SOUTHAMPTON CITY COUNCIL

NHS
Southampton City
Clinical Commissioning Group

Better Care Fund

Reducing Demand for Hospital Care over Winter 2014/15

Thursday 30th October 2014

Agenda

Introduction to Southampton

Our Plans for Winter

- Better Care Fund -
&
- Operational Resilience & Capacity Plan -

Our Targets & Impact Over Winter

Introduction to Southampton

- Southampton's Population is **c.265,000**
- Our spend on acute activity is **54%** and growing
- A higher proportion of older people in Southampton rely on **input from social services** than is the case nationally (**5.2%** compared with 3.8%)
- Around **86,000 people** in Southampton are estimated to be living with **long-term health conditions**
- The **over 65s** population is set to increase by **11%** between 2012 and 2019
- A review of **non-elective hospital admissions** for 2013/14 showed that **38%** (10,260) were **over the age of 65**

Our Better Care programme is therefore focussing on older people and those with multiple long-term conditions

Introduction to Southampton

Our vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as **locally** as possible and **person centred**.

Southampton's Health and Wellbeing Board's priority is to **build resilience** and use **preventative** measures to achieve better health and wellbeing, ensure a best start in life and support living and ageing well.

We have adopted a 'one city' approach with active partnership between **health, housing, community and social care** and have established an Integrated Commissioning Unit to take forward our plans for stronger integration.

OUR VISION

Health and social care working together with you and your community for a healthy Southampton

Our Plans for Winter

The **Better Care Fund** is our key strategic goal to **shift the balance of care**. Our core interventions include:

- Person Centred Coordinated Local Care
- Better Discharge and Reablement
- Engaged & Resilient Communities

Our **Operational Resilience & Capacity Plan** describes how the system will operationally **work together** to deliver our Better Care Programme.

This plan will:

- ✓ **Accelerate** the implementation of our **Better Care Fund** strategy over the winter
- ✓ **Reduce elective and non elective** demand for hospital care over the winter

South West Operational System Resilience

Urgent Care Pathways

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Self-Help, Primary Care, Social Care

NHS 111

GP

Pharmacy

Dentist

Patient has an urgent problem that can't be managed through self-help, primary care or social care.

NHS 999

Urgent Care

Minor Injuries Unit

Eye Casualty

First Responder

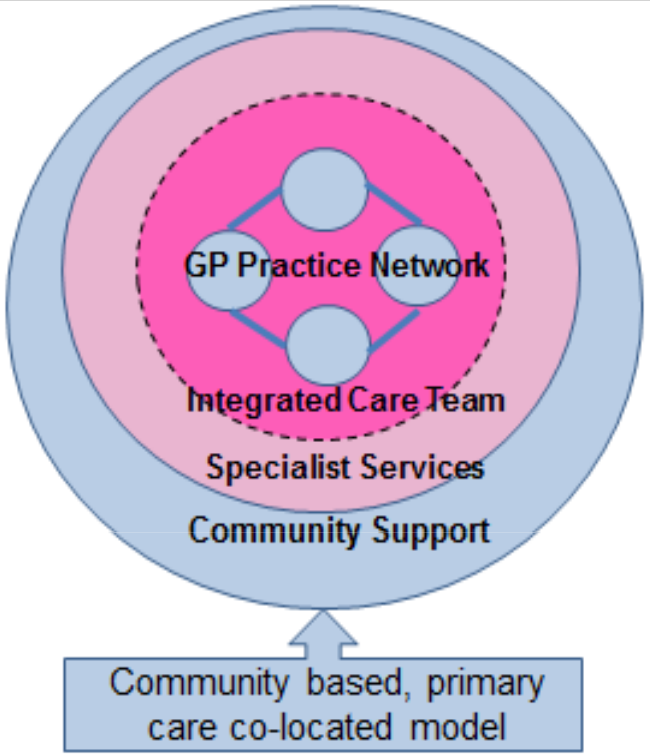
ED

A&E

Ambulance

Elective outsourcing to relieve pressure and avoid cancellations

Better Care Fund



Our approach:

- Reconfiguration of health into integrated cluster based teams, based on GP practice populations, with strong links to social care
- Teams to include community nurses, therapists, geriatricians, MH nurses, primary care, housing and voluntary sector
- 7 day working within teams
- Development of a personalised care promoting workforce across all services
- Introduction of a common trusted assessment and planning tool and accountable professional role
- Full integration of mental health into the integrated care model
- Introduction of a single point of access for integrated care

Southampton City wide services
(more specialist service or where economies of scale require a city wide model)

