DECISION-MAKER:		**CABINET**		
SUBJECT:		**APPROVAL TO PROCEED WITH PHASE TWO OF AN INTEGRATED SERVICE FOR CRISIS RESPONSE , REHABILITATION, REABLEMENT AND HOSPITAL DISCHARGE**		
DATE OF DECISION:		**16 FEBRUARY 2016**		
REPORT OF:		**CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE**		
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STATEMENT OF CONFIDENTIALITY				
NONE				
BRIEF SUMMARY				

The Southampton Better Care Plan is a joint approach by Southampton City Council and Health towards transforming health and social care and the vision is to achieve significant benefits for clients and reduce costs for services. This report seeks approval for implementation of the next phase (Phase Two) of the re-designed Integrated Service for Crisis Response, Rehabilitation, Reablement and Hospital Discharge that will mean clients will have a better experience. This will be through integrated health and care services which are centred on the needs of individual clients and which help them to become independent. Consideration was given to consultation feedback before finalising the proposals in this report.

The City Council has been committed to prevention and early intervention as an approach and the central focus of this report is a shift from caring for people in institutions (hospitals, nursing homes, residential homes etc.) to caring for them in their homes for as long as possible. This is to avoid situations occurring, re-occurring or worsening and promote recovery through person centred rehabilitation and reablement.

National research has consistently demonstrated the significant benefits of home based reablement for clients, for example, improving independence, prolonging people's ability to live at home and therefore reducing or removing the need for commissioned care hours, in comparison with standard domiciliary home care. There is evidence to show a reduction in care hours for a majority of service users and for the reduction in service hours being maintained for at least 2 years. The best results show that up to 62% of reablement users no longer need a service after 6−12 weeks (compared with 5% of the control group), and

that 26% had a reduced requirement for home care hours (compared with 13% of the control group).

The implementation of Phase Two is expected to lead to an increasing proportion of domiciliary care from the Council's new Domiciliary Care Framework where the unit costs of care are significantly lower; and over time reduce the proportion of care sourced from the Council's in house Reablement Team (City Care First Support) as vacancies occur through natural staff turnover.

The implementation of Phase Two will also include the closure of bed-based provision at Brownhill House which is a City Council facility. However, exploration of further usage or potential disposal of Brownhill House is not included in this report and will be reported to Cabinet at a future date.

The staff involved in providing rehabilitation and reablement services at Brownhill House also provide respite and "emergency" respite services at Brownhill House. The consequence of integrating bed-based rehabilitation and reablement services in Phase Two will also necessitate a transfer of responsibility for these respite services. Suitable alternative provision has been identified and costed in respect of respite and "emergency respite" so that people can continue to access these services as required.

As an indirect consequence of approval of Phase Two, the Day Services provided by Social Care in Action (SCA) at Brownhill House will also need to re-locate. The Council has been working with SCA and identified at least two suitable potential alternative venues for the Day Services.

RECOMMENDATIONS:

	(i)	To note the consultation feedback and representations received, and after taking into account of the feedback and representations, to approve the implementation of Phase Two of the re-designed Integrated Service for Crisis Response, Rehabilitation, Reablement and Hospital Discharge. This implementation will include the closure of bed-based provision at the City Council facility, Brownhill House and redirection of resources into domiciliary care and more community focussed options of flexible bed based provision e.g. extra care housing.
	(ii)	To approve the commissioning of an increasing proportion of domiciliary care from the Council's new Domiciliary Care Framework (implemented from April 2015) where the unit costs of care are significantly lower; and over time reduce the proportion of care sourced from the Council's in house Reablement Team (City Care First Support, CCFS) as vacancies occur through natural staff turnover.
	(iii)	To approve a formal consultation about future employment/roles with all relevant affected staff in the City Council on the implementation of Phase Two, as set out in paragraph 61 of this report**.**
	(iv)	To delegate authority to Director of Quality and Integration and Service Director: Legal and Governance following consultation with the Cabinet Member for Health and Adult Social Care to do anything necessary to give effect to the Phase Two proposals incorporating any changes resulting from the staff consultation.

	(v)	To approve the inclusion of the Council's budgets for the Hospital Discharge Team (£0.52m) and the Reablement Team (£1.18m) in the Rehabilitation and Reablement Scheme of the Section 75 Better Care Partnership Agreement Pooled Fund to enable costs and savings to be shared in this way as outlined in paragraph 75.
	(vi)	To approve delegated authority to the Section 151 Officer to agree additional investment of up to £0.400M to enable the commencement of the "invest to save" proposals as outlined in paragraphs 88-93.
	(vii)	To note the potential to explore further usage or potential disposal of Brownhill House is outside of the remit of this work programme, and will be the subject of a future separate Cabinet report.

REASONS FOR REPORT RECOMMENDATIONS

1.	The recommendations in this report 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 • Provides a clear and effective pathway to promote recovery and independence and which can: • Increase efficiencies by reducing service duplication, providing co-ordinated care and a more tailored use of bed-based resources • Reduce spend across the health and social care system by reducing the future demand for services as the population gets older e.g. reduce spend on avoidable hospital admission rates, length of hospital stay and need for on-going complex packages of care.
2	A number of national studies have been carried out e.g. De Montfort University with Leicestershire County Council: External Evaluation of the Home Care Reablement Pilot Project (2000) and research via Social Care Institute for Excellence (SCIE 2011). These studies and others have clearly demonstrated the significant and sustainable benefits to clients of a home based reablement approach. For example, the best results show that up to 62% of reablement service users no longer need a service after 6 – 12 weeks (compared to 5% of the control group), and 26% of people had a reduced need for ongoing home care hours (compared with 13% of the control group).
3	Cabinet received a report on 18th August 2015 which highlighted the significant pressures on City Council resources and pressures on the health system, and made a strong case for change e.g**.** • Rates of unplanned admissions to hospital and delayed discharges from hospital are above the national average • Pressure on hospital beds is unsustainable and unsafe • A higher proportion of older people in Southampton rely on input from social services than is the case nationally and demand for services is rising • 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. Two separate Phases of development were proposed to achieve a re-designed integrated health and social care rehabilitation/ reablement service for Southampton.

