SOUTHAMPTON CITY COUNCIL ®

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Clinical Commissioning Group

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28 June 2013

To whom it may concern

Please find attached a joint application from Southampton as our expression of interest to become a pioneer site.

Southampton is in an enviable position with regards to the potential to make this work. We have a strong community identity as a city with a coterminous council and CCG, a first class university and teaching hospital, community services that are working together and a proven track record of joint working between health and social care. We have worked hard as a whole system to get to this position, are active members of a local co-production network and are committed to working together to further improve the lives of the people who live in our city. Furthermore, we all believe this is something we have really got to do; it isn't just a nice option.

Southampton is sometimes described as a northern industrial city on the south coast. As our joint strategic needs assessment makes clear, we have some of the most deprived wards in the country and substantial inequalities continue to exist between the diverse communities. Our statistical neighbours are Liverpool, Portsmouth and Plymouth.

The performance of our healthcare system is generally good. However, like many places, the pattern of healthcare provision we have has grown incrementally over a long period and looks increasingly ill-fitted to the future we are facing. In common with many other parts of the country, the continued pressure of rising unscheduled care admissions places our hospitals 'on the edge'. Similarly our social care system is experiencing increasing pressure with an ageing population within a reducing financial envelope. Therefore, this opportunity not only comes at a propitious time for us, we know we have no choice but to make it work.

We have made integration and person centred care the central plank of our strategy as a city. We have a shared vision of a healthy system where people recognise the interdependence of all parts, primary, secondary, social and community care; where mutual success is ensured because we are bold enough to change the part we play so that our services are designed and integrated to fit the needs of people as individuals, not expecting people to fit in with the way it suits us to be organised. This will be a sustainable system, able to live within its means despite the real challenges we face, because we have put 'doing the right thing' first, driving out the wasteful transactions that don't add value to people's care, and liberating more creative solutions. For our service users and the general public this will mean we have a system where there is real accountability and trust and where we all share the same commitment to solve the challenges that lie ahead.

Behind this passion for improvement are real, practical plans and the capability to make it work. Our strategy is about bringing this all together in our integrated person centred care programme. This approach unites risk stratification of our practice populations so that we know who is most at risk of becoming unwell, early intervention and self care supported through more generic, integrated teams. We will be testing and developing new and creative co-produced services, shaped by the people who live here.

Person centred care will be at the heart of everything we do. This means big changes not just for community services, but also a fundamental challenge to the way primary care is delivered.

This is an exciting vision of change and we believe will fundamentally improve people's lives and relieve the pressures on the system too.

Leaders of all our organisations have agreed to vigorously support the expression of interest in becoming Pioneers.

Alongside our bid document, please take a few moments to watch the attached video that explains why we feel so passionate about making this work

Yours sincerely

Dave Shields

Councillor David Shields

Chair Health & Wellbeing Board

Dr Steve Townsend

Chair of Southampton City CCG

Southampton Pioneer Integrated Care Enterprise (SPICE)

Southampton City Expression of Interest - Health and Social Care Pioneers

Our Vision

We believe Southampton's fantastic people are its heart and inspiration to all we do. Our vision is ambitious and seeks to mobilise and support people to shape their communities and the services, opportunities and choices within them.

We are a recognisable City with a coterminous unitary City Council and CCG, a first class university, a nationally renowned Teaching Hospital, strong community provision, an active voluntary sector and an excellent track record of partnership working and commitment to improve. This is evidenced by a wealth of multiagency integrated services (e.g. Children and Young Peoples Development Service, Reablement services), strategic joint planning and joint posts. Furthermore, we all believe this is something we've really got to do; it isn't just a nice option.

We are already on a journey to inspire and mobilise our city to "**pull together**" and deliver sustainable cultural change that transcends public sector organisations and reaches out to communities, neighbourhoods, faith groups and businesses.