Cluster team Based around practices | Cluster team Based around practices | Cluster team Based around practices | Cluster team Based around practices | Cluster team Based around practices | Cluster team Based around practices

Wrap around Community Support

Better Care Fund

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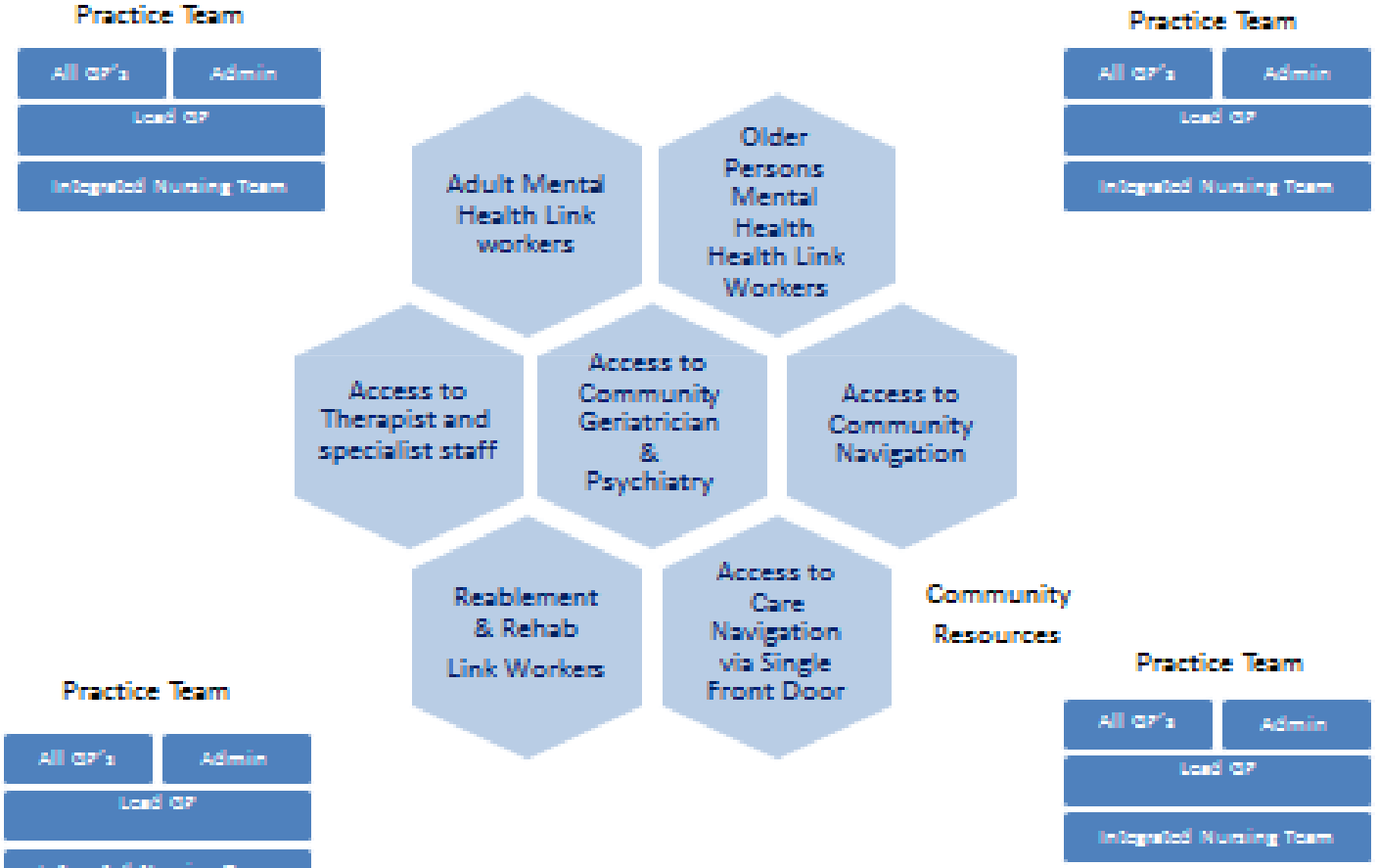
At a Cluster Level