4	Cabinet approved (18th August 2015) Phase One of the service re-design, and following consultation this is now being implemented. At the core of Phase Two is the principle that people are best supported to regain or maintain their independence within their own home or usual place of residence. This includes a shift towards a more domiciliary / community based model of care which will require fewer specific rehabilitation and reablement beds to be provided by council in-house services**.**
ALTERNATIVE OPTIONS CONSIDERED	
5	Option: Implement Phase One (re-structure staffing resources and bring together all the functions associated with crisis response, rehabilitation, reablement and at a later date hospital discharge, into a single integrated service) but **not** proceed to Phase Two. This option is not recommended 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 supported in the community/own home with better outcomes • Efficiencies and savings across the rehabilitation and reablement care "pathway" would not be realised • Resources would not be transferred to positively promote new ways of working to deliver Better Care Plan principles.
6	Option: Implement Phase Two but **without** reducing the proportion of domiciliary care provided by the council's in-house Reablement Team. This option is not recommended because it would reduce the savings generated by Phase Two, which in turn are available for reinvesting in more rehabilitation and reablement activity to meet increasing need, and deliver the wider system change across Health and Adult Social Care.
DETAIL (Including consultation carried out)	
	Background
7	Cabinet received a report on 18th August 2015 which highlighted the significant pressures on City Council resources and pressures on the health system, and made a strong case for change to address this and to increase the benefits for clients. Two separate Phases of development were proposed to achieve a re-designed integrated health and social care rehabilitation/ reablement service for Southampton as set out in the Southampton Better Care Plan approved by Cabinet in January 2014. This report provides an update on the implementation of Phase One of the proposals, and recommendations for approval to proceed with Phase Two.
8	Cabinet approved (August 18th 2015) a consultation with stakeholders in respect of a preferred service model to integrate crisis response, rehabilitation, reablement and hospital discharge functions, to provide a seamless response to service users. The functions were delivered by a variety of teams across the City Council and Solent NHS Trust.

9	The consultation was on proposals covering two separate Phases of development. Phase One: a proposal to re-structure staffing resources and 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 would better support people in their communities and maximise their potential for independence. Cabinet approved 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 subsequent to the staff consultation. Phase Two: a proposal for a reconfiguration and overall reduction of rehabilitation and reablement beds to achieve the most appropriate balance of bed based and domiciliary care to support the new integrated service model, whilst offering a more flexible range of suitable alternative provision to meet clients' outcomes, and represent a better value use of resources. This Phase would include the closure of beds at the City Council provision Brownhill House and a redirection of resources into domiciliary care and more community focussed options of flexible bed based provision e.g. extra care housing.
10	The Phase Two proposal represented a reduction from 68 rehabilitation beds to 43 rehabilitation beds. It proposed to keep the community beds at Royal South Hants (RSH) hospital where medical cover is provided, and to cease using the 25 beds at Brownhill House, shifting the setting of care for those individuals without medical needs to alternative settings, e.g. people's own homes, extra care housing. The proposal included a significant investment in domiciliary care to enable more people to be supported in their own homes both for time limited periods of reablement and also for longer term packages of support. The additional domiciliary care capacity would be primarily sourced from the council's new Domiciliary Care Framework which was implemented from April 2015.
11	Phase One: All affected staff were consulted for a 45 day period from 15th October – 18th November 2015. The integration of the staff teams was progressed by the Acting Director of Adult Social Care on approved delegated authority. All affected staff have been successfully re-employed within the new integrated management team or re-deployed within Solent NHS Trust, and therefore the new integrated team structure is now in place. The necessary agreements to facilitate full integrated working between Health and Social Care (Section 113 and Section 75 agreements, NHS Act 2006) are being established.
12	Phase Two: All potentially affected staff in the council and Solent NHS Trust were consulted for a 45 day period from 2nd November – 16th December 2015. Staff were encouraged to complete the Consultation Survey and also invited to raise any other comments/suggestions / concerns in the consultation meetings.
13	All other stakeholders were consulted for a 12 week period from 7th September to 27th November. Appendix 1 is a summary of the consultation programme and an analysis report of the public feedback.
	CONSULTATION DETAIL
14	The public Consultation Survey generated a total of 210 individual responses, of which 33% of respondents identified themselves as local residents, 19% as family members of service users at Brownhill House, 12% as service users at Brownhill House, and