We have embarked on a 5 year programme of work led by the Health and Wellbeing and Integrated Commissioning Boards to transform the way that we improve the lives of people with complex needs in the city. This involves promoting **self-help options**, more flexible and **integrated care planning** processes that cross agency, professional and community boundaries and identifying early those who are most vulnerable or at risk and working with them collectively and proactively to manage, reduce or negate those risks. People will have the information they need to make the right choices for themselves and know who to go to when they do need help. The programme is supported by the Health & Wellbeing Board and all system leads including a broad range of providers with a further focus on high quality and robust quantitative and qualitative evaluation undertaken in collaboration with Southampton University. We have established **strong partnerships** across the region with the academic community including the Wessex Health Innovation and Education Cluster which is a regional partnership committed to improving health and social care outcomes, the Schools of Medicine & Nursing and the newly formed south east Academic Health Science Network.

Our vision is to take this to the next level by focussing our collective multi-agency energy in one neighbourhood to test and develop new and creative co-produced service delivery, shaped by the people who live there. We will use pooled, integrated and personal budgets, and community and self-funding opportunities creatively to support our vision. Our decision making will be inclusive, transparent and informed by high quality evidence and evaluated experience.

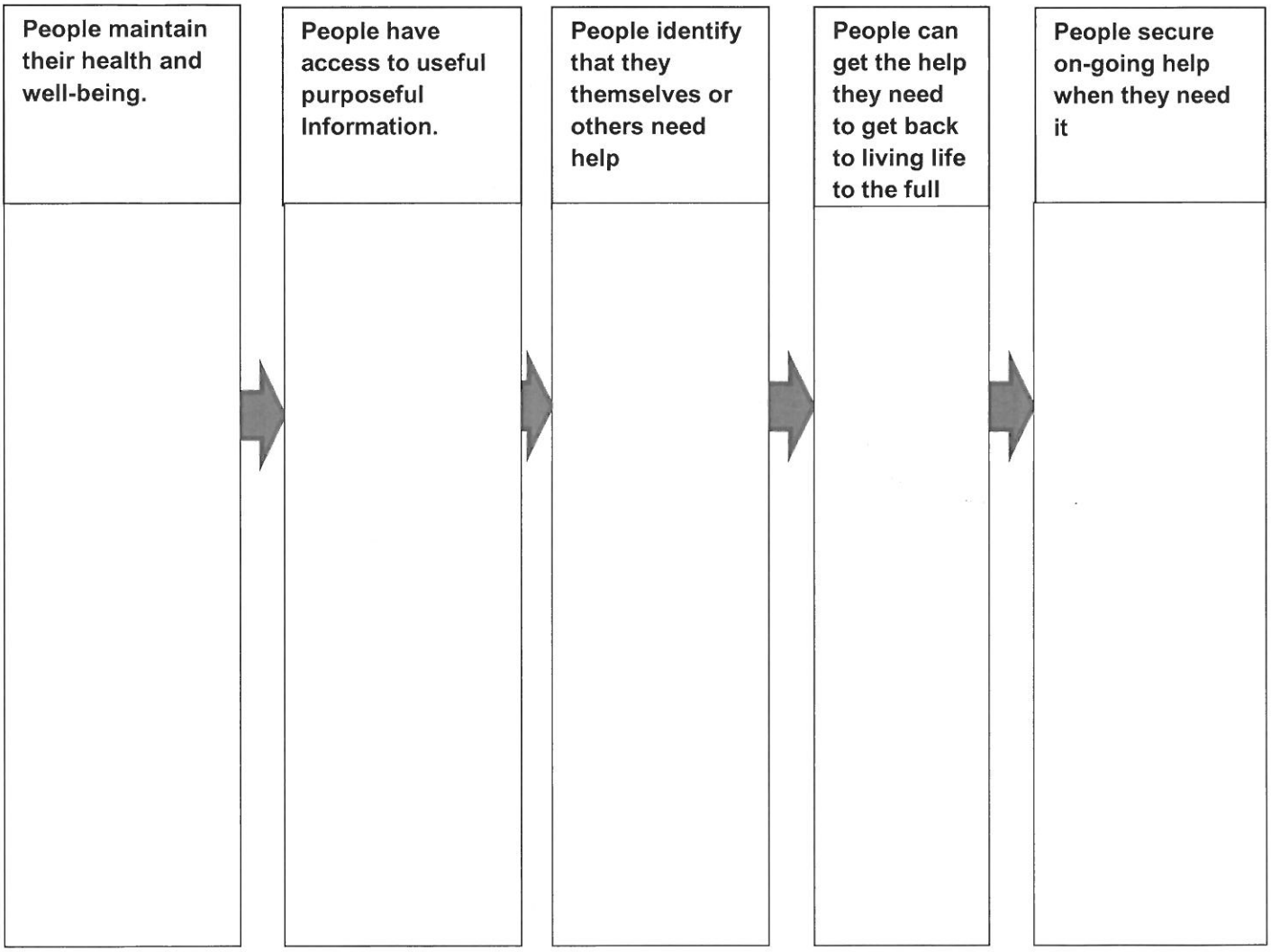
Each local community is **unique** so we can't take a one size fits all approach. By focussing on one neighbourhood, we will be able to test out ways of building on community assets. Our key aims are to improve the outcomes for people needing help in the city, ensuring that wherever possible people experience support from within their communities and when high cost services are used it is appropriate, seamless and for the right amount of time, wherever possible enabling people to return to their own communities. Outcome measures will be a reduction in hospital, residential and nursing home admissions, and a reinvestment in local communities and neighbourhoods to further enhance vibrant and established community capacity, e.g. peer support programmes, self-help networks and user led organisation models of care that support people to live safely at home.