Southampton Performance

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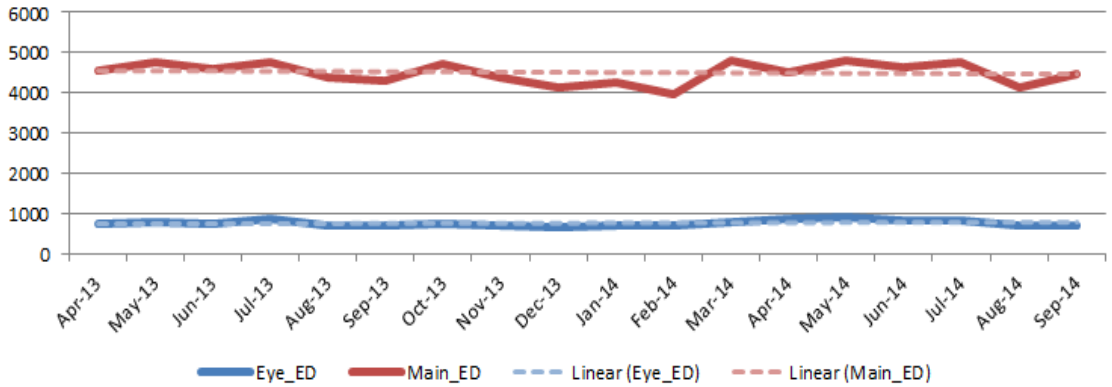
A&E Attendances

(Apr 2013 - Sep 2014)

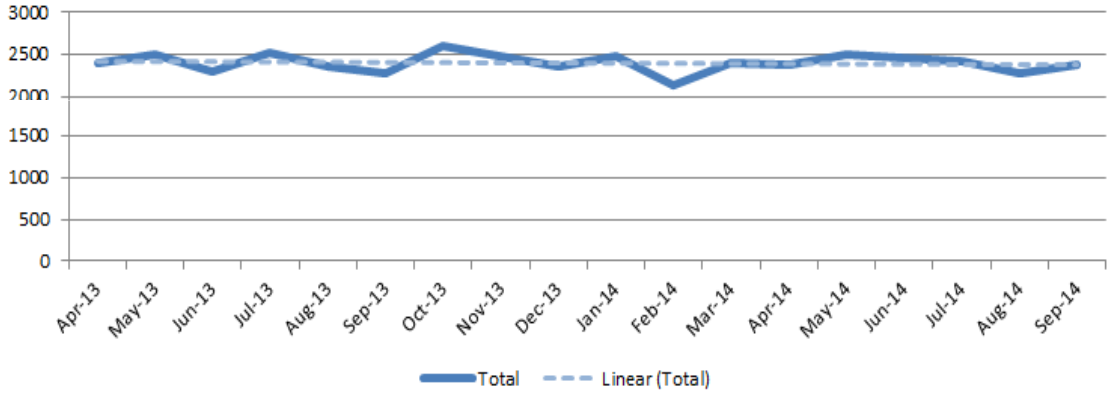
Source: SUS Data



Non-Elective Inpatient Admissions

(Apr 2013 - Sep 2014)

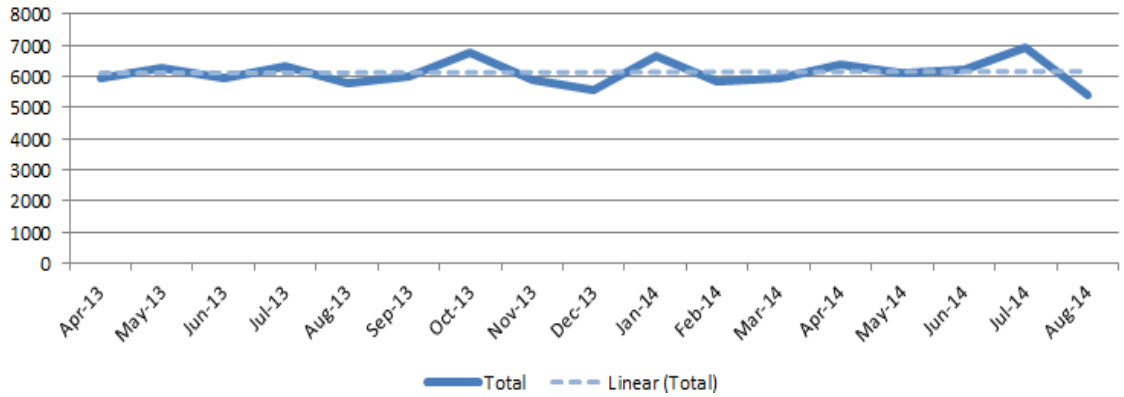
Source: SUS Data



Referrals

(Apr 2013 - Aug 2014)

Source: C3 Report



Our Plans for Winter

Our Better Care Fund and Operational Resilience & Capacity plans will focus on **3 key areas** over the winter:

- **ED Front Door**
- **Back Door**
- **Managing Long-Term Care in the Community**