	14% as Day Service clients. 70% of all respondents agreed with the overall vision for a new Integrated Service.
15	In respect of the presented preferred Option (Option 2: Joining together Council and Solent NHS Trust staff teams involved in rehabilitation, reablement, crisis response and hospital discharge services AND prioritising support at home or in people's communities): • 34% of respondents agreed with the option • 26% were neutral • 40% disagreed with the option. Data analysis has shown that the 40% who disagreed with the option were mainly service users and their families, the majority of whom disagreed with the option; whereas a majority of local residents and staff agreed with the preferred option.
16	All consultation feedback from staff and public has been carefully considered and discussed at meetings of the Programme Board (Integrated crisis response, rehabilitation, reablement and discharge service) on 17th December 2015, and 21st January 2016; and by the Project Team on 23rd November, 14th and 22nd December 2015, and 7th January 2016.
17	The Phase Two proposals have been further amended to take on board consultation feedback: • The links between the new Integrated Service, GP Cluster teams and new developments in community solutions are being strengthened to ensure that people receiving rehabilitation/reablement at home are supported to access their wider communities and are not isolated socially • The additional staff hours for rehabilitation therapy in the community have been re-calculated • The monitoring processes for provision of domiciliary care have been strengthened.
18	There were many positive responses to the proposals e.g: • "I believe this resource could be used much more effectively if individuals were rehabilitated in their own homes" • "The vision sounds perfect in comparison to what is in place at the moment" • "I think this is a very sensible solution that will make much more efficient use of resources whilst giving patients and carers flexible choices that suit their needs" • "I would be less fearful of hospital admissions if I knew all efforts were being made to get me back home a soon as clinically possible."
19	However there were also a number of concerns which were individually considered and discussed at the Project Team meetings. The most commonly raised issues of concern in the consultation can be summarised as concerns about:- • Availability, effectiveness and sustainability of home care alternatives, leading to a rise rather than a fall in hospital readmission rates • Lack of choice of appropriate quality care • Lack of alternatives for respite and "emergency respite" care. These concerns and other key concerns expressed during the consultation are addressed in detail in the sections below.
	Concerns: Availability, effectiveness and sustainability of home care

	alternatives, leading to a rise rather than a fall in hospital readmission rates
20	The main concerns expressed were**:-** • Impact of "winter pressures" on health and social care system if fewer rehabilitation and reablement beds (i.e. no provision at Brownhill House) • People not able to access the same levels of therapy support in the community/own home as they do at a specialised facility (Brownhill House) • Provision of more home-based/community service will require more staff when there is already a shortage and a reliance on temporary or Agency staff • Provision of more home-based/community service will require more staff time for travel and will be less efficient • Community services do not have the capacity to cope with increased demand and therefore hospital admission will be the default • What will happen to people who are assessed as being unsafe to go home? • Provision at Brownhill House helps prevent hospital admission following crises at home • Provision at Brownhill House has beneficial social impact rather than isolation at home.
	Considerations:
21	There has been a continuous audit of admissions to the rehabilitation and reablement beds at Brownhill House over the period Sept – December 2015 to explore the suitability and availability of alternative provision for each individual should Brownhill House no longer be an option. Of the 71 cases examined between September 2015 and January 2016, it was assessed that 75% of clients could have been discharged from hospital to their own home if an appropriate support package had been available, 7% had medical needs which could in the future be managed in the community reablement beds at Royal South Hants (RSH) hospital and only 18% required 24 hour supervision due to falls risk which would in the future still need residential bed provision.
22	The Phase Two proposals include plans for purchasing additional activity from the Residential Care sector to meet the needs of those rehabilitation and reablement clients who require 24 hour supervision. This has been factored into the costings of the new service model as set out in paragraph 84. The council works with over 50 Residential Care providers across the city and there is additional unused capacity within this market.
23	The new Integrated Service model includes regular and continued therapeutic support being provided to clients during their short-term stay in Residential Care as appropriate. Rehabilitation and reablement clients within these beds will remain under the care management of the Integrated Service which will assess their needs, plan and oversee their care and ensure timely transfer to their future place of residence as soon as appropriate.
24	The Phase Two proposals also include plans for purchasing additional short-term bed-based provision for rehabilitation and reablement clients within the Extra Care Housing sector. This has also been factored into the costings. Currently there is 1 unit at Rozell Court (Council Extra Care Housing) being used for social care clients. From August 2016, 1 additional unit will be available at Erskine Court (Council) and 3 additional beds at Weston Court (Council Supported Housing) for rehabilitation and reablement clients, who will be supported by specifically tailored packages of care.

25	The new Integrated Service model includes the recruitment of additional staff to provide short-term intensive therapy support at home, as part of the care pathway on discharge from hospital. The Council and Solent NHS Trust have a recruitment strategy in place and these additional costs have been factored in as above.
26	Recent monitoring of the Domiciliary Care Framework contracts has also confirmed that the majority of providers now have robust recruitment strategies in place and are moving to systems where they are able to offer a greater number of staff contracts guaranteeing hours of service delivery. For new areas of work, the Council is requiring providers to evidence how they will recruit to ensure capacity requirements are met, and also to commit to meeting specified levels of service.
27	The Council and Solent NHS Trust are developing workforce development plans to support the new Integrated Service model, and this includes working with providers to identify people currently working in support services who would be willing to undertake additional training to enter the care employment market.
28	The "step up" community beds at RSH will be an option to provide time limited support following crises at home. The numbers of people accessing RSH in this way will be regularly monitored.
29	Taking a sustainable approach to supporting clients to access their wider community and develop/maintain relationships and social networks, wherever their care is provided – at home or in a short term residential care bed - is an important part of the new Integrated Service model and part of the ethos of reablement. The service will work closely with local communities and available resources to ensure that clients are supported to make social connections as part of their reablement plan and that there is a "planned" exit from rehabilitation/reablement support into the wider support networks, services and activities being developed in communities under the Better Care programme e.g. GP Cluster Group self-management initiatives, Community Navigators, Time Banks, voluntary sector clubs/groups etc.
30	Therefore, the responses to the main points of concern are: • The need for bed-based provision has been closely audited and provisions have been built into the model for this • Account has been taken in the model of the need for additional staff to carry out therapeutic programmes in the community • Significant investment will be made in additional domiciliary care to support reablement • Sustainable links between the rehabilitation and reablement Integrated Service, the GP Cluster teams and development of community solutions are being strengthened to ensure that people are supported to access their wider communities and are not isolated socially • Recruitment strategies are in place, and experience so far amongst domiciliary care providers on the Framework shows that they are being able to recruit to meet commissioning requirements.
	Concerns: A lack of choice of appropriate quality care
31	The main concerns expressed were**:**