The "National Voices Narrative" and "Making It Real" have come at the right time for us chiming with our current thinking and direction of travel. Our aspirations are high and the challenges formidable but we have the collective **willingness, ambition, competence and strength** of character to meet these challenges head on.

Whole System Change

System chiefs, elected members, GP's, the voluntary sector, local health providers, users and carers have all come together with a commitment to lead this much needed change championed by a strong Health and Wellbeing Board. The Southampton Integrated Person Centred Care Board has been working on a **change programme** for primary care and other agencies including, housing and social care, designed to establish integrated care, develop a risk stratification process and promote self-management.

Figure 1 below illustrates 5 overarching delivery goals which we have jointly established as a whole system.



We will engage local individuals, groups, services and organisations in making fundamental changes to the way they relate to each other and deliver support that is **predictive, preventative and person centred**. To achieve the whole system change necessary we have chosen to proceed in a controlled way, concentrating and learning from designated "**Incubator neighbourhoods**" before transferring this focus, knowledge and experience on to other neighbourhoods.

Our aim is to have undertaken **major transformation** across the whole city within 5 years beginning with a single "Incubator" neighbourhood. We will use the experiences, the people and the evaluated evidence to inform the development of further neighbourhoods with the speed of change increasing as ours and the neighbourhood's knowledge and experience grow. Some enabling activity is already underway and will be rolled out earlier to ensure the change programme is built on firm foundations. For example over the past 3 years Southampton CCG has supported primary care in developing risk

stratification and integrated case management of patients assessed as being vulnerable. The nationally agreed roll out of a Risk Stratification & Care Planning Directed Enhanced Services (DES) builds on these foundations. The CCG has also identified additional funding to support the introduction of the DES driving **improvement in quality and effectiveness** through agreed audit and peer review activity.

We have also established three GP practice pilots who are working on developing risk stratification, self-management and integrated care planning. GP practices have also developed **"cluster"** groups within local neighbourhoods and community nursing has realigned their services around these clusters. This is a hugely important development in preparing to be in a position to support localised system change.

"The NHS of the future will "be built up on a foundation of integrated, community-shaped generalist health care services" ("A vision for General Practice in the future NHS" (Royal College of General Practitioners, May 2013)")

We are currently seeking "expressions of interest" from the newly established GP clusters to become the nucleus of the proposed "Incubator" neighbourhood, the level of interest thus far is extremely promising from all quarters of the city further demonstrating the **enthusiasm** and willingness to re-develop primary care to be more person centred, proactive and integrated with the wider community and other services within it.

