Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**SOUTHAMPTON CITY COUNCIL**
Clinical Commissioning Groups	**SOUTHAMPTON CITY CCG**
Boundary Differences	**Southampton City Council and Southampton City CCG boundaries are coterminous. The only difference will be where non Southampton residents have chosen to register with a GP in Southampton or residents have opted to register with a GP outside of Southampton city. 99.6% of Southampton residents are registered with a Southampton City CCG GP, whilst 5.7% of patients registered with Southampton City CCG live outside of Southampton City.**
Date agreed at Health and Well-Being Board:	**29 January 2014** **Progress report presented 26 March 2014 outlining feedback received on first cut submission and changes being**

	made to the final version of the plan following this and other feedback. **Joint HWBB with provider session to discuss plans and impact on providers held 23 April 2014.** **Meeting with the chair of the HWBB took place on 15 September to sign off the revised submission for 19 September.**
Date submitted:	**19 September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£924,000**
2015/16	**£15,325,000**
Total agreed value of pooled budget: 2014/15	**£2,210,000 (although not pooled until 2015/16)**
2015/16	**£132,718,000** **(Southampton intends to take a holistic approach to out of hospital health and social care and fund and commission it in that way. Our ambition is to encompass all services that fit within the scope of the Better Care model)**

b) Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	Southampton City CCG
By	John Richards
Position	Chief Officer
Date	19 September 2014

Signed on behalf of the Council	Southampton City Council
By	Dawn Baxendale
Position	Chief Executive
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	Southampton City Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor David Shields
Date	19 September 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Summary presentation of Southampton's Better Care Fund local plan	Provides a user friendly summary of our plan.
Original Project Initiation Document and Engagement Plan	Sets out the governance arrangements and processes we used to develop our Better Care Fund local plan, along with the plan we used for communication and engagement.
"Healthier Lives in a Healthier City" - Southampton's Health and Wellbeing Strategy	Southampton City's Health and Wellbeing Strategy which is based around 3 key priorities: to build resilience and use preventative measures to achieve better health and wellbeing; ensure a best start in life and support people living and ageing well.
Integrated Reablement/Rehabilitation Service – concept paper	Outlines the model for developing our integrated reablement and rehabilitation service.
Strategic Context for Telecare and Telehealth in Southampton 2013	Sets out our vision, aims and key principles for developing telecare and telehealth in Southampton and the model we propose to adopt. A business case is in development.
Southampton City self management framework, 2013	Sets out how we will encourage, support and assist the wider development of self management with individuals and professionals in a wide range of care settings.
Southampton City personalisation –strategic intent, 2013	Our strategy for personalisation in Southampton.
Integrated progress framework, 2014	Southampton City CCG and Southampton City Council have signed up to Think Local Act Personal (TLAP) and 'Making it Real' (MiR). This document explores, identifies and sets out the key features to deliver Personal Health Budgets; 'Making it Real' and 'Integrated Person Centred Care' as well as presenting our self assessment.
Better Care Project Assurance Report	This provides assurance to the Integrated Care Board that our plans are progressing to timescale and we are delivering against our targets. The report is updated monthly.
Southampton Better Care Joint Communication Strategy	This sets out Southampton's joint Better Care communication strategy going forward.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Over the next 5 years, our vision is to completely transform the delivery of care in Southampton through our jointly led CCG and City Council Better Care programme so that it is fully integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.

Southampton's Health and Wellbeing Board has made strong progress in agreeing the Joint Health and Wellbeing Strategy: ".Healthier Lives in a Healthier City" with priorities 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. Our aim is to deliver better health outcomes for the people of Southampton by ensuring we have the very best health and social care services possible. We believe that by working together in a seamless and integrated way we can achieve this. That is why we have an established Integrated Person Centred Care Programme which is jointly led by Southampton City CCG and Southampton City Council. 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 and aim of moving investment from a traditional organisation-focussed model of service provision to personalised, people-focussed solutions which are based on prevention and early intervention.

Our stated vision is for:

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

We are communicating this vision through adoption of the National Voices ambition **"I can plan my care with people who work together to understand me and my carer(s), [empower me to take] control, and bring together services to achieve the outcomes important to me"** (with some adaptation to reflect feedback we have received from community and voluntary sector partners).

Having good partnership working is different to developing the power of a strong inclusive community to boost health and wellbeing. We recognise the need to work with and learn from current and new partners to enable the development of strong, resilient and inclusive communities and to widen mutual understanding of interpretations, concepts or collective ideas around community development, encompassing social models, neighbourhood approaches, expert patient groups, mutual, cooperatives and peer support systems that transcend community, social and health environments.

Person centred care will be at the heart of everything we do. It changes and challenges personal, professional and organisational power - for community services and also fundamentally the way primary care is delivered. We are working with primary care to understand and overcome these challenges, and are working as a pilot site with the national organisation TLAP (Think Local, Act Personal) to develop this approach within the city (see our personalisation strategic intent document and integrated progress framework).

Our overall aims for integrated care in Southampton are:

- Putting **people at the centre of their care**, meeting needs in a holistic way
- Providing **the right care, in the right place at the right time**, and enabling people to stay in their own homes for as long as possible
- Making **optimum use of the health and care resources** available in the community, reducing duplication and closing gaps, doing things once wherever appropriate
- **Intervening earlier** in order to secure better outcomes by providing more coordinated, proactive services

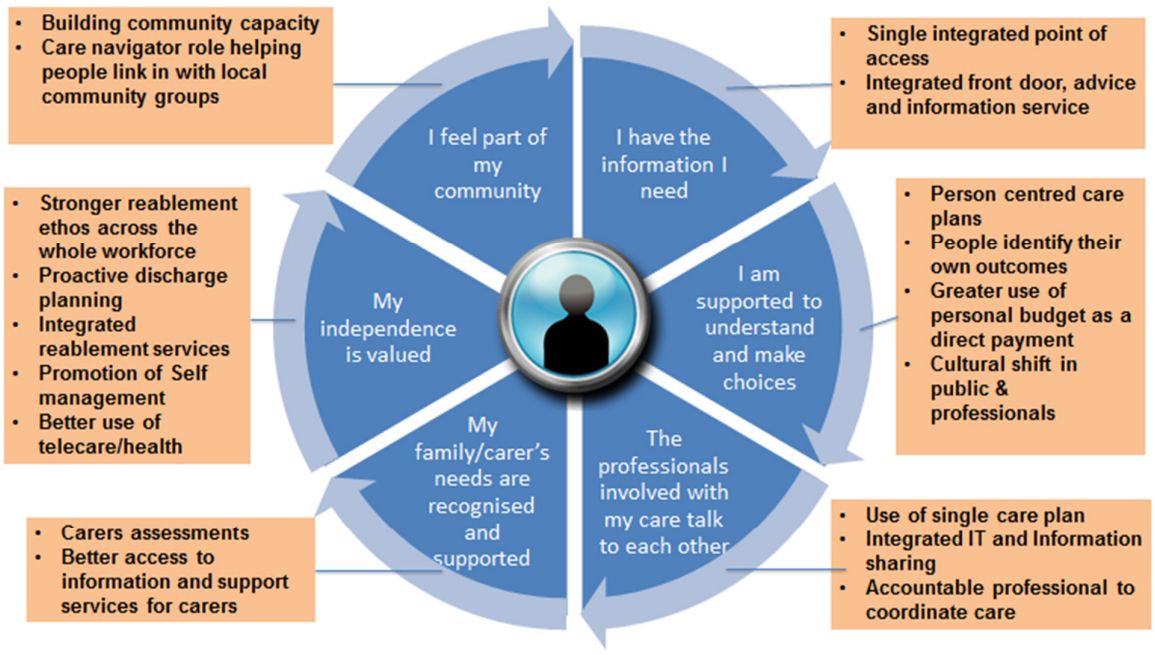
These aims, along with our objectives, outcomes and measures for success are set out below:

Aims	Objectives	Outcomes	Measures
To put people at the centre of their care	People are well informed and supported to manage their own conditions	Needs are met Outcomes for people are improved Health inequalities are reduced A sustainable health and social care system.	• Increased uptake of direct payments/ personal health budgets • Increase in self management • Increase in number of integrated person centred care plans • Positive feedback from service users and their carers
	Physical health, mental health and social care needs are addressed in a joined up way		
	Uptake of joint health and social care personal budgets is increased to maximise choice, flexibility and control.		
	Plans include resources from community, carers, family, alongside health and social care elements to provide holistic person centred working		
To provide the right care, in the right place at the right time	There will be easy access to high quality responsive primary care.		• Fewer people in acute care for less time – reduction in admissions, shorter lengths of stay, fewer delayed transfers of care • Fewer people in residential care • Fewer people dying in hospital • Increased engagement in community services
	Services will be provided in a timely way, when they are needed. This includes rapid response to urgent needs.		
	People will only be in hospital for the time when they need care that can only be provided in the acute hospital setting.		
	Reactive, unscheduled care will reduce and planned care will increase.		
	Direct payments and personal health budgets will be used to secure right services for the individual		
	Communities will provide increasing elements of local community services as an integral part of the care plan.		
To make optimum use of the health and care resources available in the community	Carers are supported to help maintain them in the effective role they play		• Increase in carers assessments • Increased use of telecare/telehealth
	Use of new technologies is maximised, including telecare and telehealth		

	People will be appropriately signposted to local voluntary sector and community support.		• Increased community capacity and utilisation
To intervene earlier in order to secure better outcomes	People's health and wellbeing are maintained for longer People remain as independent as possible Integrated risk stratification and proactive care planning will be rolled out and there will be a much stronger focus on prevention		• Greater number of anticipatory care plans developed following risk stratification • Earlier identification and support for people with dementia • Fewer falls

b) What difference will this make to patient and service user outcomes?

The diagram below illustrates what the future system will look like from the perspective of patients and service users.



From the perspective of patients and service users, the changes we are making will mean:

- **I have the information I need.** People will have easier access to information about the help available to them in their local communities through their local team or a community navigator. Better information and advice will be provided about the services

available and people will be able to telephone or visit the single integrated point of access to health and social care to assess their own needs or be directed to the most appropriate service.

- **I am supported to understand my choices and to set and achieve my goals.** People will be in control and will choose when to invite others to act on their behalf. They will draw up their care plan, in partnership with professionals and others where they choose, and be able to make choices about the support they use, including drawing on their own family and wider community assets. If they choose to do so, more people will be able to receive their personal budget as a direct payment and source their own support. They will have better access to information and resources such as telecare/telehealth that help them manage their own condition at home.
- **The professionals involved with my care talk to each other. We all work as a team.** People will have a single integrated care plan which they can access and control and is used by professionals from health and social care so that they do not have to keep repeating their story. A named lead will coordinate their care and ensure continuity.
- **My carer/family have their needs recognised and are given support to care for me.** Carers will be identified and be given information about their rights and the support they can access to help them cope and live their lives to the full, whilst caring for their loved one.
- **I feel part of my community.** People will have the opportunity to be linked into local voluntary sector schemes and community groups by their care coordinator or community navigator, which enable them to develop a network of support and share experiences. For example, people might choose to access a local time bank which will enable them to make a contribution to their local community and develop wider friendships.
- **My independence is valued.** Care coordinators will play a key role in proactively identifying when people need additional help or support to manage a crisis. When people are admitted to hospital, the care coordinator will coordinate everything that is needed to get that person back home as quickly as possible; planning for discharge will start as soon as someone is admitted. Reablement services will be more proactive in supporting people's recovery, available 7 days a week.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

To deliver its vision, Southampton City had already embarked on a system wide change programme (the Integrated Person Centred Care programme) before the announcement of the Better Care Fund. Success requires substantial change in the way services are provided and staff work with people, local communities and each other.

The Better Care Fund provides a timely opportunity to go further, faster. It will bring together a wider range of existing resources from across the CCG and City Council to commission in a more joined up way, coordinating care, driving out duplication and increasing efficiencies. We will be exploring how different contractual and funding models can support this. Efficiencies from improved utilisation of resources and reductions in activity in the acute hospital sector will release money to be reinvested in the integrated out of hospital model.