	• People who are not able to go home for their support will get a worse service • Some residential care homes offer a poor quality service - high staff turnover • Some home-based services are poor quality - staff lack skills/knowledge, poor timekeeping • Brownhill House offers a first class service – council jobs being eroded and business going to independent sector.
	Considerations:
32	As previously noted (paragraph 22), any rehabilitation and reablement clients who are unable to directly return home and need a placement in short-term Residential Care instead, will remain under the care management of the Integrated Service even though they are in a residential care bed. The Integrated Service will monitor delivery of their care, and report to Commissioners if they have concerns about any particular residential home so that these can be actively managed.
33	A new Service Specification has been written to clearly state the requirements and standards that providers of rehabilitation and reablement provision in Residential Care are to meet – Appendix 3.
34	The Council and Health implemented a new Domiciliary Care Framework from April 2015. In order to ensure high standards of quality are delivered and maintained within this provision, a monitoring framework has been implemented and a Quality Standards Monitoring Tool (Appendix 4) introduced to support providers in reporting on quality. Quality starts from the premise that services provide dignity in the delivery of care. A dedicated Quality Assurance team (City Council and Health) will also review care plans to ensure these are person-centred, that plans show how the risks to individuals at home are identified and managed, and also that services are responsive to changing needs and wishes. Specific feedback on provider performance is also sought from other professionals involved with domiciliary care clients to enable a more rounded assessment of quality. “Quality” review visits are arranged with high volume providers and those where concerns have been raised as above.
35	Monitoring meetings with domiciliary care providers in November and December 2015 have identified a number of positive improvements since the implementation of the new Framework e.g. an increase in the number of frontline care staff overall, and an improvement in day to day communication between agencies and Health and Adult Social Care staff. The monitoring meetings have also been used to address specific performance concerns in more detail e.g. responsiveness to new work, the ability and capacity to provide care to people with the highest support level needs, and the duration of visit times. Development work on these areas is continuing with provider agencies and will form part of the ongoing monitoring meetings which will be held quarterly.
36	There were many positive comments in the Consultation from clients, and families of people who had used the services at Brownhill House. The quality of service delivery at Brownhill House is not a point of issue. The implementation of Phase Two is about redirecting underused funding to support the delivery of crisis response, rehabilitation, reablement and at a later date, hospital discharge services in a different way, focusing on the individual in their community.
37	Phase Two is an investment in domiciliary care to enable more people to be

	supported in their own homes both for time limited periods of reablement and also for longer term packages of support. The additional domiciliary care capacity will be increasingly sourced from the new Domiciliary Care Framework where the unit costs are significantly lower. The savings associated with this shift to the independent sector have been costed into the service model as set out in paragraph 83.
38	Therefore, the responses to the main points of concern are: • Clear quality standards and robust monitoring arrangements are in place for both residential care and domiciliary care providers; there is strong support from the dedicated Quality Assurance team of experienced social care and nursing staff in monitoring these contracts • The Integrated Rehabilitation and Reablement Service will continue to oversee the care of clients when in these provisions and will identify and escalate any issues or concerns relating to quality • Quality improvements are already being seen since the implementation of the new domiciliary care framework in April 2015 • The commissioning of an increasing proportion of domiciliary care from the Framework will only happen over time as vacancies occur through natural staff turnover in the CCFS team.
	Concerns: A lack of alternatives for respite and "emergency respite" care
39	The main concerns expressed were**:** • What will happen to clients needing respite services? • What will be available for "emergency" respite? • What will be available for emergency safeguarding? • Cost of alternative provision for both respite and "emergency" respite.
	Considerations:
40	The same staffing resource supports the rehabilitation and reablement beds and the respite beds at Brownhill House. It is therefore a consequence of approval of Phase Two that bed provision for respite and "emergency respite" services at Brownhill House will also cease.
41	The audit of the usage of the 12 respite and "emergency" respite beds at Brownhill House identified 14 clients who could be categorised as "regular" respite users i.e. taking planned respite provision on two or more occasions in any one year. All 14 clients have had a Review in the last 2 months and suitable alternative respite provision can be offered in Residential Care Homes across the city .This has been factored into the plans and costs already included in Phase Two for purchasing additional activity from the residential care sector for respite and "emergency" respite clients, as well as rehab and reablement clients whose needs require a bed based solution for a time limited period. 30 clients have accessed Brownhill House for "one off" periods of planned respite during the last 12 months.
42	The Council and SCCCG are also currently undertaking a Review of Replacement Care (respite) Services across the city. The re-provision of respite and "emergency" respite care for clients who have/ would have accessed Brownhill House has been included in the Phase Two proposals. Direct contact has already been made with a number of providers of residential care for older people and there is scope to increase the provision locally.
43	An audit of "emergency" respite usage of Brownhill House (June – December 2015)