Our health providers for older peoples services within Southampton have also embarked on a new change to the patient pathway and all services are **working together**, in consultation with local GPs and the local authority, to provide a pathway for frail older people which is integrated, primary-care facing, and person-centred for our frailest and most complex patients. The pathway is an extension of the locality model implemented throughout the Older People Service within University Hospitals Southampton Foundation Trust (UHSFT) in 2011. We are looking for this model to tie in with the overall integrated care agenda again looking to focus on the "Incubator" neighbourhood.

Southampton has also invested in the development of community services to support older people and **prevent** unnecessary admissions to acute care and although as is the national trend admissions to acute care have increased the rate of increase is much less than other comparator areas. The City has 3 full time geriatricians working in the community as part of a well-resourced multi professional team. We have brought together teams working to support an individual's physical healthcare with mental health services. The physical healthcare team have received training to deliver low level psychological interventions to patients on their case load with long term conditions which has been implemented across the City over the past year alongside this project is a formal evaluation programme the outcomes of which are due over the next few weeks.

Southampton City CCG is developing its partnership with Business Solent as 'Solent champion'. Solent Champions' enable the work of Business Solent in **influencing positive change**, facilitating solutions and making things happen. By working together we have a louder voice and can promote the Solent region as a great place to work, invest, study, live and enjoy. Benefits include:

- Business Solent to assist in communicating the key health messaging for the City out to the wider business audience
- Southampton Portal – CCG, Southampton information to be placed on the new Discover Southampton Portal averaging 40,000 hits per month with the opportunity to provide ongoing content
- Promotion newsletters / e-news / website
- Business Solent newsletter in relation to the new facilities– circulation to over 4000 businesses
- Facilitating cross-sector connections and opportunities

The City Council is already on a redesign journey re-focusing services on earlier intervention and personalisation using re-ablement to get people back into their communities and living life to the full.

We have a jointly funded reablement service which is provided by the City Council's personal care reablement team working with the health Community Trust's Rapid Response provision demonstrating **commissioning and provider partnerships** working together to deliver a unique service that brings together health care, housing services (who provide a community alarm response) and personal social care but also provides an overnight shared provision to meet the needs of those with complex conditions.

Key components of the service include:

- Provision of a service to enable users to make long term decisions in an informed way and to have a quality opportunity to leave their own home if necessary rather than doing this straight from a hospital setting.
- Provision of a trial period to assess long term care needs in a known environment so as to 'right size' ongoing support planning. In many cases no ongoing support is required despite initial expectations of care package need.
- Reducing long term care needs by maximising capability in a known environment
- Reducing length of stay in hospital because significantly higher needs can be met due to the overnight provision and involvement of nursing.

This partnership has developed rapidly with recognition that we have increasing **opportunities** for further synergy. The service saw 1400 people last year through reablement and support up to 160 at any one time of which up to 15 may have overnight care. Our average length of stay with the service is just under 5 weeks and 31% result in not needing any care at the end of the service, whilst a further 39% achieve reduced care needs. Our target is to achieve 60% not needing care in the coming year.

We are building on **great working relationships** with the voluntary sector, local faith groups and business that will be important in driving forward change in a city that the 2011 Census showed to be more ethnically diverse than many comparable urban areas outside of the large metropolitan conurbations like London, Leeds, Bradford, Birmingham and Manchester.

The City Council has been trialling a community budget approach to integrate wider budgets and support into employment preparation for targeted residents, including DWP, housing, skills and criminal justice funding. Within a three month period, the pilot has evidenced a 20% into work outcome, as well as wider health and social benefits.

Southampton has been working jointly with Portsmouth and Solent LEP to negotiate a "City Deal" with government to unlock economic growth. Whilst the 'flag ship' element of the Deal focuses on unlocking infrastructure and development sites promoting the region as a national marine and maritime area of excellence, the two cities and LEP have been determined to ensure that there is a strong, underpinning suite of activities to support local residents to access the jobs which will be created, including residents that have been experiencing long term unemployment and multiple barriers. In particular, a strand of the "Deal" involves the development of local provision for 1000 long term unemployed people who have been on the government's Work Programme for two years, and have not found employment. The interventions will include paid placements linked to the jobs being created through City Deal, and a wider, multi-agency support package through a Whole-Place Community Budget methodology including health, care, skills, accommodation, family, criminal justice input. The Deal is being negotiated with government ministers on 17 July.