<u>Current State</u>

There is a need to move from a reactive system where there is duplication and gaps, characterised by high numbers of delayed discharges, to a more proactive system where care

is delivered with and around the person in a joined up way, focussed on meeting need at the earliest opportunity and connected to local communities.

In Southampton primary care services are delivered to 268,200 registered patients by 33 GP practices, the average list size being around 7,000. Out of hours primary care is provided by Care UK who also now provide the city's Minor Injuries Unit (MIU). There is one main acute NHS Trust provider, University Hospital Southampton (UHS), delivering secondary care to the majority of Southampton's residents with small amounts of activity at neighbouring Trusts, e.g. Salisbury, Winchester and Bournemouth hospitals. UHS is the main provider of accident and emergency care in Southampton. There is an acute ISTC, provided by Care UK, which accounts for approximately 35% of the CCG's elective activity. The CCG commissions adult Mental Health and Learning Disability services from Southern Health NHSFT, IAPT from Dorset and the majority of its remaining community provision from Solent NHS Trust. There is an increasing amount of independent sector activity. Over the last two years other providers have come into this landscape, such as Millbrook Healthcare who delivers the Wheelchair service and jointly commissioned Joint Equipment Service and a series of AQP contracts for ENT/Audiology and Back and Neck pain.

Southampton City Council currently provides the majority of adult social care itself but is part way through a significant transformation that will improve the customer pathway with a focus on personalised approaches and increased choice. The council also owns a lot of housing stock in comparison to other authorities and therefore opportunities for Extra Care and other alternative housing options have been created.

The CCG is coterminous with Southampton City Council and has a strong history of partnership working which has led to the establishment of an Integrated Commissioning Unit (ICU) in January 2014 which also incorporates Public health. There are already a number of joint commissioning arrangements including S75 agreements for Learning Disabilities, Mental Health, the Joint Equipment Service, and Substance Misuse as well as jointly funded provision such as the JIGSAW joint disability service for children, the Behaviour Resource Service for young people, Sexual Health services and reablement provision.

We have a good basis to work from but recognise we still have a long way to go.

Primary care is key to delivering our vision. All 33 GP practices in Southampton have signed up to the Avoiding Unplanned Admissions Avoidance DES (Proactive Care Programme) and are using the risk stratification tool (ACG tool). We have reconfigured Community nursing into 13 teams around groups of GP practices and are building on this for the cluster arrangements described in Better Care Scheme One. Case management is firmly embedded for all elderly patients at risk of admission, care being coordinated by community matrons with a care plan and support in primary care to proactively manage their needs. We are exploring different organisational models with GP practices, such as federations, and have applied to become a co-commissioning pilot (see Section 6c). Some practices are beginning to work differently. Several GP practices have been piloting self management approaches and one neighbourhood (comprising two GP practices, social care, community nursing, older people's mental health services, as well as local voluntary and community groups) has been piloting an advanced model of integrated care to identify early and support people at risk of hospital admission. The pilot has a strong evaluation basis which is being led by Southampton University.

However levels of engagement and capacity within primary care generally are a long way from where they need to be. A key priority in 2014/15 is therefore primary care communication and engagement (see our Communication and Engagement Plan attached).

In addition we are investing £1.287m under the Everyone Counts £5 per head initiative into the provision of elderly care nurses to work in practices supporting them in discharging their responsibilities in caring for people over 75 years under the GMS contract. This has been based on evidence from a pilot in a local practice (Old Fire Station surgery) that has been well reviewed and audits have shown a reduction in admissions. The scheme has been developed with strong practice engagement and different models of employment are being piloted across the city. This will be linked into the Better Care clusters described in Scheme One.

Another key area of focus for Better Care in Southampton is discharge, rehabilitation and reablement. Discharge processes need to become much more proactive. Southampton has an Integrated Discharge Bureau (IDB) which coordinates complex discharge and manages around 23 patients discharged from Section 2/5 a day (split roughly equally between Southampton City and West Hampshire). On a daily basis there are around 140-170 active Section 5s. Approximately 40% are discharged within 3 days, 50% within 5 days. We have set a target to increase this to 60% discharged within 3 days. We are in the process of recruiting a jointly funded IDB manager to strengthen leadership across the system in the discharge process and are working towards a much more proactive model which commences the discharge process at the earliest point within the patient's journey. The agreed direction of travel across all partners is that people are not expected to make life changing decisions in hospital, and that home should be the default position for discharge destination. To facilitate this, it has been agreed that there should only be two discharge pathways out of hospital – simple, covering an anticipated 80% of discharges and complex for the remaining patients. It is anticipated that 80% of discharges will be simple and a model of trusted assessor is being rolled out for this group whereby Southampton City Council are training health staff to undertake simple assessments and restart/initiate simple packages. For the 20% complex discharges we have sourced 12 additional nursing placements to allow for speedy discharge and assessment outside the hospital. Ward staff will be commencing the discharge process at the point of admission.

Our Better Care Scheme Two takes this one step further by integrating health and social care rehabilitation and reablement services. Southampton has two health based rehabilitation wards (Royal South Hants (RSH) with 43 beds across two wards) and a Local Authority Unit (Brownhill House with 25 rehab beds) that is partially health funded to provide rehabilitation for people who are medically fit. Both sets of provision offer "step up" from the community and "step down" from an acute setting. Clinical support to the Local authority unit is provided by the health team at the RSH. Collectively these units are operating under capacity. The intention is therefore to consolidate community bed-based provision with a strengthened rehabilitation/reablement offer both in the community hospital and community. This is described in more detail in Scheme Two.

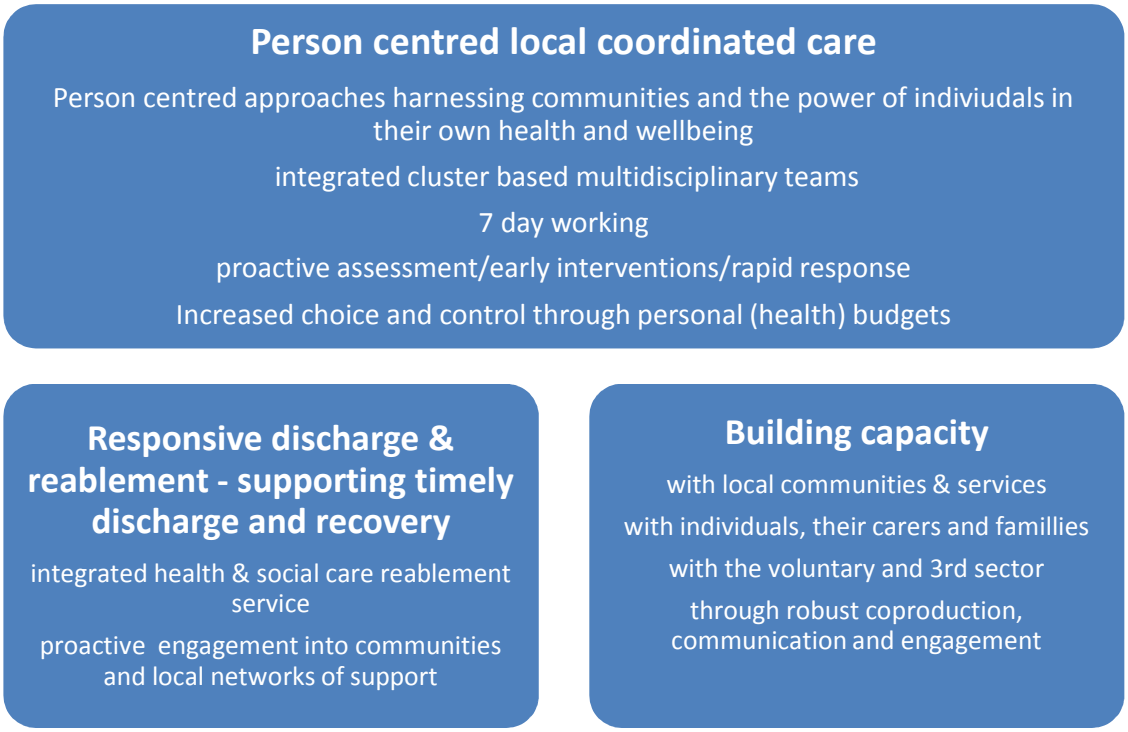
To support the above model, the ICU is also retendering domiciliary care provision. The domiciliary care market currently within Southampton provides care for approximately 1,810 people in any given week (1,750 SCC and 60 SCCCG). There are currently 10 framework providers but up to 65 spot purchased providers) in the city delivering care packages on behalf of SCC and the CCG. The provision includes domiciliary care, supported living and extra care. Whereas usage has reduced over the last 3 years, investment in domiciliary care has

increased, showing the intensity of the services is increasing. Responsiveness of domiciliary care is an issue. Adult domiciliary care is allocated on geographic areas, reflecting the need to reduce travel times and work in smaller areas of the city. However, with only one provider in each area whenever capacity, quality and or safeguarding concerns occur there has been no directly commissioned market provision to provide cover. This has resulted in significant use of spot purchase arrangements (over 45%). Domiciliary care agencies have historically worked in silos, without fully understanding the part they play in contributing towards Southampton's strategic position.

The intention of the new Framework which is being tendered for commencement February 2015 is therefore to increase flexibility, capacity, better support personalisation and Individual Service Fund (ISF) approaches, thereby creating more choice and control for users, ensuring services are able to respond to changing needs and demands and offer better value for money. There will be a focus on the importance of ongoing reablement within the new specification.

Changes to Service Delivery

Our approach to system redesign has 3 basic components:



The core principles underpinning our model are set out below:

- **Person Centred** - individuals will have maximum choice and control through person centred care planning and supported self management of their health and wellbeing.
- **Personal control** – patients and service users can decide how the money allocated for their care should be spent.
- **You, not your illness** - the approach to care will be holistic and not focussed around diseases or conditions.

- **Being the best we can be** – we will make the most of the skills and resources available to us, building on the strengths of people, their families, carers and local communities.

- **Integrated and seamless** - services will be delivered in an integrated way at all levels wherever possible with a focus on local care.

- **Round the clock** - out of hospital care will be a 7-days-a-week service and will be consistent both in and out of hours.

- **Community-led** – the vast majority of people's needs will be managed in the community by the local cluster teams and wider community support. Community services will be the first port of call for people seeking help for themselves or others.

- **Efficient and consistent** - care planning and assessment may be undertaken by any agency using a common trusted tool.

The following sections describe the changes to the pattern and configuration of services in more detail.

Person centred local coordinated care

This includes:

- **Formation of multidisciplinary cluster teams -** Building on our principle of care being as local as possible, we will further develop our integrated nursing clusters and virtual ward model to create a number of fully integrated teams around clusters of practices. These teams will be multidisciplinary including health staff (community nursing, therapists, geriatrician, MH nurses, primary care staff), housing workers, voluntary sector, reablement with strong links to social care and will in-reach into acute settings to facilitate timely discharge. The teams will be co-located in each cluster area. It is expected that each team will cover a population of approximately 30,000 - 50,000. Work has already commenced to align staff and older people's mental health staff have just integrated within the community nursing teams.

  2014/15 is a period of transition. This will include identification of need in each area through the pooling of intelligence and beginning to jointly identify those people most at risk who may benefit from early preventative planning or intensive case management. The link to our Joint Strategic Needs Assessment (JSNA) data compendium below shows how we have already begun to collate demographic and need data about each of the clusters:

  http://www.publichealth.southampton.gov.uk/HealthIntelligence/profiles-local.aspx

  Throughout the transition stage there will be a focus on opportunities for joint training, shadowing and staff rotations.