	has also shown that approximately 40% of the "emergencies" could potentially have been averted with better integrated working between Health and Adult Social Care. Better Care developments include a range of initiatives designed to promote early intervention and recognition of need. For example:- • Joint working and co-location • Workforce development, such as the development of an "Every Contact Counts" culture • Shared person-centred care planning • Increasing emphasis on contingency planning with clients and, as appropriate carers/families • Developing a Lead Professional case management model of working to identify need and coordinate support appropriately • Developing Risk Stratification approaches at a community level to support the early identification of need and reducing the need for planning in an "emergency" as involvement would be more proactive • Developing a "step down" approach to support the transition between receiving rehabilitation and reablement services and regaining independence. This is important as people are enabled to continue to support themselves with appropriate self-management planning and those individuals who remain vulnerable would be identified and supported by a risk stratification process reducing the need to plan in an "emergency" as involvement can be more proactive.
44	The identified alternative provision of short-term residential care or Extra Care Housing would also have been suitable for approximately 70% of the "emergency" respite cases. However, approximately 20% of the clients requiring "emergency" respite in the audit were either too young to be appropriately placed in short-term residential care / Extra Care Housing, or had additional needs e.g. substance misuse issues or were homeless. For clients in these circumstances a range of alternative provision with specialist Agencies/ support has been considered, and an appropriate and suitable alternative will be provided on an individual case basis as required.
45	Approximately 10% of "emergency" respite cases were in relation to clients unable to be in their own homes due to housing related issues or adaptations needed to the accommodation. The previously identified alternative access to short-term residential care for clients at high falls risk, or Extra Care Housing will also be suitable options for these clients for reablement – and has been costed into the service model (paragraph 84).
46	Therefore, Cabinet is requested to note that the responses to the main points of concern are: • Alternative provision for meeting existing respite and "emergency" respite needs for clients using Brownhill House has been identified. Provision will be sourced from Extra Care Housing and the Residential Care sectors and has been costed into the proposals • The Replacement Care review during 2016/17 may open up alternative opportunities for meeting this need in future but this is a separate piece of work.
	Concerns: Specific feedback from Carers

47	The main concerns expressed were**:** • People will come home without access to enough support for rehabilitation and reablement, and cares will have to take on even more • The impact on carers' well-being • Provision of replacement care (respite).
	Considerations:
48	Better Care is about improving outcomes for clients and their experience of health and social care, this includes taking a person-centred approach by putting people at the heart of decisions about their own care. Each case will be assessed as to individual need and wishes, also taking into account the wellbeing of any carers. As a result, for some clients a short-term residential care option may be the preferred option. Clients will be able to access rehabilitation and reablement support through a short-term placement in residential care and will remain under the care management of the Integrated Service.
49	The council works with over 50 Residential Care providers across the city and there is additional unused capacity within this market. People will be offered short-term placements in residential care as close to their main place of residence as possible to facilitate regular contact with carers/family.
50	The new Integrated Service model includes the recruitment of additional staff to provide short-term intensive therapy support at home, as part of the care pathway on discharge from hospital.
51	Carers are entitled to an assessment in their own right from Social Care under the Care Act. The Council has also commissioned Carers In Southampton to help identify carers, provide a range of information, advice and support services, and carry out Carers' Assessments.
52	Replacement care (respite) will continue to be provided, other than at Brownhill House, as set out in paragraphs 40 - 46.
53	Therefore, the responses to the main points of concern are**:** • For each client, their rehabilitation and reablement plan and how/ where this is provided, will be based on an assessment of individual need and wishes, also taking account of the wellbeing of carers • In circumstances where needs are such that it would be to the detriment of the client's care or carer's wellbeing to provide rehabilitation and reablement at home, a residential option will be considered • Account has been taken in the model of the need for additional staff to carry out therapeutic programmes in the home/community • Carers in Southampton is a commissioned service to enable carers to access support and Carers' Assessments.
	Alternative suggestions raised during consultation
54	The consultation invited views on any alternative suggestions to the Phase Two proposals. The main suggestions can be summarised as: • Make more use of Brownhill House e.g. move patients from RSH wards, or invest in more equipment for Brownhill House so that it is suitable for a greater range of client needs