Implementation of our plans will also help to accelerate the delivery of our **Better Care Fund outcomes**:

Better Care Fund Outcomes

- *Non Elective Admissions*
- *Delayed Transfers of Care*
- *Older people staying at home longer after discharge*
- *Injuries due to Falls*
- *Permanent Admissions of Older People to Residential & Nursing Homes*
- *Patient experience*

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ED Front Door

ED Front Door

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What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Additional GP Out of Hours *7 day working*  ✓ **324 additional GP appointments out of hours** in the evenings and at weekends ✓ Target population is patients with **long term conditions** ✓ This is a **key risk group** for non elective admissions outside of core GP opening hours	Accident and Emergency • Reduction in **A&E attendances and non elective admissions**, by providing patients with more GP appointments. NHS Minor Injuries unit • **Reduction in utilisation WIC and MIU** by improving access to services in the community.	**December 2014**
In-Hospital Therapy *7 day working*  ✓ **Additional therapy staff** on the front door, **across 7 days** ✓ Focus on **pulling patients out of ED/AMU** and into the **Medicine for Older Persons wards** and providing acute **rehab** during their hospital stay.	 • Reduction in patient **length of stay**  • Reduction in **wait for rehab** beds as some patients will be able to go directly home  • Reduction of **ED breaches**	**Mid November 2014**

ED Front Door

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What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Mental Health Support in A&E *7 day working* 	✓ **Additional Mental Health practitioners** at the front door, during the **night, weekends and bank holidays (7 day working)** ✓ This will support the assessment and treatment of patients who present with mental health needs and **improve the throughput in ED**	Accident and Emergency • Preventing unnecessary **non elective admissions** by arranging appropriate community care • Improved **response times** and fewer breaches	**In Progress**
	✓ **Vulnerable Adult Support Team** (VAST) undertaking psychological interventions ✓ Ensures that **underlying mental health problems are addressed**, in addition to urgent physical health needs.	Accident and Emergency • Reduction in **non elective admissions** • Reduced **length of stay in ED** • **Reduced risk of repeat attenders**	**In Place**

ED Front Door

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
ED Front Door Transfer Team *ED Flow* 	✓ **New front door transfer team** to reduce the delays around **patient moves** to downstream wards.	 • Reduction in current **transfer times** by 2 hours.  • Reduction in **length of stay** in ED and AMU  • Releases **AMU capacity** to support ED admissions	**November 2014**
ED 'Pit-Stop' Service Model *ED Flow* 	✓ Implementation of an **additional 2 assessment areas** to implement front door early assessment and treatment, called 'pit stop' ✓ **Diagnostics and assessments are carried out at the front door**, rather than waiting until the patient is in majors.	 • Improved **patient flow** in ED  • Reduction in **length of stay** in ED	**Start October 2014**

ED Front Door

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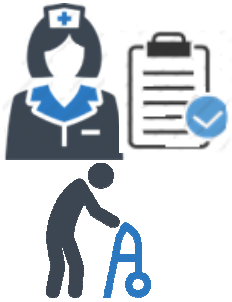
What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Frailty Rapid Assessment Service 	☑ **Additional staff** at the front door to carry out **comprehensive geriatric assessments** of patients in ED ☑ If appropriate, pull patients into the **ambulatory care** pathway.	Accident and Emergency • Reduction in **non elective admissions** for over 80's patients.  • Reduction in **ED length of stay** for over 80's patients.  • Reinforce links across older persons pathway (**Cluster Teams** & acute care)	**End October 2014**
Personalised Care for over 75's *£5 per head* 	☑ **20 additional senior practice based nurses** across Southampton, funded by the £5 per head scheme ☑ Right skills and experience to meet the needs of the **over 75 population** and to work **collaboratively** in primary and secondary care, together with **social care and local community groups.**	Accident and Emergency • Reduction in **non elective admissions** for over 75's  • Reduced **length of stay** for over 75's  • Reduction in **urgent GP appointments** for over 75's	**Phased Approach** 10% additional nurses now in place 30% in place in Nov 60% in place in Dec

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Back Door

Back Door

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What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
In-Reach Coordinators *7 day working* 	✓ **Extension of in-reach coordinator roles** for AMU, Medicine for Older People (MOP) and Trauma & Orthopaedic wards ✓ In reach coordinators **identify and navigate the transitions of care** across health and social care ✓ Focus on trauma cases 65yrs+ ✓ Focus on orthopaedic & MOP cases 80yrs+	 • Reduction in **length of stay, excess bed days and delayed transfers of care**  • Reduction in **readmission** rates  • Reduction in **patients on IDB list**  • Reduction in **waiting for community beds**	**In-Reach Coordinators in place** **Extension in Nov-Dec**
Integrated Discharge Bureau Manager 	✓ Appointment of an **Integrated Discharge Bureau Manager** to lead the delivery of discharge across the city	 • **Improved flow** from hospital into the community  • Reduction in **length of stay/excess bed days**	**January 2015**