  This new model of local cluster teams will be underpinned by:

- **Implementation of the new GMS contract** which brings a significant shift of focus, through QOF requirements, into supporting older people. This includes the introduction of a named accountable GP for patients over 75, a contractual duty to monitor the quality of the Out of Hours service and support integrated care by record sharing and a new enhanced service for patients with complex needs. The enhanced service requires practices to improve access, ensure other clinicians can contact the GP for advice, carry

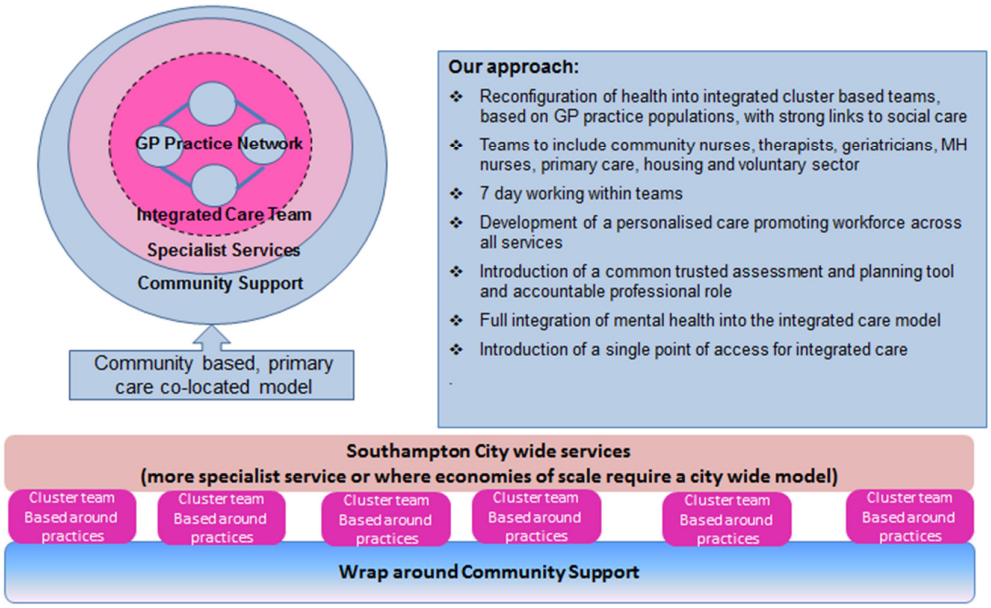
out regular risk profiling to identify at least 2% of patients a year, provide proactive care and support for at risk patients with personalised care plans with a named accountable GP and care coordinator and work with hospitals to review and improve discharge processes. This is progressing well within the city.

- **Introduction of a common trusted assessment and planning tool across health and social care** (building on the comprehensive geriatric assessment but adaptable for all client groups covering medical, mental health, functional capacity and social needs) together with proactive risk profiling to identify high risk patients using predictive tools and combined intelligence. As stated above, we are currently rolling out the "trusted assessor" role amongst our hospital discharge and in-reach coordinator teams to enable them to restart or make small changes to social care packages to facilitate the discharge process.
- **Joint workforce development / development of core generic skills,** e.g. person centred planning, risk profiling, self management, care coordination, brief intervention skills, working with those with dementia and leadership in a multiagency context. This will require working closely with the Local Education and Training Board.
- **Implementation of the care coordinator/accountable professional role** for every person identified as at risk to oversee the person's integrated care plan, coordinate their care and act as a single point of contact for them and their family/carers, building on the existing case coordinator role for older people. During 2014/15 we are developing a common skill set for this role and rolling out a programme of workforce development.

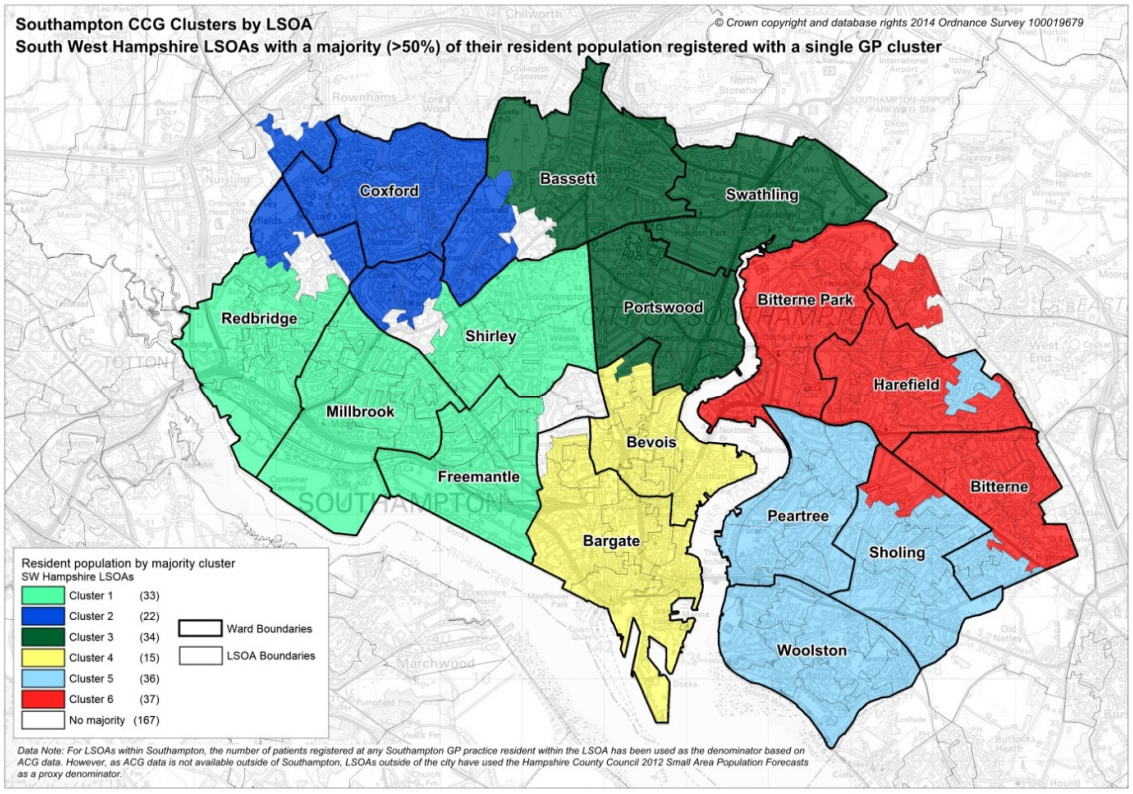
- **Full integration of mental health into the integrated care model.** People with long term conditions, e.g. diabetes are more likely to have mental health problems. Where mental health co-morbidities exist, care can be 45-75% more expensive and patients are less likely to be discharged in a timely way. Therefore it is crucial that the model considers mental health needs. This will include assessment of mental health needs as part of the common assessment tool as well as tailored psychological therapy when necessary. This will be delivered through skilling up the local primary care and community workforce to manage non complex mental health problems, improved psychiatric liaison and further roll out of IAPT, building on the training already provided to some community staff on the use of psychological approaches which is proving to be effective

- **Integration of specialist services for people with Long Term Conditions into the model.** Specialist services will also reconfigure to actively work within the clusters and some outpatient clinics currently located in the hospital will be delivered locally. This will include work with acute and community geriatricians with a focus on frailty.

The diagram below illustrates the role and function of the cluster teams.



The proposed 6 clusters are illustrated below.



The configuration of the clusters has been based on the following principles:

- To be developed through co-production, involving public, patients, services, voluntary sector

- To be built on a geography which is understandable, e.g. that people see as a community, that takes account of transport routes
- To be based on practice populations
- To provide a balance between economies of scale, local responsiveness and cost effectiveness
- To reflect the use of local resources (e.g. schools, churches and faith communities, libraries, housing offices, voluntary groups) and knowledge of the community

The integration that Better Care Southampton provides will enable us to achieve the following:

- 7 day working within teams
- Increased use of technology for delivery of services and support.
- Development of a personalised care promoting workforce across all services
- Greater adoption of Personal Health Budgets ,Personal Budgets and uptake of direct payments as the method of arranging care and support to meet individual need, underpinned by implementation of support planning services and changes to finance systems to support delivery of a personalised health and social care environment
- Introduction of a common trusted assessment and planning tool across health and social care plus proactive risk profiling using combined intelligence
- Implementation of accountable professional role for every person identified as at risk to oversee the person's integrated care plan
- Full integration of mental health into the integrated care model
- Introduction of a single point of access for integrated health and social care providing user friendly information that allows people to assess their own needs and onward referral for intervention
- Increased use of self management approaches

Responsive discharge and reablement

This includes:

- **Redesign of an integrated health and social care rehabilitation/reablement service for the city** bringing together the following individually managed services:
  - Brownhill House (City Council reablement residential provision) and the RSH wards (managed by Solent NHS Trust)
  - Telecare and telehealth
  - City Care First Support (CCFS and CCFS 24) which is a City Council "reablement team", the function being to offer practical support and encouragement to clients in their own home focussing on goal orientated plans that promote independence. The team works with160 Clients (day time) and 15 Clients (overnight).
  - City Council Reablement Team which is a new SCC team developed to act as the practitioner support to CCFS introducing a multidisciplinary team (MDT) approach to reablement goal planning. The team is made up of care managers, OT's and OTA's.
  - Health Community Rehab Teams provided by Solent NHS Trust which are locality based and multi-professional, comprising of Occupational Therapists, Physiotherapists, Associate Practitioners, Community Support Workers, OPMH Support Workers and Consultants in Integrated Medicine for Older People. The teams support people with complex rehab needs in the community, and specialise in the assessment and treatment of falls.

- Rapid Response and Out of Hours service provided by Solent NHS Trust which is a multidisciplinary health and social care team working in Southampton City caring for vulnerable adults who have a medical, nursing or social crisis and can be cared for safely at home for up to seven days. The service also provides nursing care out of hours and on occasions earlier hospital discharges for clients awaiting Care Package start dates for up to seven days.

- Reablement and rehabilitation services help people maintain or regain their ability and confidence to live at home following a period of instability. Key aims of the integrated service will be to:
  - sustain recovery momentum and build confidence
  - focus collective resources to improve potential for successful reablement
  - develop a culture that promotes independence and self management as the default position
  - reduce demand for nursing/residential care or long term social care input
  - reduce, delay or negate the need for people to access acute services through proactive management of care and risk in the community
  - support effective and timely discharge and reduce risk of readmission

- The integrated service will be available 7 days a week and enhanced to provide more people with reablement opportunities. Discharge planning will start at the point of admission or as soon as possible after stabilisation of a crisis and there will be a focus on reablement earlier in the patient's pathway to support speedier recovery. Service users will get tailored and practical support. Straightforward needs will be met early without the need first for extensive assessment. Reviewing processes will be developed to identify people who may not have been ready for reablement initially but following a period of care, reablement may become an option. Explicit methodology will be developed along with consistent, clear routes into reablement.

- There will be much stronger emphasis on embedding a reablement culture across wider community provision and supporting people to engage with existing support in the community, recognising that reablement is wider than the activity associated with a distinct team. This will include enhancing the reablement focus within the locality/cluster teams and with domiciliary care, nursing and residential home providers. In developing the model consideration will also be given to which functions should remain central city wide functions (e.g. community beds, out of hours cover) and which would be better integrated into the locality/cluster teams.

- A key element of the service will be falls prevention. This will include development of a liaison function between the fracture clinic and rehabilitation/reablement team to ensure that all fallers are followed up and an appropriate management/rehabilitation plan is devised, including use of medication. Discussions are also underway with the voluntary and community sector, housing and leisure providers to develop a programme of exercise that patients can be referred into to improve core strength and balance.

We will use the Better Care Fund to:

- Ensure 7 day availability across service
- Ensure more proactive response to meeting straight forward needs
- Increase use of technology for delivery of services and support.