	• Give people the choice to pay for their own care at Brownhill House.
	Considerations:
55	The quality of service delivery at Brownhill House is not a point of issue. The implementation of Phase Two is about supporting the wider transformation of the way care is provided in Southampton within the rehabilitation and reablement ethos of Better Care. It is about using resources differently to invest in a more flexible system with a focus on keeping people as independent as possible within their own homes and communities. National research has shown that people are more likely to regain good health if they receive care within their own home /community.
56	It would not be possible to sustain investment in the structure of Brownhill House to accommodate the range of necessary equipment, or the funding for on-going services, on the basis of an unknown potential number of people paying for their own care.
57	The response to the alternative suggestions is, that the proposals represent a redesign of rehabilitation and reablement which better meets the needs of more clients, delivers improved outcomes and represents better value for the system as a whole.
58	All of the consultation feedback has been used to update the Equality and Safety Impact Assessment attached as Appendix 5.
59	Cabinet is requested to note the consultation feedback and responses, this will involve a genuine and conscientious consideration of the representations and after taking them into account to approve the implementation of Phase Two of the re-designed Integrated Service for Crisis Response, Rehabilitation, Reablement and Hospital Discharge; to achieve a more appropriate and cost effective balance of bed-based and domiciliary care that will meet the needs of clients and deliver better outcomes for them, whilst achieving best value use of resources. This implementation will include the closure of all services at Brownhill House including the closure of bed-based provision at the City Council facility and redirection of resources into domiciliary care and more community focussed options of flexible bed based provision e.g. extra care housing. It will also include the relocation of the Day Services run by SCA.
60	Cabinet is requested to approve the commissioning of an increasing proportion of domiciliary care from the council's new Domiciliary Care Framework (implemented from April 2015) where the unit costs of care are significantly lower; and over time reduce the proportion of care sourced from the Council's in house Reablement Team (City Care First Support, CCFS) as vacancies occur through natural staff turnover.
	Implementation process
61	Cabinet is requested to approve a formal consultation about future employment/roles with all relevant affected staff in the City Council on the implementation of Phase Two. The consultation is proposed to start on 26th February and will extend beyond the standard 45 day period until 17th April 2016 in recognition of Easter holiday period. The consultation methods will include written particulars, meetings with relevant recognised unions, team meetings and 1:1 sessions and will follow agreed Council policies and procedures.
62	The implementation of Phase Two will mean the closure of bed-based provision at the City Council facility, Brownhill House, and a redirection of resources into domiciliary care and more community focussed options of flexible bed based provision e.g. extra care housing. This has the potential to put 41 Full Time Equivalent (FTE) Council posts at risk. 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.
63	Cabinet is requested to delegate authority to Director of Quality and Integration and Service Director: Legal and Governance, following consultation with the lead Cabinet Member for Health and Adult Social Care to do anything necessary to give effect to the Phase Two proposals incorporating any changes resulting from the staff consultation.
64	A draft Implementation Plan to proceed with Phase Two of the Integrated service has been prepared - Appendix 2.
65	It is proposed the 25 Rehabilitation and Reablement beds at Brownhill House will be closed to referrals from 18 April 2016. The average length of stay within the Rehabilitation/ Reablement beds over the last 18 months has been 36 days. It is therefore anticipated that all clients will have completed their initial rehabilitation/reablement programme at Brownhill House, and returned to their home or accommodation of choice by 1st June 2016.
66	It is proposed that the 12 Respite and "emergency" use beds at Brownhill House will also be closed to admissions from 18th April. The average length of stay within these beds over the last 18 months has been 28 days (when one exceptional case of a prolonged stay is removed from the calculation). It is therefore anticipated that all clients will have vacated the respite and "emergency" beds to return home or into suitable alternative provision by 1st June 2016.
67	The welfare of current users is being taken into account at all stages and individual assessments will be carried out so that all individual risks of the closure are considered and minimised. These assessments will include a Care Act 2014 assessment or review, updated care and support plan (if any) mental capacity assessment, if needed. The individuals will be supported during this assessment, which may involve independent advocates. All clients will be provided with suitable alternative care settings or care packages in their own home.
68	Plans are in place to bring on line the additional domiciliary care capacity required from the Framework through a mini-competition process from 18th April 2016, and to commission the additional activity required from the residential care sector from 18th April 2016, subject to Cabinet approval of the implementation of Phase Two.
69	The staffing resource supporting the rehabilitation, reablement and respite beds is therefore also planned to transfer from Brownhill House on 1st June 2016. However, the Brownhill House service will only close at the point of all the beds being vacant.
	Social Care in Action (SCA) Day Services
70	As an indirect consequence of approval of Phase Two, the Day Services provided by Social Care in Action (SCA) will need to re-locate. The Council has a contract with SCA to provide Day Services (and associated transport) for older people (High Level Physical Dependency) at Brownhill House. The Day Service has a capacity of 18 places per day and operates for 5 days per week (Monday – Friday) for 48 weeks of the year. A total of 51 people are currently using the Day Services across the week. Cabinet is requested to note that the additional potential costs of provision from an alternative venue have been included in the recommendation to proceed with Phase Two.

71	A possible alternative venue is Freemantle Community Centre. The building meets all requirements from SCA's perspective e.g. accessible toilets, exclusive occupancy of rooms, catering facilities etc and satisfies the key mitigating factors of a move:- (i) enabling clients to retain existing friendship groups (ii) ensuring client transport time is retained at the existing level i.e. completed in fifty minutes (maximum). A further potential venue is the Fenwick Centre in Lyndhurst which SCA already use for other provision.
72	The City Council will continue to work closely with SCA to facilitate the relocation of the Day Service. It is anticipated that the Day Services will be operational from a new venue by 1st April 2016.
	Future of Brownhill House
73	Cabinet is asked to note that the potential to explore further usage or potential disposal of Brownhill House is outside of the remit of this work programme, and will be the subject of a future separate Cabinet report.
RESOURCE IMPLICATIONS	
Capital/Revenue	
74	Included within the scope of this project, there are City Council services that have an aggregated budget of £3.690M and Southampton City Clinical Commissioning group (SCCCG) funded services that total £9.750M bringing a total combined resource to £13.440M The table below outlines the services, the associated funding and FTE that are proposed to be included within this project.

City Council Services	FTE	2015/16 Budget £M
Hospital Discharge Team	**18.69**	**0.52**
Brownhill House (respite and emergency care)	**41.13**	**0.56**
City Care First Support (reablement care)	**112.94**	**1.43**
Reablement Team	**32.53**	**1.18**
Total	**205.29**	**3.69**
SCCCG Investment and Services	**FTE**	**2015/16 Budget £M**
City Care First Support (reablement care)	**As above**	**1.31**
Brownhill House (rehab and reablement care)	**As above**	**0.80**
Community ED Team	**10.43**	**0.21**
RSH Ward and therapy staff	**73.83**	**5.19**
Community Rehab Team	**37.78**	**0.89**
Rapid Response	**38.33**	**1.35**
Total	**160.37**	**9.75**

75	As per the recommendations within this report it is proposed that all of the above resources, or equivalent for 2016/17, are incorporated within the existing Rehabilitation and Reablement Scheme of the Better Care Pooled Fund S75 agreement. This will require the budgets for Hospital Discharge Team and Reablement Team to be formally included within this pooled fund; all other budgets are already included. This will ensure that adequate system wide financial oversight is in place for this initiative which