Alongside Portsmouth we have also expressed an interest in the Transformation Network to roll out Whole Place Community Budgets, and discussions with Treasury have commenced to agree areas for development. Early dialogue has particularly focussed on employment support integration across wider agency input, to maximise care, health, wellbeing, community safety outcomes as well as taking

forward substantial efficiencies and savings for the local authorities and the Treasury. It is anticipated that this will dovetail with and form part of the Integrated Person Centred Care Programme.

Having identified our initial "incubator" neighbourhood local services including voluntary organisations primary care, housing and social care we have agreed to work collectively to deliver wholesale change. Effectively we are looking to "hot house" a range of initiatives by concentrating and maximising community assets (building, people, and resources) and pooling resources to develop an integrated person centred community supported by a formal evaluation process.

Within the "Incubator" neighbourhood all agencies have agreed to use a co-productive approach to redesigning services and developing new ones using stepped approaches such as the Birmingham governance International Co-Production Toolkit. The overall workforce will undertake training together to seek to support the development of alternative engagement and working practices. We are dedicated to the concept of using budgets flexibly and inventively testing out new and diverse opportunities to work collectively as communities to use resources as effectively as possible to improve quality and efficiency. This would include "neighbourhood funding" which would be used to deliver local services coproduced with local people.

"Co-production is about professionals and citizens making better use of each other's assets, resources and contributions to achieve better outcomes or improved efficiency."

Governance International http://www.govint.org/our-services/co-production/

Alongside all of this work will be active coproduction of a raft of information tailored to meet the needs of communities, capturing their knowledge and experience designed to help them to identify what they need and what will be the best way to meet those needs.

Our Commitment to Change

We have **commitment** at the highest level to deliver this programme transformation from all system leaders. Supported by an active Health and Wellbeing Board, we have a multi-agency Integrated Person Centred Care Board and regular representation from across the City with direct links into single agency, voluntary and integrated management and governance structures. These organisations include housing, the CCG, social care, key health providers from both the community and acute trusts, Healthwatch and Southampton Voluntary Services (SVS).

We are developing a City Council and CCG Integrated Commissioning Unit which will include shared posts, joint management structure and clear governance arrangements. The development of the integrated Person Centred Care agenda is right at the heart of this developing unit **sharing** the same **core values, principles** and the **ongoing determination** to achieve our planned changes.

Southampton has a **25 year history** of establishing joint pioneering projects such as the Homeless Healthcare Team, Drugs Advisory Service and GP Referral Scheme. Within this history we have also demonstrated the ability and skill to use the experience and knowledge we have gained incrementally to bring about increasing levels of change throughout the City which still resonates today.

An example of this is the Behaviour Resource Service, a national "Beacon" service and the largest and only surviving example of the original 10 CAMHS grants designed to test the Health flexibilities Act 1999. The experience gained from this project has been applied to a number of other services including "JIGSAW" an integrated children's disability services in 2005, which also garnered national attention, and in turn formed the basis of a currently developing overarching Integrated Children and Young Peoples Development Service which includes the highly successful SEND Pathfinder work on integrated Education, Health and Care plans.

Other initiatives would include:

- Jointly funded reablement service
- Aiming High programme for Children with Disabilities
- A number of dementia care initiatives
- The roll out of personal health budgets within substance misuse services
- Multi-agency End of Life work.
- Neighbourhood Community Budget pilots.

We know that within the **diversity** of our city we have new and as yet unidentified creative and energetic individuals with fresh imaginative ideas who can help us achieve our goals supported by strong political and system leadership and a wealth of knowledge and collective change and problem solving experience.

The City is aware that the economic situation which we currently live is not going to be short lived and that if we are to continue to serve the needs of the most vulnerable in our community well we need to radically change how we plan and deliver services. To this end we have established a joint management team working across the City Council and the CCG to **better bridge delivery across health and social care**.