Other key aspects of the model (not solely dependent on the Better Care fund) include:

- Building a reablement culture into wider community provision, e.g. domiciliary care, nursing and residential providers
- Increasing use of self management approaches
- Improving focus on helping people plan to return to employment

Building capacity

This includes:

- **Increased support for carers -** The Council and CCG have pooled available resources to re-commission direct support services during 2014/15. These services will streamline current provision while expanding the identification, advice, information and support provided to the increasing number of unpaid carers. This work is ambitious in its remit and will work with young, adult and older carers in appropriate ways. Services are required to meet the critical areas set out nationally and locally, in particular supporting those with caring responsibilities to identify themselves at an early stage, providing accessible and meaningful information through website, literature, face to face contact and wider technical communication channels, recognizing carers in their own right, maximising the education, employment, income and benefits of carers and building community capacity to improve the wellbeing of carers (and those cared for). This will support the new eligibility framework within the Care Act where, for the first time, councils will be under a duty to provide support for carers who have eligible needs. Initial modelling work suggests that between 5% (249) and 25% (1243) carers providing 50 or more hours of unpaid care per week will request an assessment of need in 2015. As awareness increases over 2015, it is anticipated that a further 5-10% of carers will request an assessment of need in 2016. It is planned to substantially increase the number of carers identified from April 2014, rising from under 3,000 to over 5,000 by March 2015. This will be supported by the creation of a single contact point for advice and information for all adult carers in Southampton.

- **Development of more person centred approaches.** The philosophy of personalisation is relevant to all residents, of all ages, in Southampton to ensure they have the greatest level of choice and control over the care and support needs relevant to them. This includes individuals being able to access good clear and accurate information to support them in making well informed and relevant decisions, through to personal budgets offered and taken by the individual in a way that they feel they have as much choice and control as they would like. Person centred care sits at the heart of personalisation and requires the workforce to work with the individual, once they need care and support, in partnership, so that the individual's expertise and skills about their own situation is combined with the expert knowledge of the professional. Over the next 5 years, we will be improving uptake of Direct payments for residents accessing adult social care. The council currently has a low take up of direct payments in comparison to other authorities. The focus will also be on increasing access to personal health budgets for those eligible for continuing health care (during 14/15) and those with long term conditions (from 2015). We will be developing our workforce to promote the philosophy of personalisation, supported by a CQUIN scheme as part of all our NHS provider 14/15 contracts that requires organisations to self assess where they are in terms of staff awareness, systems and practice and set their own action plans for improvement. Through commissioning we are ensuring a variety of Support Planning approaches that empower and enable individuals to plan their care and support, drawing on strength based approaches, maximizing individual assets and local communities.

- **Development of community assets -** This will include maximising use of local facilities and gathering and making available information about activities and support networks that promote good health and wellbeing such as access to public transport, housing advice and leisure options. Gathering of local community intelligence and building partnerships with

the community, and other stakeholders such as police and fire services, will be a key priority for each of the cluster teams working in shadow form during 2014/15. Community development will be further supported by the **introduction of a community/support navigator role to act as a single point of contact in each cluster.** This role will also include building a knowledge base of local resources/facilities, signposting staff and service users to services/community assets and stimulating community development. We have been further defining this role in partnership with Healthwatch and the voluntary sector with a view to appointing the first care/support navigators later this year. It is envisaged that this role could be undertaken by any discipline or agency and would not require a formal health or social care qualification.

- **Placements and packages –** our commissioning strategy will take into account profiling of future needs and changing demographic factors. It is expected that demand for long term residential and day services will change over time as many older people will want to stay at home for as long as possible. This will require changes in the market to maintain more people at home, remaining healthy and with a sense of wellbeing for longer. This will include reviewing and adapting City Council owned housing stock and development of extra care provision. There are already examples of this underway within the City. The Integrated Commissioning Unit will have a key part to play in shaping the market, for both commissioned provision and provision purchased directly by people through personal health budgets/direct payments or self funders. For this reason, the City Council and CCG have invested specifically in a market development team which forms part of the Integrated Commissioning Unit and in the development of a capacity planning tool
- In the shorter term, the Integrated Commissioning Unit has embarked on a programme of quality and capacity development within nursing homes in order to reduce delayed transfers from hospital. This includes strengthening nurse leadership, improving nurse recruitment and development and negotiation with nursing homes who have voids to take social care clients.

The integration of resources under the Better Care Fund enables us to:

- Develop markets and communities to maximise local capacity to support health and well being of community, including local action to reduce loneliness and social isolation, achieved through robust communication and engagement work
- Develop proactive support through voluntary sector partners to attract and maximise alternative funding opportunities (e.g. Big Lottery, Trust funds) into local communities of identity (e.g. ethnicity, diagnosis, neighbourhoods)
- Provide an integrated health and social care information, advice and guidance service, linked to single point of access
- Develop markets and communities to provide an active and vibrant environment for social enterprise, micro enterprises and self help mechanisms to flourish
- Increase support for carers through new jointly commissioned support services, underpinned through better information for carers, greater identification within community services and increasing assessments
- Implement support planning services to empower and enable individuals to plan their own care and support to those with single diagnosis or low to moderate FACS eligibility.
- Provide greater encouragement and support for self management and person centred care planning through community and early contact points
- Refresh demand and capacity plan for community support (nursing homes, residential homes, day care)
- Quality and capacity development programme with local nursing homes

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

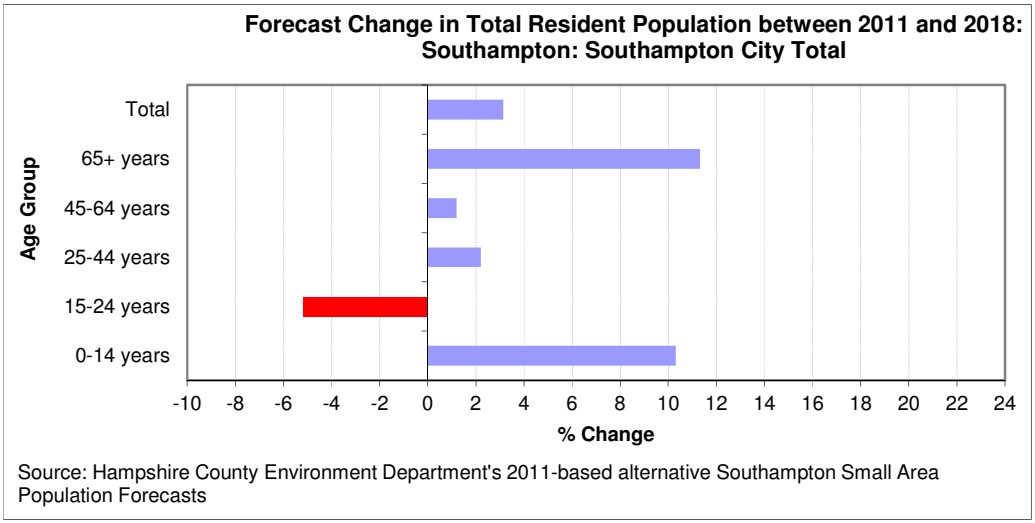
There is a strong case for change. CCG spend on acute activity is 54% and growing, rates of unplanned admissions and delayed transfers are above the national average, pressure on beds is unsustainable and unsafe and there are high rates of admission to residential and nursing homes. A higher proportion of older people in Southampton rely on input from social services than is the case nationally (5.2% compared with 3.8%). This is against a backdrop of rising need.

There are health and social care challenges associated with key population changes that we need to plan for and address. Specific challenges highlighted in the JSNA include:

- The increasing proportion of older people and accompanying increase in dementia
- The increase in unhealthy lifestyles leading to preventable diseases
- Work stresses and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (education, poor housing, transport and economic regeneration)

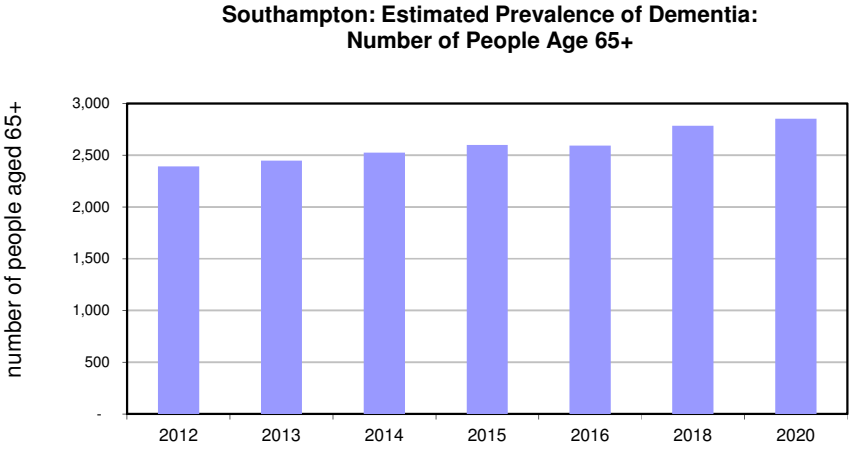
In 2011 the Census recorded the resident population of Southampton to be 236,900 with 268,200 people registered with GP practices in January 2013. In Southampton 17.6% of residents were born outside UK which is a greater proportion than in any of the city's comparator authorities. Southampton has a higher proportion of households where no-one has English as their main language (7.7% compared to 4.4% nationally).

The overall population is forecast to rise by 3% between 2011 and 2018. The over 65s population is set to increase by 11% (see below) and the number of people over 85 years from 5400 to 6100 between 2012 and 2019.



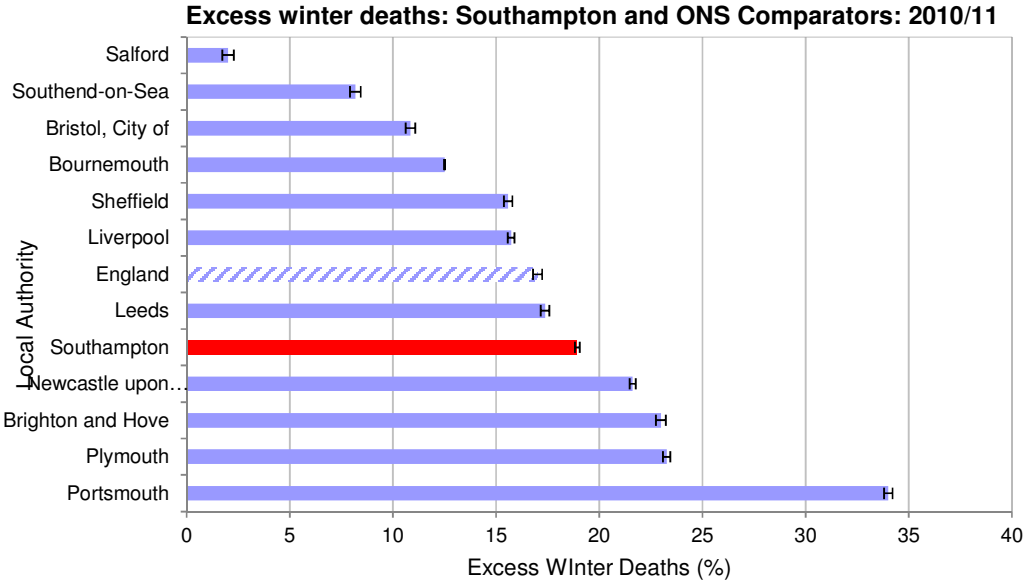
Source: Hampshire County Environment Department's 2011-based alternative Southampton Small Area Population Forecasts

Accompanying this rise in the older population, Southampton is seeing an increasing number of older people living with dementia.