	will include effective performance and financial monitoring to ensure that outcomes, investments and savings are achieved in line with the proposals within this report. Cabinet is requested to note that within the pooled fund it is proposed, in respect of this scheme, all savings and investments are shared on an equal basis (50/50) with both partners regardless of where the saving should fall. The pooled fund will be managed by a Senior Commissioner from the Integrated Commissioning Unit. The Commissioning Partnership Board will take a strategic view of this scheme.
76	It should be noted that for 2016/17 the proposed estimates to be agreed at Council 16th February 2016 include an increase, above those for inflationary of annual pay award purposes, of £0.387M for City Care First Support. This is due to the observed cost arising from the changes to the scheme for pay and allowances implemented in June 2015.
77	It should be noted that, in respect of this project, a part year saving of £0.400M for 2015/16 and a full year £0.800M for 2016/17 was agreed as part of the Council's approved savings in February 2015. However, owing to slippage, this project will not deliver savings until 1st June 2016, when services cease from Brownhill House. Correspondingly this adversely impacts on the timescale for delivery of these savings. However, for 2016/17 a saving of £0.300M, a reduction of £0.500M from the approved £0.800M, has been included within the Health & Adult Social Care budget based on the revised projections included within this report.
78	In the Cabinet paper of August 2015 which sought permission to consult on the proposals, the scope of the total annual net savings to be achieved from this project across the whole health and social care system were modelled as £0.210M in the first year, increasing to £0.825M by year 5. This calculation included both the impact on Operational costs of the changes to the rehabilitation and reablement services as well as the costs and anticipated savings of the wider Invest to Save initiative. Within this report, the details of the Organisational proposal and the Invest to Save proposal have been shown separately to provide greater clarity and to allow for separate consideration. Cabinet is asked to note that some of the original resourcing assumptions have also been revised on the basis of further analysis, which has had the effect of increasing the savings.
79	Cabinet is requested to note that the confirmed net savings that are currently directly achievable from the implementation of Phase Two (Operational savings only) are calculated to be £0.631M full year effect in the first year rising to £1.223M, full year effect, by year 5 as outlined within the table contained in paragraph 85 below. At this stage potential savings from the Invest to Save initiative are not included within this total due to the inherent degree of uncertainty that accompanies savings from proposals to influence demand.
	Operational costs and savings
80	The proposal to reduce the current number of manager post by 3.5fte and to cease service provision from Brownhill House will save £0.188M and £1.313M respectively from both SCCCG and the Council's Health & Adult Social Care budgets. However, as indicated within this report there will be a requirement to source alternative provision for eligible clients funded by either partner.
81	The cost of reprovision is estimated to be £1.018M full year effect on a recurring basis, generating an annual net saving of £0.483M. In addition there are savings of £0.148M in year 1 to £0.740M in year 5 from increasing the volume of less costly external provision compared to internally provided reablement care. Overall this generates a

	saving projection of £0.631M full year effect in the first year, rising to £1.223M, full year effect, by year 5.
82	Based on the proposed saving and investment share with SCCCG of 50/50 the Council's proportion of these savings will be £0.315M full year effect in the first year rising to £0.612M, full year effect, in year 5. This increase in saving beyond the initial £0.315M is not included within the Council's Medium Term Financial Forecast. It will therefore be subject to a further savings proposal in preparation for the 2017/18 budget.
83	The operational savings associated with the approval of Phase Two are**:** • Closure of services at Brownhill House for which alternative provision will be provided within clients' homes, or within alternative community based, more flexible bed resources (i.e. temporary Residential Care and Extra Care Housing), at an anticipated lower unit cost • The transfer year on year through natural staff turnover of some of the work undertaken by the Council's CCFS team to the new Domiciliary Framework providers. The cost difference between Framework providers and the CCFS team is approximately £16 per hour. A saving of £0.148M based on 10% of provision is expected for the first full year through this approach and a further 10% year on year has been modelled into future years • An integrated management structure for the 7 currently separately managed health and social care teams which will require fewer management posts – reduction of 3.5 FTE posts.
84	The operational costs associated with the above are as follows**:** • Additional investment in equipment to support reablement in people's homes • Additional Domiciliary Care hours purchased through the Domiciliary Framework providers. There is an assumed need of 280 hours a week, based on 20 clients at any one time needing an average of 14 hours a week each • Access to residential care beds for clients who would not be able to go straight back to their usual place of residence for reablement care e.g. awaiting housing adaptations, high falls risk. A requirement for 5 beds at any one time has been assumed based on a review of Brownhill House admissions during the period September – December 2015 • Some additional therapy resource will be required within the Integrated Rehabilitation and Reablement service to cover the additional travel costs of providing therapy to individuals within their own homes as opposed to within a single bed-based setting • Access to 4 beds (1 x Extra Care Housing at Erskine Court, 3 x Supported Housing at Weston Court) for clients • Alternative provision for respite clients currently using Brownhill House. This has been based on 741 planned respite days in the last 12 months (by 44 people - 14 of whom are regular respite users) and re-providing this activity in a residential care home • Alternative provision for "emergency" respite clients currently using Brownhill House. Based on a recent audit of Brownhill House usage, it has been assessed that 2 beds would be required at any one time • Costs associated with relocation of the SCA day care provision which currently uses Brownhill House.

85

	Operational				
	1	2	3	4	5
	£	£	£	£	£
Domiciliary Care					
Additional Hours, Framework	218,400	218,400	218,400	218,400	218,400
Transfer hours from internal provision to framework	(148,082)	(296,164)	(444,246)	(592,328)	(740,410)
Integ Rehab & Reab Service					
Reinvestment of management saving to support discharge to alternative settings & therapy in home setting	188,160	188,160	188,160	188,160	188,160
Equipment					
Increase in level of Equipment	374,000	374,000	374,000	374,000	374,000
Management					
Reduction in Managers of 3.5fte	(188,160)	(188,160)	(188,160)	(188,160)	(188,160)
Brownhill House					
Closure of Brownhill House	(1,313,000)	(1,313,000)	(1,313,000)	(1,313,000)	(1,313,000)
Reprovision of Respite / Emergency service	80,942	80,942	80,942	80,942	80,942
Reprovision of Day Care accomm	23,000	23,000	23,000	23,000	23,000
Residential Care Beds	113,150	113,150	113,150	113,150	113,150
Extra Care Housing Beds	20,800	20,800	20,800	20,800	20,800
Total	**(630,790)**	**(778,872)**	**(926,954)**	**(1,075,036)**	**(1,223,118)**

Invest to save initiative

86 Cabinet is requested to note that a key aim of this scheme also includes delivering a greater impact across the wider Health and Social Care system by investing additional resources to increase Rehabilitation and Reablement activity and meet the needs of more people. The expectation is 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
- Hospital admissions
- Delayed discharges from hospital.