Back Door

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Responsive Discharge & Reablement 	✓ **12 additional beds** from the nursing home sector for **CHC and other complex patients (discharge to assess)**	 • Reduction in **length of stay, excess bed days and delayed transfers of care**	**12 CHC beds in place** **Dom Care from February 2015**
	✓ Additional integrated **rehabilitation & reablement capacity**	 • Reduction in time from **checklist to discharge**	
	✓ Recommissioning **domiciliary care** provision	 • Additional capacity to **discharge to assess 12 additional CHC patients a month**	
Trusted Assessors 	✓ **Social care training** for In-Reach Coordinators and Hospital Discharge Facilitators, enabling them to be competent at **restarting pre-existing care packages**	 • Reduction in **length of stay**	**Early November 2014**
		 • Reduction in **waiting for discharge**	

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Managing Long-Term Care in the Community

Long-Term Care in the Community

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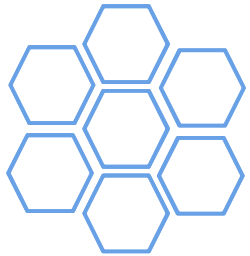
What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Cluster Teams Integrated Working *7 day working* 	✓ Work proactively with the most **complex client group** towards meeting their future needs	• Working with the In-Reach Coordinators to enable a **pull approach to discharge**	**In Progress**
	✓ Promotion of **self-management**	• More **robust long-term care**	
	✓ Early **intervention & prevention**	• Development of **person-centred plans** and promoting use of personal budgets and direct payments	
	✓ Signposting to community resources within local area		
	✓ Delivering **health improvement plans** for the Cluster population		
Community Navigators *Building Community Capacity*	✓ Development of **community solutions** (co-production)	• Patients who require low-level support to move towards managing own care will have **access to additional services**	**January to March 2015**
	✓ Development of our **Community Navigator** role, embedded within 3rd sector partners		

Long-Term Care in the Community

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What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Personalised Care for Over 75's 	✓ Community nursing for over 75's, working in **partnership with Cluster Teams**	Accident and Emergency • Reduction in **non elective admissions** for falls or medication related incidences  • Increase in the number of patients **self-managing**  • Shift in balance of care from institutional to **home-based care**	**In Progress**
Risk Stratification *Earlier Intervention* 	✓ Development of a **proactive multi-agency risk stratification** tool ✓ Bringing together a breadth of information to **identify those people most at risk** of deterioration and intervene earlier, maintaining and promoting independence. ✓ Target group is **older people (65+)** and those with multiple **long-term conditions**	 • Greater number of anticipatory care plans developed following risk stratification Accident and Emergency • Reduction in **non-elective admissions**	**In Progress**

Long-Term Care in the Community

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What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Increasing Capacity of Primary Care & Community Nursing 	✓ Increasing the **community nursing capacity** across the city to support primary care ✓ Placing **advanced nurse practitioners** into a small number of GP practices	Accident and Emergency • Reduction in **non elective admissions**  • **Care plans** for patients with long-term conditions	**In Progress**
Long-Term Conditions Community Management *COPD & Diabetes*   	✓ **Integrated pathway** for adults with Chronic Obstructive Pulmonary Disease (COPD), providing both community based consultant and nurse led clinics and home visits ✓ Implementation of **primary care Diabetes Accreditation Scheme** to enhance quality of care ✓ Implementation of **diabetes integrated model of care**, with stronger focus on self management & professional education ✓ Influenza and Pneumonia **vaccinations**	Accident and Emergency • Reduction in **non elective admissions**  • Reduction in **excess bed days**	**In place or In Progress**

Our Targets & Impact Over Winter

Reduce Non-Elective Admissions	**2% Reduction** next year, starting Q4 14/15
Reduce Delayed Transfers of Care (DTOC)	DTOCs are high in Southampton and we have seen significant growth during the start of 2014/15. Our target over winter is to **hold this growth**, with a reduction planned in 2015/16
Reduce Permanent Admissions to Residential & Nursing Homes	**5% Reduction** next year, starting Q4 14/15
Reduce Injuries due to Falls	**12.5% Reduction** next year, starting Q4 14/15

Our System Wide Governance Structure