Data Source: Projecting Older People Population Information System (POPPI)

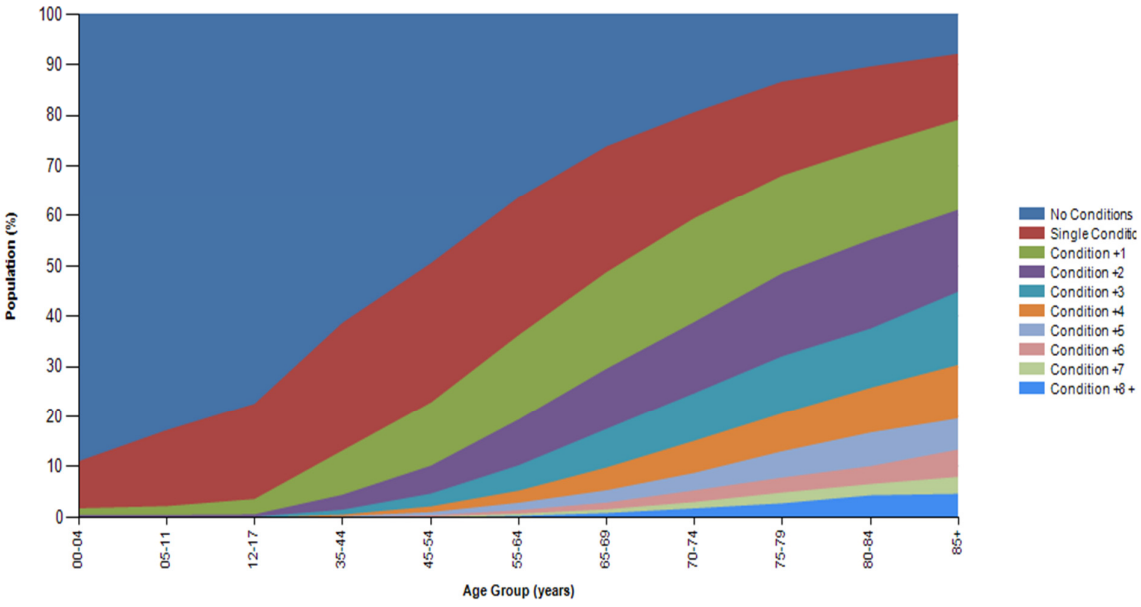
Social circumstances are also changing. There are far more people living alone - 11,283 households in the city consist of older people living alone with increased risk of loneliness and associated poor physical and mental health. More people also own their own homes. There are a significant number of people who die prematurely during winter months in Southampton (see below).



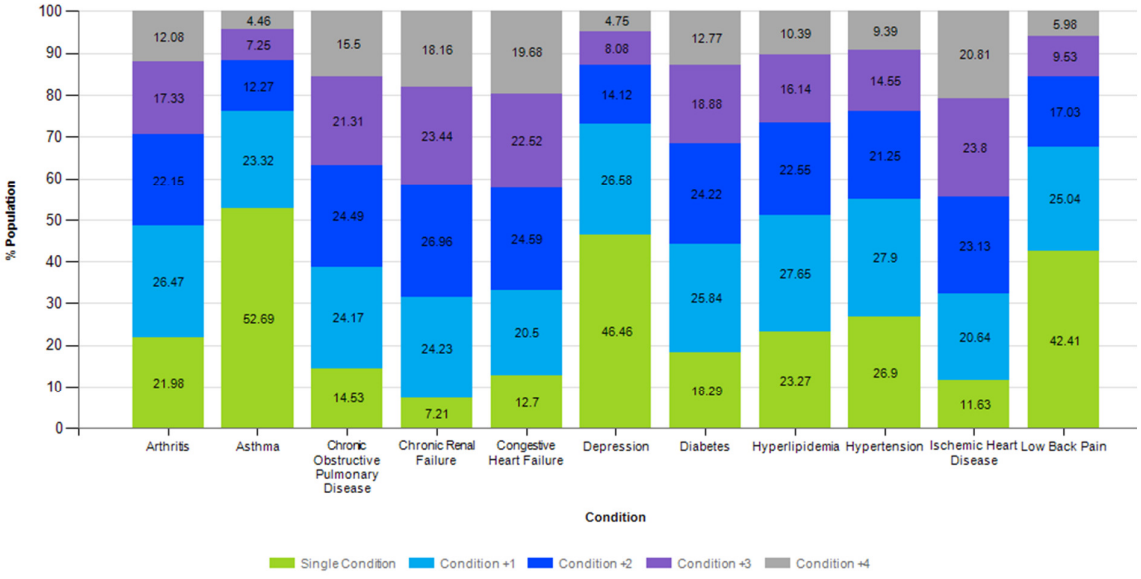
Source: Public Health Outcomes Framework

The number of people with long term conditions is also increasing. There are around 86,000 people in Southampton estimated to be living with long term health conditions, such as asthma, diabetes, heart disease, hypertension, epilepsy and severe mental illness. The table below

illustrates the number of people diagnosed with one or more long term conditions by age in the City, demonstrating that as people get older they are likely to have more long term conditions.



Data from 12 GP practices in Southampton was analysed showing that 85% of people aged 65+ have at least one chronic condition and 30% of them have more than four (amongst the over 85's the equivalent figures are 93% and 47%). The diagram below further illustrates this co-morbidity:



The changing needs of the population are putting increased pressure on health and social care at a time when resources are reducing. Legislative changes, for example the duties posed by the new Care Act, are also requiring services to identify need earlier and respond to a national minimum eligibility threshold.

Attitudes and expectations are also changing. The expectations of people who will reach older age in the next 10 to 20 years will be different to older people now. People are used to expressing far greater choice and control over their needs and aspirations. Currently, people are much more socially mobile than before and have generally experienced a wider exposure to different goods and services. People now and in the future will expect more from their local authority, NHS and care providers in terms of the range and quality of services on offer.

The importance of prevention and early intervention are well evidenced to help people stay well, live independently and remain healthy for longer. It is important to ensure that a wide range of good quality preventative services are available to support people across the spectrum of need, including those who do not approach the Council for support or meet its eligibility criteria. This will ensure that people do not go without the support which could prevent critical needs developing in the future.

All this means that historical models of care are no longer appropriate or affordable. There is a need for more planned care, provided earlier in settings outside of hospital, greater integration between health and social care to improve service user experience and achieve efficiencies, better use of community resources, better service user information about what is available and a much more personalised approach to the way care is accessed and delivered, responsive to both clients eligible for social care and those who are self-funders. This requires a radical transformation of primary, community and social care as well as the surrounding environment including individuals, family, carers and voluntary sector services.

<u>Areas of focus</u>

We have chosen older people (over 65s) and those with long term conditions as the initial focus of our integrated care model as this is where we have identified the greatest need, both in terms of population forecasts and vulnerability to poor health and poor social outcomes as well as the greatest opportunity to make a difference from a more integrated health and social care model.

A review of unplanned hospital admissions for 2013/14 (27,620) showed that 38% (10,260) were over the age of 65. A breakdown of all these admissions (all ages) by HRG chapter showed that the 5 most common types were:

- Respiratory – 10% (2735)
- Cardiac – 12% (3194)
- Digestive – 13% (3615)
- musculoskeletal – 10% (2884)
- childhood diseases and neonates – 15% (4090)

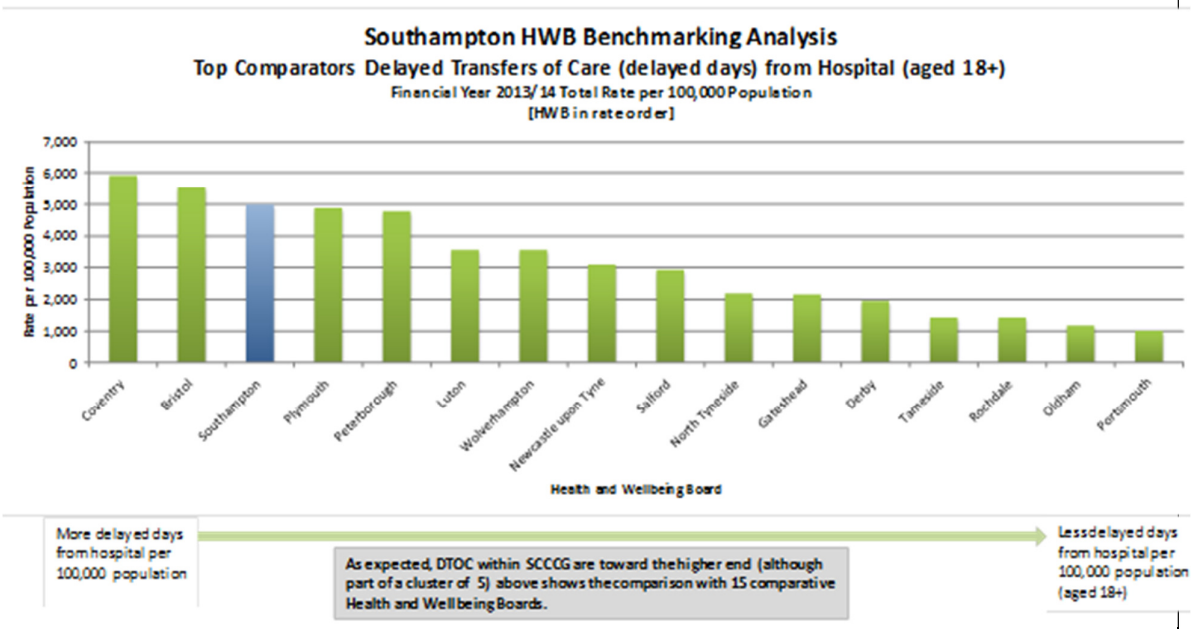
The CCG's QIPP programme is already focussing on a number of these areas, in particular:

- chest pain and abdominal pain pathway
- high volume paediatric admission pathways

Whilst reducing avoidable unplanned hospital admissions is a key priority, our focus for Better Care in Southampton is on reducing pressures in the whole of the health and social care system, the key focus being on supporting people to stay safe and healthy in their own homes and communities. This is supported by recent reviews of our health and social care system. In 2012, for example, following sustained difficulty in maintaining the national A&E waiting time standard (of 95% of people being admitted or discharged within four-hours), the Emergency

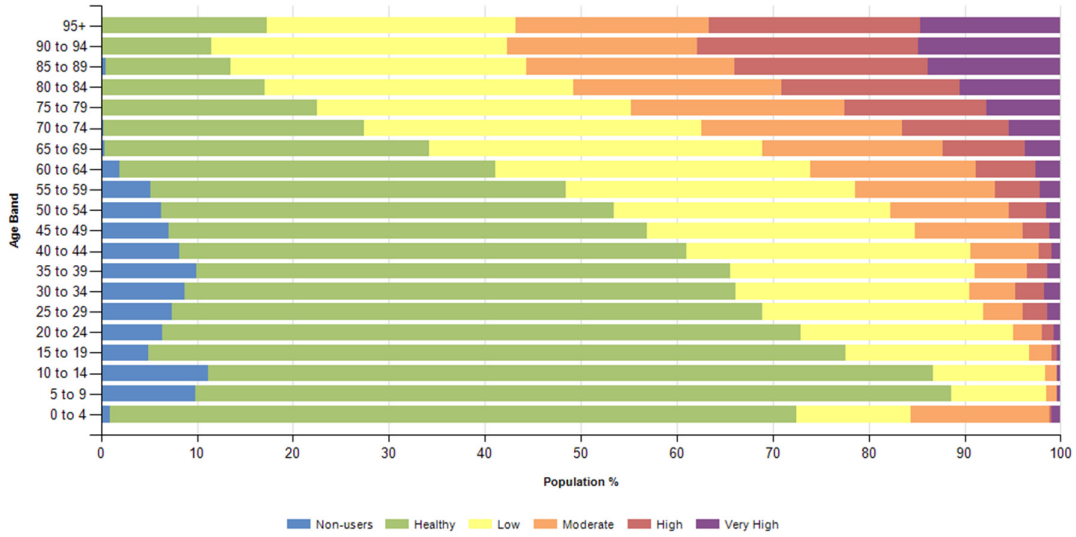
Care Intensive Support Team (ECIST) carried out a review of provision both within UHS and across the wider health and social care system. They concluded that, despite some successes, there had been an over-reliance on schemes to avoid admission and insufficient emphasis on improving discharge planning and onward care. In essence they concluded the whole health and care system needed to change from a culture of trying to 'push' people out of hospital to release capacity, to one where community services intervened to help maintain people in their own homes and 'pull' patients through hospital by means of pre-planning effective community or home-based support.