The details of this “invest to save” proposal are outlined below and have potential for increasing the net saving indicated in paragraph 85 above.

87 Within this proposal there will be additional and equal investment required by both partners to drive out further net savings. The financial model included within paragraph 97 is based on implementation assuming the full programme of investment from the outset and the estimated impact this may have on demand.

88	Based on this model the combined cost of the investment is £0.796M in year 1 increasing to £0.854M by year 5. The increase is due to a minor programmed expansion of staff within the integrated Rehabilitation and Reablement service. The Council's proportion of the investment would be 50%, £0.400M, in year 1.
89	The potential saving achieved through a corresponding reduction in demand is estimated to be £1.003M full year effect in the first year rising to £1.940M, full year effect, in year 5.
90	Therefore, the net saving is anticipated to be £0.208M full year effect in the first year rising to £1.086M, full year effect, in year 5. The council's proportion of this net saving would be £0.104M full year effect in the first year rising to £0.593M, full year effect, in year 5.
91	However, savings achieved through taking actions to reduce demand are, by their nature, very difficult to either predict or provide a high degree of certainty of achievement in advance. To mitigate the impact of this significant risk it is proposed that an incremental approach is taken whereby investment required to enable the increase in activity to reduce demand is agreed in phases.
92	It is proposed that only when the programmed savings for each phase are evidenced to be achieved will further additional investment be released. It is proposed that the decision to release each phase of council investment is delegated to the Council's Section 151 Officer.
93	Should this proposal be agreed the initial investment outlay would instead be £0.10M each for both partners, providing an initial investment total of £0.20M.
94	The savings associated with the "invest to save" proposals are as follows**:** • Reduction in non-elective hospital admissions amongst the 65 year old plus age group– this has been phased over 5 years to allow the team to embed with a 5% reduction in year 1 (just 93 admissions) building up to a 25% reduction by year 5 (465 admissions) • Reduction in excess bed days amongst patients aged 65 and over – this has been remodelled following further audit and analysis of excess bed days in October 2015 which showed the potential to halve the average number of excess bed days per complex discharge patient from 15 days to 7.5 days through a discharge to assess approach, informed by the findings of a pilot undertaken by University Hospital Services during 2015/16 • Reduction in nursing and residential care permanent admissions – based on bringing Southampton's rate down to the national average over the next 5 years.
95	The costs associated with the "invest to save" proposals are as follows**:** • Additional domiciliary care purchased through the Domiciliary Care Framework providers, equating to an additional 28,291 hours a year, which constitutes a 50% increase in current provision • Investment in more staff within the integrated Rehabilitation and Reablement Service to provide additional capacity for therapeutic support, early intervention and crisis management • Access to additional community based short stay beds to address known blocks in the system and facilitate earlier discharge. This includes a dedicated bed for bariatric clients ready for discharge and 3 beds for Homelessness clients.
96	The table below shows the overall impact of the "invest to save" proposals based on full implementation from the outset. It should be noted that these are in addition to the costs and savings shown in paragraph 85 above**.**

97

	Invest to Save				
	1	2	3	4	5
	£	£	£	£	£
Integ Rehab & Reab Service					
Support workers additional 7.25fte ramping up to 8.9	273,088	288,155	301,338	316,405	331,472
Total	**273,088**	**288,155**	**301,338**	**316,405**	**331,472**
Domiciliary Care					
Additional Hours, Framework	424,360	424,360	424,360	424,360	424,360
Community Based Beds					
Additional community beds	98,000	98,000	98,000	98,000	98,000
Total	**795,448**	**810,515**	**823,698**	**838,765**	**853,832**
	1	2	3	4	5
Savings projected					
NEL Admissions	(73,728)	(152,064)	(234,240)	(321,792)	(413,184)
Excess Bed Days	(573,807)	(573,807)	(573,807)	(573,807)	(573,807)
Nursing & Residential Care Admissions	(355,712)	(508,160)	(647,904)	(800,352)	(952,800)
Total (Saving)/Pressure	**(207,799)**	**(423,516)**	**(632,253)**	**(857,186)**	**(1,085,959)**

98 It is proposed that the achievement of savings are monitored during 2016/17 in order to ascertain a reliable forecast of saving from this initiative. It is anticipated that a long term saving will be proposed for this initiative during the 2017/18 budget setting process.

Property/Other

99 Cabinet is asked to note that the potential to explore further usage or potential disposal of Brownhill House is outside of the remit of this work programme, and will be the subject of a future separate Cabinet report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

100 The Care Act 2014 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.
101	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.
102	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.
Other Legal Implications:	
103	The Council is under a duty to consult with affected staff on the implications to them in respect of Phase Two. The consultation duties will be met in respect of Phase Two by following the steps set out in Recommendation (iii) and paragraph 61.
104	Cabinet must give genuine and conscientious consideration of the consultation feedback and representations and take them into account before making its decision.
POLICY FRAMEWORK IMPLICATIONS	
105	This service re-design 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.	Analysis of Public Consultation
2.	Draft Implementation Plan
3.	Service Specification – Residential Care Reablement Provision
4.	Quality Standards Monitoring Tool
5.	Equality and Safety Impact Assessment (revised)

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.		**Yes**
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.	**None**	