Scale and Pace

Southampton City is known for its ability to tackle large system change in structured, risk managed and a sustainable fashion. We have project management support built into our delivery capability and approach change with confidence and a high level of expertise.

We repeatedly demonstrate the necessary skills that allow us to break down organisational and system barriers utilising enthusiastic **problem solving** and enabling forums such as an established Lead System Chiefs Meetings and the City Council and CCG Joint Management Team structures. We are well versed at establishing our vision and working collectively to commit and mobilise people and other available resources to achieve the transformation we want to achieve. Our enviable record of achieving integrated change affords us the confidence to think "**outside the box**" flexibly pooling financial, people and capital resources, testing new initiatives and working with community leaders and service users and carers to achieve change in a timely and safe manner.

One example is the SEND (Special Educational Needs Disability)Pathfinder, where we have received **national recognition** for our work on the development of education, health, and social care integrated plans for all children with disabilities and those with special education needs meeting challenging timescales consistently.

The Aiming High Programme for children with disabilities which gained **national recognition** in terms of the coproduction of services alongside families, the development of choices that families control including "buying power" through a voucher system, an eligibility process based totally on self-assessment and delivery of sustainability. This was all delivered within time frames and supported throughout by system leads.

In the past engagement of primary care was weak, and needed strengthening. However we have strengthened the commitment of local GP's in the wider community agenda by building on existing areas of good practice. The development of the CCG has seen a **much greater GP involvement** in service development and commissioning including important aspects of this agenda such as the development of GP "clusters", redesigning community nursing and the developing use of the ACG risk assessment tool, and associated process. The recent development of GP clusters and community nursing redesign was undertaken over a matter of weeks **delivering rapid change**, full engagement and maintaining clinical safety.

We strongly support individuals taking direct control over their services and have developed sound processes to enable personalised (health) budgets and have gained nationally recognised experience as one of only two sites developing personal health budgets within substance misuse services. Implementation of the pilot personal health budgets began in April 2011 with evaluation and mainstreaming activity undertaken a year later.

Designing services with **users, carers and the public** is central to the development of this programme a good example of this is in dementia care which has been transformed across the City. Specialist nurses and advisors work in neighbourhoods, providing advice and support designed to help dementia sufferers to build and maintain their community networks, so they can live well in their communities.

We are about to implement a pilot initiative using new accommodation units, supported within sheltered housing for people with dementia bringing together a range of agencies from across the city with an aim to keep people in their communities. This will give us good baseline information to further develop similar schemes in the city. Faith groups are currently mapping social clubs and other activities across the city and promoting this information within communities through a range of mediums. The voluntary sector have worked hard to develop exercise programmes for older people at risk of falling, developed time banking schemes to **stimulate the market**, and developed initiatives across the city to keep older people active and well.

The **Community Health Programme** in one of our neighbourhoods which is one of the most deprived neighbourhoods in the south of England has pioneered the use of participatory budgeting for allocating health expenditure in line with the resident community's preferences. The City Council will be looking to its new public health team to build on this and extend this way of working to other parts of the city.

Another key strength of Southampton is our **IT capability**. For example the area is served by the Hampshire Health Record (HHR) which is a repository for all health and social care data. The record has recently been developed to provide care planning functionality. Our aim is to have a single care plan accessible by patients and those supporting them available across the system in real time. The HHR is also developing to allow telecare/medicine feeds to be used by individuals and clinical staff.

Core service changes in primary care are key to developing risk stratification, integrated care planning and self-management work. **Strong clinical leadership** is in place as is CCG support through funding for access to the NHSI Productive Practice series and implementing TARGET (Time for Audit Research Governance Education and Training) which provide primary care planned regular time for service improvement.

Sharing Lessons Learned

The City has a proven **track record** of learning and development across agencies and sectors. We have been able to seek out best practice nationally and internationally and draw in a wide variety of stakeholders to locally implement solutions and improve outcomes for individuals. We in turn welcome many organisations and individuals who seek to understand our experiences for example our involvement in the development of integrated Education, Health and Social Care planning as part of the SEND Pathfinder programme has garnered much national praise which we have been keen to share widely.