This is supported by the chart below which shows that the numbers of delayed transfers of care (DTOC) in Southampton are high compared to other areas.



In terms of demographics, Southampton is most comparable to Portsmouth, Salford, North Tyneside and Plymouth.

Looking more widely at the use of health resources by age, the ACG risk stratification tool is able to break down the population into Resource Utilisation Bands (RUB) to show that as people get older they use a greater amount of health resource. The average cost to the NHS of a very high Resource Utilisation Band (RUB) patient is £19,100 per annum, the cost of a high RUB patient is £10,631 per annum, the cost of a moderate patient is £4343 per annum, compared to the cost of an average healthy patient £694 per year.



In Southampton, the population breaks down roughly as follows:

RUB Group	Number Patients
Very High	4,997
High	8,978
Moderate	21,977
Low	60,539
Healthy	137,576
Non users	15,022
TOTAL	249,089

Approximately 5% of Southampton's population are in the very high and high groups. Considering this alongside the Kaiser Permanente Triangle and rates of emergency hospital admissions by different risk groups (based on Wennberg et al 1996), it is possible to make a judgement as to how many hospital admissions might be attributable to this group – ie. 34.1% or a total of 9418 using 13/14 data. Those patients in the moderate risk category who would benefit from supported self care account for roughly 25.5% of total admissions, so approximately 7043.

Roland M BMJ 2012. Preventing Emergency Admissions – excessive focus on "frequent flyers"?

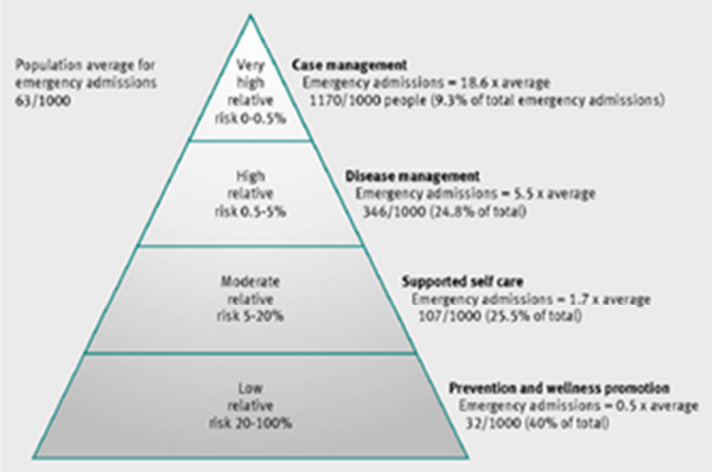


Fig 2 Rates of emergency hospital admission by different risk patients (based on Wennberg et al 1996).[9] Percentage of all emergency admissions is equal to the relative rate multiplied by the size of the population group

Our Better Care programme is therefore focussing on older people and those with multiple long term conditions and seeking to intervene early and proactively in an integrated way to help them to keep themselves healthy and well in their own homes and communities. We have identified the following key schemes:

1. Local person centred coordinated care - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, promoting self management, 7 day working – this will impact on those people in the highest risk groups identified above who will benefit from case management and disease management, roughly 5% of our population (around 12,000 people), but also support those in the moderate group (35,500 people) who would benefit from supported self care. The majority of this target group, as it has been shown, will be older people (65+) and those with multiple long term conditions. This is the group who are also most reliant on social care resources. It is estimated that the high risk groups account for around 9,400 unplanned admissions and we are aiming to prevent approximately 200 (approx. 2%) of these over the next 12 months through a combination of this scheme and the more responsive proactive discharge, rehabilitation and reablement model described below. This scheme also focuses on the medium risk group who would benefit from supportive self care and it is estimated that this group accounts for approximately 7,000 unplanned admissions of which we are aiming to prevent 400 (5-6%) through this scheme. This scheme also contributes significantly to our targets for reducing permanent admissions.

2. Long Term Conditions pathways – supporting local person centred coordinated care – key areas of focus are COPD, given the high proportion of respiratory admissions, and diabetes. We are expecting the COPD element of this scheme to reduce respiratory unplanned admissions by a further 5% in 2015/16 from the 2012/13 baseline. This equates to approximately 135 fewer unplanned admissions. With regard to diabetes and the other long term conditions pathways, we are reviewing how these can better support the model of local person centred coordinated care and are attributing around a further 120 fewer unplanned admissions to this scheme.

3. Integrated discharge, reablement and rehabilitation service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deteoriation, as well as supporting people's recovery and reablement following a period of illness. The scheme will particularly focus on reducing long term admissions to residential and nursing homes and preventing delayed transfers of care (DTOC). Our plan is to reduce DTOC in 15/16 by around 3 per day from the 14/15 position. This scheme will contribute to this reduction, alongside the work we are doing to develop the market for packages and placements. Our target reduction for reducing permanent admissions is 6.1% for 14/15 and 9.7% for 15/16 compared to the previous year.

4. Community development – this scheme is aimed at developing local community assets and supporting people and families to find their own solutions. This is key to the overall development of our local person centred coordinated care model.

5. Supporting carers – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care.

6. Developing the market for placements and packages – this includes work we will be doing to develop the market to provide greater opportunity and choice, encourage a recovery/reablement focus and support people to remain as independent as they can be in their own homes. It is key to reducing delayed transfers of care (we estimate that it will account for a third of our target reduction) and will make a significant contribution to our target for reducing permanent admissions.

Please note that the figures quoted in relation to reduction in unplanned admissions include growth at 1% per annum.

Our analysis of the impact that these schemes will have on the drivers covered in our Case for Change can be found in Annex 1.

The identification of these schemes to meet the needs of older people and those with multiple long term conditions has been based on:

- Views of a wide range of clinicians and practitioners based on evidence and experience. A series of workshop events reviewed national evidence and local best practice, considered potential impact and effectiveness, along with ability of the system to implement the changes, to identify key priority areas for focus. Part of this work was facilitated by Peter Colclough who had been closely involved in the successful implementation in Torbay (Kings Fund 2011 Integrating health and social care in Torbay Peter Thistlethwaite)
- User feedback as outlined in Section 8a and the outcomes from the work with TLAP. This enabled us to identify "Joan" who is central to the work in Southampton. She is a fictitious user of health and social care services in the City but has been used to focus thinking about how care could be improved for her.
- Review of evidence from elsewhere undertaken by CCG Integrated Care Clinical Lead. This was used as a basis for the work, especially the review of learning from Department of Health pilot sites which evidenced the importance of single point of access, integration of health and social care assessment, development of a shared care list identifying the most vulnerable, collaboration (GPs, community health workers, allied health services, social services, voluntary sector, housing, secondary care), provision of key worker as primary contact point, integrated information systems, virtual ward rounds involving all professionals not only health, individual care planning for patients with an emphasis on self-management and joint working across GP practices.

- Review of evidence related to priority areas, as outlined in detailed scheme descriptions in Annex1.
- Work with other areas, especially NE Lincolnshire, Leeds and Torbay. This provided information on outcomes and effective approaches.

This has been further substantiated by evidence shared as part of the current Better Care submission which provides a synthesis of the integrated care evidence base. This supports the local prioritisation of local person centred coordinated care with multi-disciplinary teams developing individualised care plans and effective care co-ordination and case management. Other local priorities of intermediate care, reablement and rehabilitation, falls prevention and a focus on self-care are also identified as effective.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The timelines below map out the key milestones associated with delivery of each of the 3 components of our model. Each section also outlines the key interdependencies.

1. Person centred local coordinated Care

Scheme	14/15 Milestones	15/16 Milestones	16-18 Milestones	18-20 Milestones
Development of person centred local coordinated care	Implementation Unplanned admissions DES (May – Sept) Extensive stakeholder engagement around function and requirements of clusters (May – Oct) Implementation of Everyone Counts practice based nurses for over 75s scheme in primary care to increase capacity (from Oct) Cluster teams established and beginning to work together (Oct – Mar) Develop key components of integrated working: risk profiling & proactive case management, care coordination & key worker role, single	Embed key components of integrated working focussing on over 75s and people with LTC: risk profiling & proactive case management, care coordination & key worker role, single assessment (Apr – Sept) Enhance psychological support for people with LTC – roll out of IAPT training amongst cluster teams (Apr – June) Implement single point of access for integrated health and social care (Apr – Sept)	Roll out of key components of integrated working to adults with LD and MH problems and children & young people	Continue to embed, evaluate and develop

		assessment - focussing on over 75 population (Oct – Mar) Interoperable IT solution in place using Hampshire Health Care Record, accessible to health & social care staff and receiving health & social care feeds (by Nov) Clusters operating each with development plan in place (Jan – Mar) Scope single point of access for integrated health and social care (Jan – Mar)			
	Review Long term conditions pathways	Embed and evaluate integrated pathway for adults with COPD (by Mar 15) Review and develop future model for heart failure (by Mar 15) Diabetes • implementation of primary care Diabetes Accreditation Scheme to enhance quality of care (from Oct) • Implementation of integrated model of care, with stronger focus on self management & professional education (Oct – Mar) • Finalise plans for footcare (by Jan) Implement scheme to reduce Influenza and Pneumonia admissions with focus on vaccination coverage and	Diabetes - Implementation of new footcare MDT to reduce foot disease (from April) Review and develop how specialist LTC support will be provided in future through cluster model (Apr – Sept) Commence recommissioning process for LTC (Sept onwards)	New model in place (from Apr 16)	

	admission avoidance (Sept – Dec)			

Key interdependencies for this part of our strategy include:

- Good robust engagement and coproduction with all stakeholders – see our Communication and Engagement Plan for how we are taking this forward.
- Workforce development – a workforce development plan is being developed in 14/15 to underpin the change in culture and new ways of working (including trusted assessor model, person centred planning, motivational skills) required by the cluster model
- Primary care development and GPs signing up to new enhanced service for unplanned admissions – all 33 GP practices have signed up to the new Proactive Care programme.
- Identification of suitable accommodation within each cluster area to provide a team base
- Information sharing agreements and interoperable IT across health and social care settings – we are working with our Commissioning Support Unit (CSU) to develop the appropriate information sharing agreements, templates and IT interoperability. Work is underway to produce a shared care plan prototype using the Hampshire Care Record which will be available for roll out by November 2014.
- Strong leadership – this is provided through the Integrated Care Board which includes leaders from across the health and social care system, as well as the voluntary and community sector, and oversees our Better Care work programme. Leadership is also strong through our Health and Wellbeing Board.

2. RESPONSIVE DISCHARGE & REABLEMENT - SUPPORTING TIMELY DISCHARGE AND RECOVERY

Scheme	14/15 Milestones	15/16 Milestones	16-18 Milestones	18-20 Milestones
Integrated Discharge, rehabilitation and reablement service/hub	Model developed and agreed (by July) <u>Phase I implementation</u> New discharge pathway agreed (by end Aug) Discharge planning to commence at point of admission (by end Sept) Trusted assessor model rolled out, all discharge facilitators and inreach coordinators trained and able to restart and set up simple packages (by end September) Discharge to assess model in place – additional 12 beds commissioned in nursing homes to	<u>Phase II implementation</u> Implementation of wider integration (Jan 15 – May 15) Fully integrated service in place (June 15)	Continue to embed, evaluate and develop model	Continue to embed, evaluate and develop model

		support model (from Sept) IDB manager in place to strengthen leadership (by Nov) Additional domiciliary care resource in place (Feb) Implementation new integrated falls pathway to identify and target all patients who have fallen for rehab and prevention future falls (Jan – Mar) <u>Phase II</u> Work up and Consultation on integration proposals (Sept – Dec) Commence implementation (from Dec)			
	Telecare/telehealth strategy	Maximise potential of existing community alarm service to increase access to telecare (Nov – Jan 15) Market testing and development of enhanced offer (Nov - March)	Implement enhanced telecare/telehealth offer (from Sept)		

Key interdependencies for this part of our strategy include:

- Culture change to build reablement ethos into wider community services, e.g. domiciliary care
- Good robust engagement and coproduction with all stakeholders – see our Communication and Engagement Plan for how we are taking this forward.
- Strong leadership – this is provided through the Integrated Care Board which includes leaders from across the health and social care system, as well as the voluntary and community sector, and oversees our Better Care work programme.

