in this consultation not only information about the preferred option, but also an outline of the realistic alternatives, and an indication of the main reasons for the authority's adoptions of the preferred scheme.
54	The bed-based building identified in the preferred Option (Phase Two) provides temporary accommodation for service users in receipt of Rehabilitation or Respite, usually up to a maximum of 6 weeks' duration. In addition the building provides a base for day care services (delivered by Southampton Care Association) to 70 people.
55	When considering the recommendations, and in particular any decision to close any bed-based buildings, the Council must take into account a number of factors, including: • The representations made during the consultation and any analysis of the consultation • The equality impact assessment bearing in mind its public sector equality duties as well as all other relevant information • The effect on individual health, lives and well- being of service users and their carer's in having to use alternative services, particularly individuals who regularly use any building based units. Consideration of any duty under the Human Rights Act 1998 so as not to act incompatibly with the rights under the European Convention for the Protection of Fundamental Rights and freedoms ("the Convention"). The Council will need to consider whether the proposed re-provision and possible closure of a bed-based building is likely to breach any of the service users rights e.g. Article 2 the right to life, Article 3 the right not to be subjected to torture or inhuman or degrading treatment and Article 8 the right to respect for a person's family life and their home. If this decision is likely to breach the convention the Council will need to examine any particular facts and determine if such a breach is justified and proportionate. • If service users are moved from any home against their will, this is likely to constitute a *prima facie* breach of their rights under Article 8(1) of the European Convention on Human Rights. The question is therefore whether such a breach is justified and proportionate under Article 8(2). The general economic situation outlined above and the strategic direction to support alternatives to building based care need to be weighed against the impact on individual service users. It is likely that any breach will be justified and proportionate, but this judgement will need to be informed by the individual reviews of service users' needs.

Other Legal Implications:	
56	The Council is under a duty to consult with affected staff on the implications to them in respect of Phase One and Phase Two. The consultation duties will be met in respect of Phase One by following the steps set out in Recommendation (ii) and paragraph 22. The consultation duties will be met in respect of Phase Two by following the steps set out in Recommendation (v) and paragraph 33.
57	If, following consultation, a decision is taken to implement the preferred Option, negotiations will take place with Southampton Clinical Commissioning Group to establish whether a new Section 75 partnership agreement under the NHS Act 2006 is necessary. Such s75 agreements enable NHS and local authority bodies to undertake each other's functions in order to support the delivery of local objectives.
58	Such an agreement will support the Council in the exercise of its duties under s3 of the Care Act 2014, which establishes a duty to ensure the integration of care and support provision with health and health-related provision.
POLICY FRAMEWORK IMPLICATIONS	
59	This service re-design and consultation is consistent with:- Council Strategy 2014-2017 priorities including:- : prevention and early intervention : protecting vulnerable people : a sustainable council Better Care Plan including to:- : Significantly reduce permanent admissions to residential and nursing homes. : Increase the percentage of older people still at home 91 days post discharge into reablement services. : Significantly reduce delayed transfers of care : Reduce non elective emergency admissions : Reduce the number of injuries due to falls requiring hospitalisation per week.

KEY DECISION?	**YES**
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	

1.	Business Case (Exempt – Category 3)	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Does the subject of the report require an Equality Impact Assessment (ESIA) be carried out? The initial Equality and Safety Impact Assessment will be revised following consultation feedback and used to inform Cabinet decision in 2016 on Phase Two.		Yes
Other Background Documents **Equality Impact Assessment and 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	