Another example is as part of work connected with the National End of Life Strategy. Southampton was **one of 7 adult pilot sites** responsible for collecting end of life data for the DOH to inform a national tariff for palliative care and is working closely with GP's, community and acute teams to produce the information required. We are also leading on a specific work area with providers working

with the homeless and substance misuse clients, to ensure where possible, they are provided with end of life care appropriate to their needs in the place of their choosing.

We have taken part and been active members of clinical and **commissioning networks**, presenting at conferences, hosting web seminars and organising individuals and groups to meet the people who use and provide our services.

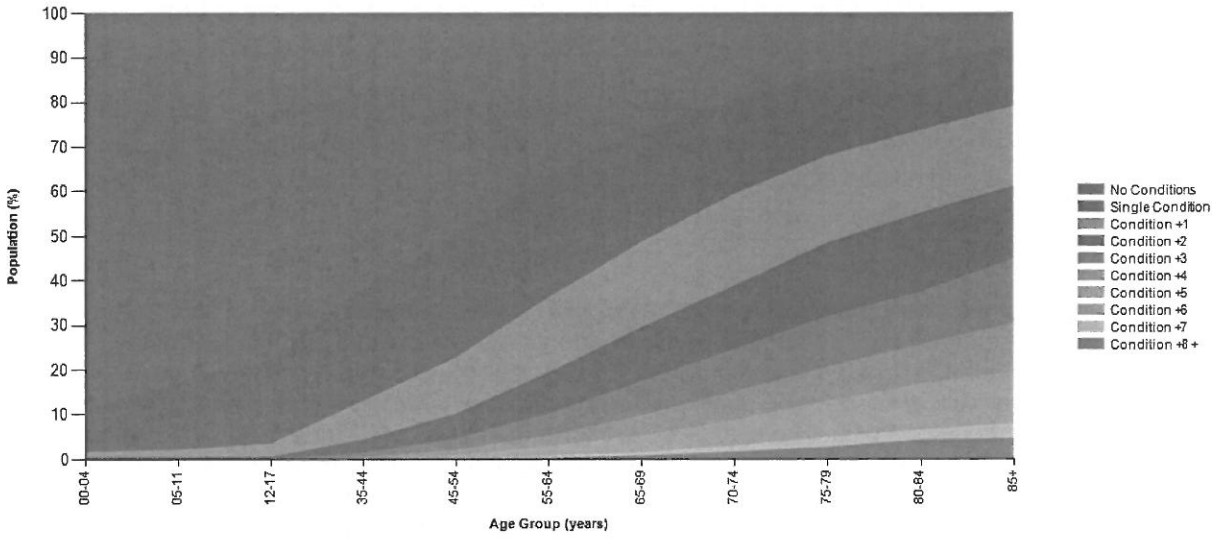
Having enthusiastically followed the experiences of the Neighbourhood Community Budget Pilots we are keen to incorporate this learning into our programme. Piloted initiatives include the development of community ownership, integration of neighbourhood services, local community development forums with shared local budget controls and coproduced and managed local health boards all of which are exciting initiatives that we are looking forward to investigating further.

Engaging with primary care and general practice in particular has historically been challenging however this agenda has proved popular and we have witnessed enthusiastic engagement by GP's across the city in making some **radical changes** in terms of their relationships with each other, the rest of primary care together with the ambition to relate differently to their patients, neighbourhoods, communities and other agencies. They have engaged extremely positively in large numbers with local training and development activity using a TARGET approach (Time for Audit, Research, Governance, Education and Training) the feedback for which has been extremely positive. This enthusiasm and engagement is very exciting and bodes well for us in developing our local plans and it is important to have clinical staff fully engaged if we are going to be in a position to successfully share our learning with others or incorporate other people learning and experience in our developments.

Our commitment to a formal evaluation of our programme has meant that we have been keen to engage the **academic community** resulting in the development of an evaluation programme undertaken and jointly funded with Southampton University. The University have also put a bid in for CLAHRC funding (Collaboration for Leadership in Applied Health Research and Care) which if successful they would align with the Southampton's change programme.