3. BUILDING CAPACITY

Scheme	**14/15 Milestones**	**15/16 Milestones**	**16-18 Milestones**	**18-20 Milestones**
Development of personalisation	Offer personal health budgets to	Personal health budgets offered	Embed person centred care	

	all people with CHC and increase uptake of direct payments (from Apr 14) Workforce development programme to support person centred care in NHS services in place through contract CQUIN (from Apr 14)	to all adults with LTC and direct payment uptake further increased (from Apr 15) Support planning service in place for direct payments and personal health budgets (from Apr 15)	across all client groups	
Community development	Implementation of community navigator role across the city (from Jan 15) Community development strategy developed (Sept – Dec) Implementation (from Jan)	Implementation community development strategy Further embed and evaluate community navigator role		
Supporting Carers	New carers information, advice and support services in place (from Sept) Explore options for carers assessments including delegated powers to 3rd sector agencies, online self-assessment and use of direct payments (ongoing to Mar 15)	Roll out carer assessments Actively Increase identification of carers in primary care (from Apr 15)		
Developing the market for Placements and packages	Quality and market development programme in place to improve capacity (from Apr)	Embed changes to residential, day and respite provision (Apr – Sept)	Development of extra care accommodation in city	Continue to embed evaluate and develop

	Demand and capacity scenario planning tool developed (by Jan) Review of day and residential services (Jun – Dec) Redesign day and residential services (Jan – Mar) Review of Respite services (Sept - Dec) Redesign and implement changes to respite provision (Jan - Mar) Complete domiciliary care tender/new framework in place (by Feb)	Demand and capacity plan in place (by June) Phase One Extra Care Housing development	Phase Two Extra Care Housing development	

Key interdependencies for this part of our strategy include:

- Good access to meaningful, accurate, up to date information.
- Finance systems capable of supporting integrated personal budgets.
- Development of capacity to increase carer assessments. This has been specifically included in the Better Care budget.
- Robust market development. This has been recognised in the development of the ICU which has a specific resource for market development.
- Good robust engagement and coproduction with all stakeholders, particularly patients, service users and carers – see our Communication and Engagement Plan for how we are taking this forward.
- Workforce development – a workforce development plan is being developed in 14/15 to underpin the change in culture and new ways of working (including trusted assessor model, person centred planning, motivational skills) required by the cluster model. A CQUIN scheme has specifically been agreed with NHS providers to develop understanding, skills and knowledge of person centred care.

4. INFRASTRUCTURE & INTERDEPENDENCIES

Scheme	14/15 Milestones	15/16 Milestones	16-18 Milestones	18-20 Milestones
Building the contractual infrastructure	Development of core service specification and integrated	Pooled fund agreement in place (Apr)	Ongoing monitoring and review	Ongoing monitoring and review

		performance framework & vary into 14/15 contract (by Oct) Review alternative contractual models which better underpin and incentivise the behaviours and actions required, eg. alliance model (Jun – Mar) Scope and draft S75 pooled fund agreement (Jun – Oct) Section 75 agreement approved (Nov – Mar)	Implement changes to contractual models (in year for 2016/17)		
Communications and engagement	See separate communications and engagement plan				
Workforce development	Development of workforce development strategy to support new clusters (Oct – Mar)	Implementation workforce development strategy			
IT interoperability	Development of shared care plan prototype using Hampshire Care Record (Aug – Nov) Implement and embed use of shared care plan (November – Mar) Hampshire Care Record upgraded with enhanced functionality (by Dec)	Continue to embed and increase usage of shared care plan			

Further detail of the actions and associated timescales can be found in our Better Care Performance report which is attached.

b) Please articulate the overarching governance arrangements for integrated care locally

Development of Southampton's integrated care programme has been coordinated by the city's integrated commissioning unit through its Integrated Care workstream. The Integrated Care Board was set up two years ago to oversee the development and implementation of the strategy. This includes taking a system-wide view of outcomes and service provision for adults and children across all sectors (health, social care, education, housing, public health, voluntary and community) and ensuring that resources across the board are prioritised and organised in a joined up way so as to maximise good outcomes, quality, safety and equity of provision. Specific functions of the board are to:

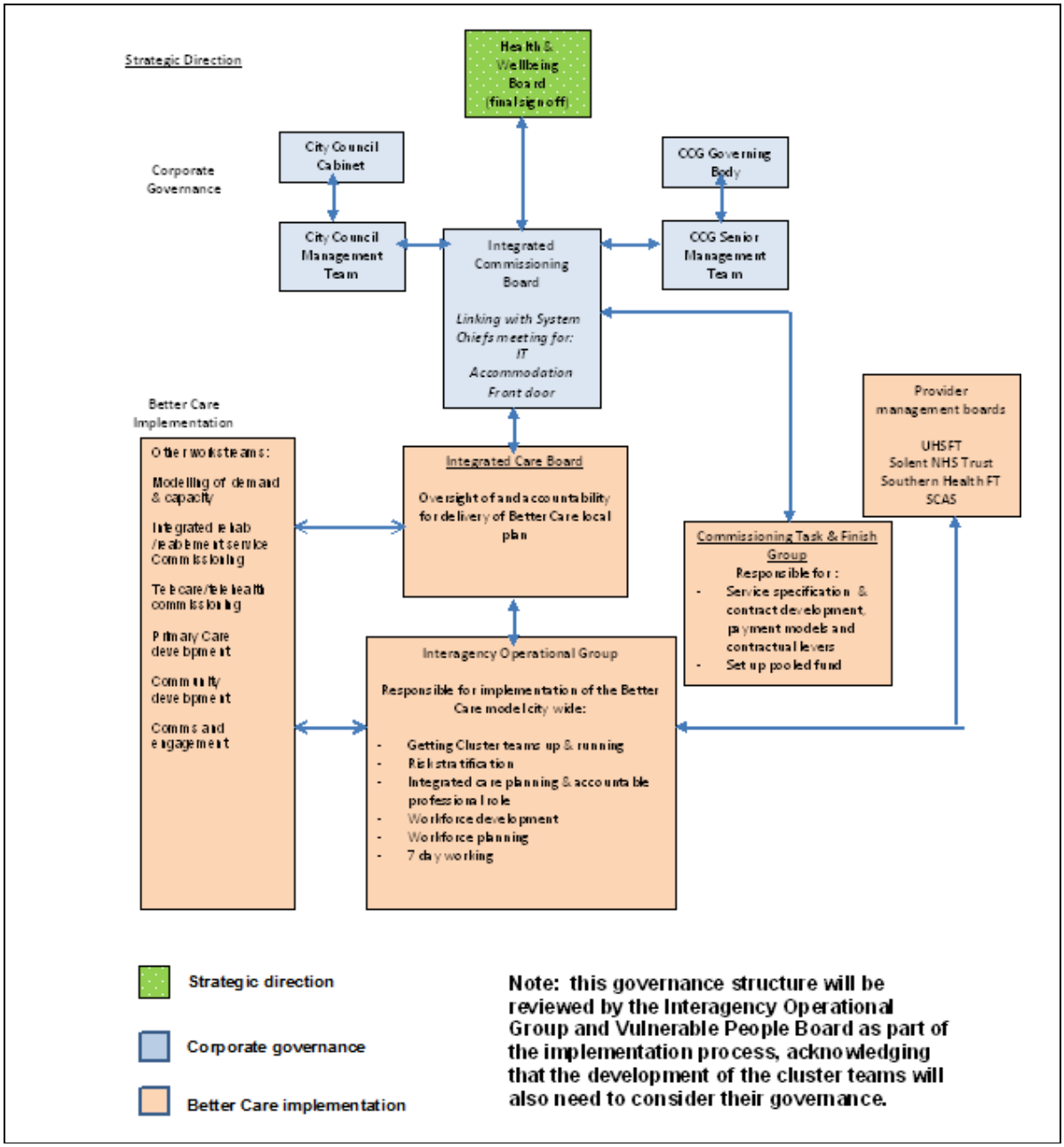
- Strategically inform and manage the delivery of the overall work.
- Review progress, identify any risks, blockages or constraints and ensure they are mitigated.
- Inform and deliver evaluation processes and measures of success that can be monitored.
- Engage with stakeholders to ensure their needs and the needs of all those affected by the Integrated Care programme are recognised and considered and that the aims, objectives and actions of the Integrated Care programme are properly communicated across the system.

Membership of the Integrated Care Board includes CCG clinical and commissioning leads for integrated care, primary care, councillor from Health and Wellbeing board, Public Health consultant, Senior Social Care leads, Community and Acute health provider leads, South Central Ambulance Service, Voluntary sector representative and Housing.

The Board reports monthly to the Integrated Commissioning Board of the City Council and CCG which is a high level board comprising the Chief Executives of the Council and CCG, Director of Public Health, GP Governing Board member, Cabinet member, Chief Finance Officers and lead Directors from the council and CCG. This Board will develop into the Partnership Board for the pooled budget

The Health & Wellbeing Board provides high level oversight of these arrangements, ensuring that partnership arrangements are effective and that plans are robust and both ambitious and realistic in their aspiration.

These arrangements are shown in the diagram below.



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Since submission of our first cut plan and the feedback received, we have been reviewing the governance arrangements to ensure a more robust framework for the operational delivery of the Better Care model in Southampton.

This includes the establishment of the Interagency Operational Group (shown in the diagram above) which brings together clinical and operational management from each of the 3 provider Trusts (UHSFT, Southern Health FT and Solent NHS Trust), the City Council and primary care, along with commissioners, Southampton Voluntary Services and Heathwatch to implement the new structures and ways of working. This includes:

- Establishing the cluster teams

- Risk stratification, integrated care planning and accountable professional role
- Workforce planning and development

A full time Transformation Manager has been seconded from one of the local provider Trusts to support the Operational Group in undertaking these tasks.

A commissioning task and finish group (also shown in the above diagram) has been set up to operate alongside this for a limited period to deliver the underpinning requirements of the model, particularly establishment of the pooled fund, scoping of future contracting and payment models and performance management. This group will be primarily made up of contracting, finance and performance officers.

It should be noted that this structure will be reviewed by the Interagency Operational Group and Integrated Care Board as part of the implementation process, acknowledging that the development of the cluster teams may well lead to some elements of governance being devolved to a locality cluster level.

A Better Care Assurance Report incorporating detailed project plans, progressing monitoring and monthly tracking of performance against the Better Care targets has been produced and is presented each month to the Integrated Care Board, alongside any remedial action plans. A copy of this report is attached. An update on Better Care is also presented at every Health and Wellbeing Board meeting.

Commissioning responsibility for the integrated care model is brought together across care and health services through our Integrated Commissioning Unit. Single, integrated service specifications with an integrated performance management framework will be signed off by the Integrated Commissioning Board. Through the Integrated Commissioning Board, the leadership of the CCG and City Council will have clear and shared visibility and accountability in relation to the pooled Better Care Fund.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Local person centred coordinated care - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working. Including: - Primary care development - Mental health integration
1b.	Long Term Conditions pathways – supporting local person centred coordinated care
2	Integrated discharge, reablement and rehabilitation service Including: - Telecare/Telehealth
3	Community development. Including - Developments to support self management - Community navigation functions
3b	Supporting carers
3c	Developing the market for placements and packages
4	Infrastructure including: - ICU quality, commissioning, market development resource, workforce development - DFG and Social Care Capital Grant

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

The risk log below has been developed in partnership with all stakeholders through the multiagency planning workshops, discussion at HWBB and the Integrated Care Board. It is regularly reviewed as part of the monthy Programme Assurance report to the Integrated care Board.