Robust understanding of evidence

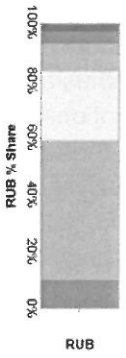
We have started to reshape the Joint Strategic Needs Assessment to understand the needs of the population based on a multi morbidity model and identify the lifestyle challenges faced by citizens in achieving good quality of life and outcomes. We are adopting the nationally recognised approach taken by The Scottish School of Primary Care's Multi-Morbidity Research Programme. Below is a diagram illustrating the comorbidity levels and age for Southampton City patients.

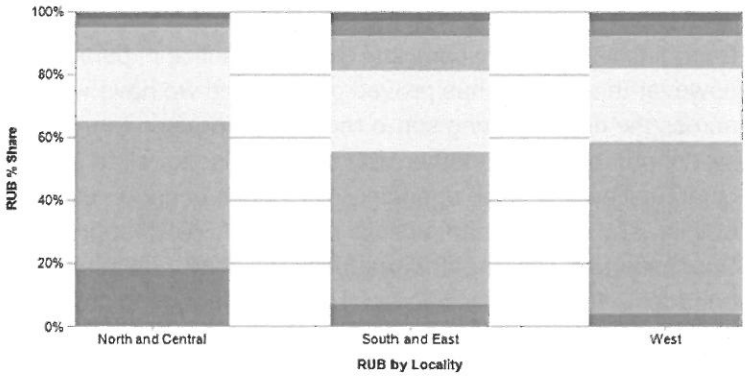


Comorbidity can often be predicted and sometimes, with timely intervention, avoided. As illustrated in the above diagram the likelihood of developing more than 1 condition increases with age as does the predicted need for high cost interventions. We are thus proactively seeking to risk assess patients at an early stage to develop proactive integrated planning to either maintain, reduce, delay or avoid predicted comorbidity and therefore future service usage. To undertake this we are using needs profiling information in conjunction with the ACG (Adjusted Clinical Groups) risk stratification tool, to identify at an individual patient, practice and locality level health utilisation, for now and in future. In doing this we are drawing together, public health, commissioning and primary care to plan and implement changes in neighbourhoods at a public, patients, service and system level. Below is a breakdown of the whole population and their relative health utilization by locality.

Totals

RUB Group	No. Patients
Very High	3,349
High	5,098
Moderate	12,666
Low	30,760
Healthy	62,385
Non-users	12,884
Total	127,142





*Resource Utilisation Bands (RUB) are produced by the ACG tool (Adjusted Clinical Groups – Risk Stratification tool), they help clinicians easily see who are high users of health care services and likely to be in greater need in the future, helping to target interventions to manage their care and improve outcomes.

We are committed to Making It Real as **whole system** across commissioners and providers. Southampton City Council undertakes regular surveys with the public to measure changes in knowledge, experience and canvass opinions. We intend to use the baseline review for Making It Real as an opportunity to further shape our aspirations and plans.

The City has developed **sound performance management** methodology to achieve greater understanding and ultimately control over the pinch points in the health and social care system. The CCG has supported clinicians to develop an Urgent Care Dashboard, which takes inspiration from Bolton. This provides real time information to primary care and community staff in order that they can mobilise and deploy resources to prevent admissions or expedite discharges from urgent care settings.

The CCG 5 Year Outline Plan is developed in collaboration with the City Council and others is based on **local assessment of need and user feedback**, broadly reflecting many of the outcomes associated with the development of this programme for example building community capacity and self-help/management options, preventative and early intervention and active person centred involvement.

As part of the change process we are developing an evaluation programme alongside public health, social care academics and economic modelling experts from Southampton University. The purpose of the evaluation is to trial and test **innovative working tools** and processes e.g. integrated planning and risk stratification, develop qualitative and qualitative baseline and outcome data, and evaluate the overall change process. The evaluation will form the basis of our further roll out of integrated working across the city and informing future commissioning activity within the local authority, CCG and other commissioning partners such as the police and schools. This is helping shape service transformation in real time. The University of Southampton intend to use the relationships with operational services and their improved knowledge of services to inform future applications for research grants.