Risk	Risk likelihood? *1-5*	Potential impact *1-5*	Overall risk factor	Mitigating Actions	Risk Owner & Timescale
Failure to achieve the cultural change required to make this happen	4 Requires very different behaviours and ways of working which will take time	4 If behaviours do not change, new ways of work will not embed. Public will continue to	16	Strong leadership / leadership development programme	CEO/Operational Directors - all providers, SCC, CCG, GP clinical leads, HWB Board (ongoing)

Risk	Risk likelihood? *1-5*	Potential impact *1-5*	Overall risk factor	Mitigating Actions	Risk Owner & Timescale
	to develop. Public confidence in out of hospital services needs to be developed if health service seeking behaviour is to change.	seek hospital based solutions; will be continued over-reliance on public sector.		Robust stakeholder engagement programme Roll out of cluster/locality working during 2014/15 through workshops, co-location, joint working Workforce development programme in place	Comms & engagement leads all partners (ongoing) ICU/Transformation Manager (ongoing) CEO/Operational Directors – all Providers (December 14)
Unable to reduce acute hospital activity leading to failure to release and reinvest funds in out of hospital model or double running and increased costs	3 Target reductions are challenging and buck historical trends. At the same time LTC and frail/elderly populations continue to increase	5 Impact is that we will have £1.5m less to invest in out of hospital model	15	Dashboard in place to report monthly activity against plan to ICB IDB manager in place to strengthen leadership in discharge process	ICU Assoc Director (June 14) CEOs all partners (Nov 14)
Demand for services increases beyond expectation putting additional pressure on system, increasing costs	2 Elderly population is forecast to grow. More and more people with LTCs - however this has been taken into account in our modelling	5 As above. Targets not achieved. Unable to invest in out of hospital services	10	As above plus: Thorough impact assessment to support plans: - implications of Care Act - demographic profiling	ICU Assoc Director (Oct 14)
Failure to establish infrastructure soon enough to support integrated working, e.g. IT systems	2 Plans are in place to develop shared care plan and interoperable IT	4 If shared care planning not possible electronically, less likely to be used and professionals will continue to assess and deliver care in silos. Patients continue to experience uncoordinated care. Care less proactive.	8	Development of shared care plan prototype Information sharing policies in place Hampshire Health Record (HHR) upgrade HHR connectivity with all GP systems and social care	ICU Senior Commissioner/IT lead (Dec 14) As above CCG CEO/CSU (Nov 14) CCG CEO/CSU (Nov 14)
Unable to get buy in from GP practices to the scale of change required	3 GP practices may see this as another top down initiative with little	4 Primary care is central to the success of the model. practices will	12	Extensive primary care engagement programme in place	GP clinical leads/CCG comms lead (Oct 14) GP clinical leads/CCG primary care team

Risk	Risk likelihood? *1-5*	Potential impact *1-5*	Overall risk factor	Mitigating Actions	Risk Owner & Timescale
	meaning to them	be responsible for coordinating care.		Maximise uptake of Unplanned Admissions DES Joint work on model at TARGET Primary care co-commissioning to support delivery of sustainable model of general practice	(Sept 14) GP clinical leads/Transformation manager (ongoing) CCG chair/GP clinical leads
Primary care unable to make the change required due to lack of capacity or resistance to change	3 Capacity in primary care is a major issue.	4 As above	12	As above plus Additional practice based nurses for over 75s in place Targeted support to practices in achieving unplanned admissions DES	CCG Assoc Director (Oct 14) CCG (ongoing)
Unable to get buy in from political leaders to scale of change	2 Political leaders have been involved in workshops and sit on the HWBB. There is good level and engagement and support	3 Failure to agree SCC changes and commitment to model would hamper implementation and impact.	6	Regular updates on BCF at Cabinet Member Briefing and HWBB	ICU Director (ongoing)
Contractual barriers, e.g. unable to secure change fast enough because of contract notice requirements	2 A proactive approach is being taken to reviewing alternative contractual models. Strong engagement & collaboration with existing providers reduces the risk of contracts being used as a barrier to change.	3 Inability to incentivise system to deliver the change.	6	Basic service specification outlining BCF requirements varied into contracts CQUIN in place for person centred care – all NHS provider contracts Alternative contractual models explored Notice given in September contractual letter of any changes during 15/16	ICU Assoc Director (Jan 15) ICU Assoc Director (Apr 14) Integrated Commissioning Board (ongoing) ICU Assoc Director (Sept 14)
Implementing change at scale may destabilise existing providers	2 Likelihood low as intention is to work in partnership with existing providers to deliver model	3 The market is limited and so any destablisation of existing providers will impact on our ability to deliver.	6	Impact assessments completed against the new model of integrated care. Risks to individual providers to be monitored throughout implementation.	CEO/Op Directors all partners via ICB (Aug 14) Integrated Care Board (ongoing)

Risk	Risk likelihood? *1-5*	Potential impact *1-5*	Overall risk factor	Mitigating Actions	Risk Owner & Timescale
Shortage of good quality providers in the market to meet need for home care	3	4 Lack of capacity. Failure to support people in home and inability to prevent admission or enable timely discharge.	12	Joint domiciliary care tender completed Provider Forum established including VCS to share learning and development	ICU Assoc Director (Feb 15) ICU Assoc Director (Jan 15)
Inability to recruit to key posts in out of hospital model, e.g. geriatricians	4 Recruitment to key posts eg. geriatricians, social workers, nursing is currently difficult.	4 Inability to deliver out of hospital capacity required to support people at home. Inability to prevent admission or enable timely discharge.	16	Joint recruitment strategy developed for key posts Workforce development strategy in place (to include consideration of joint posts, joint training opportunities, rotations)	CEO/Op Directors all partners via ICB (Jan 15) CEO/Op Directors all partners via ICB (Dec 14)

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The introduction of the Better Care Fund marks a step change in approach and a new opportunity to make change happen. This nevertheless comes with its own demands – in order to pay for better out of hospital care we have to deliver a corresponding shift of work and money out of acute services. Our plan is to reduce non elective admissions by 3% after population growth (or 2% before population growth is factored in). This is a challenging target. We must also take into account that the Better Care programme is operating in the context of an austere outlook for social care funding which is set to reduce by a third over the coming years.

We will be keeping a tight overview of performance against the Better Care targets, both through our Programme Assurance processes which include monthly reporting of activity against targets to the Integrated Care Board, and through real time information, including the Urgent Care Dashboard and Integrated Discharge bureau. We have profiled our targets month on month over 2014/15 and 2015/16 and are tracking actual activity levels against this profile.

<u>Risk sharing arrangements in place between commissioners across health and social care</u>
We are currently drafting the terms and conditions of the S75 Partnership Agreement for the Better Care Pooled fund. This will include risk sharing arrangements.

<u>Risk sharing arrangements in place between providers and commissioners</u>
The impact of the 2% reduction in unplanned admissions at our local acute trust would see a reduction in expenditure of around £850k, however due to MRET and activity over the baseline being paid at a 30% marginal rate, the actual reduction would be around £250k, with the

balance being released through investment in community services to reduce readmissions. The CCG will hold the reduction in funding from the acute sector and will only release funds into the better care fund at quarterly gateways. To minimise the risk to recurrent MRET investment of around £560k this investment in community services will form part of the Better Care funds; the CCG will not seek to divest of these funds but as the Better Care Fund gains traction use the current investment to refocus upon schemes to further the Better Care aims. The Integrated Commissioning Board will hold a gateway review on a quarterly basis to agree release of investment into the pooled fund.

We are exploring alternative contracting models, recognising that the current contracting system is not conducive to achieving the change we need to deliver:

- Risk and reward (contractual) frameworks for community and acute hospital services are misaligned. Whilst PBR incentivises acute activity, the traditional community block contract presents a disincentive to increasing out of hospital activity.
- Service specifications and contracts are individual organisation/service based (as opposed to focussing on the whole care pathway or person).
- Mental Health services are subject to a separate block contract with limited incentives to work in other health and social care settings.
- There is no open book approach to sharing data and information across the system.

The Better Care Commissioning Group has been specifically looking at alternative models, including prime provider, alliance contracting and year of care tariff options. We are following closely the experience of other authorities and CCGs who are testing these models. In the meantime, our intention is to work with existing providers within existing contracts, and introduce a risk and reward system (potentially tying in CQUIN monies) which focuses on shared delivery of whole system outcomes. This will include the development of a single integrated performance framework across all contracts, as well as revision of service specifications to become outcome based.

It will also involve reframing the block contract arrangements we have with community providers into an outcome based contract with risk and reward payment mechanisms linked to system performance on the Better Care targets. This is in early stage development; our community services provider has been working through a similar reward programme in Portsmouth so we are currently using the learning from here to build into our plans.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Southampton's Better Care plans build on the work we have been doing over the last 3 years under our Integrated person centred care programme and incorporate other initiatives already underway related to care and support. This includes:

- Implementation of Personal budgets and Think Local, Act Personal (TLAP) - Southampton City CCG and Southampton City Council have signed up to Think Local Act Personal (TLAP) and 'Making it Real' (MiR). A programme is in place which continuously reviews our progress against the key features to deliver Personal Health Budgets; 'Making it Real' and 'Integrated Person Centred Care'. This is included in the supporting documentation to our Better Care plans.

- Telecare and Telehealth strategy (included in the attached supporting documentation) – the Integrated Commissioning Unit is currently in the process of rolling out this strategy which focusses on developing robust and far reaching information and advice, increasing the use of telephone consultations, ensuring assessments embed telecare and telehealth by default, harnessing the existing and potential use of personal technology and procuring a new city wide telecare and telehealth service. This has been embedded into our Better Care programme.
- Supporting Carers (including in supporting documentation) – progress to date has included commissioning short break support and a new universal identification, advice and support service which commences September 2014. We have also been working with NHS providers, including primary care, to promote their role in the identification, provision of advice and signposting of carers. The focus going forward is on ensuring the future provision of Carer assessments is both adequate and compliant with the new Care Act. Work will also need to continue to improve the identification of carers within primary care and other NHS providers. This programme of work is fundamental to Better Care and has been integrated into Southampton's Better Care plans and is described in further detail in Annex 1.
- Everyone Counts £5 per head funding – in 2014/15 Southampton CCG is investing an additional £1.287m in practice based nurses to support practices in delivering of coordinated care to patients over the age of 75, including those identified through the DES. This initiative aligns closely to our Better Care cluster model described in Scheme One and provides additional capacity for the more proactive approach we are aiming to achieve.
- The focus on improving discharge processes and supporting people within the community aligns with the refreshed Whole System Urgent Care Action Plan and system priorities identified as part of the Operational Resilience and Capacity Plan for 14/15 which included primary care, in reach co-ordinators / care co-ordinators for enhanced 7 day service and discharge to assess provision.

All the above are integral to Southampton's Better Care programme. The Integrated Commissioning Unit is responsible for bringing these initiatives together and ensuring alignment with the overall Better Care programme.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

All the schemes described in Southampton's Better Care plan are included within the CCG's two year operating plans for 2014 – 2016 and aligned with its 5 year strategic plan: A Healthy Southampton for All - Bringing together a Healthy and Sustainable System. The CCG's plan sets out the following five goals:

- Make Care Safer: We will commission care from safe competent providers. We will listen to local people, gather their feedback on their experiences of local services and act upon it.
- Make it Fairer: We will reduce the inequalities in access to care across our population.
- Improve Productivity (achieving more with less, more effectively): We will prepare the ground for a transformation in care, doing all we can to bring control to the acute healthcare system.
- **Shift the Balance: We will integrate health and care services to ensure a better more streamlined experience for local people. Together with patients, communities and partners we will co-produce coordinated care through the Better Care Southampton programme.**
- Delivering Sustainable Finances: We will plan strategically for sustainable finances ensuring that we are driven by quality whilst being pragmatic about our resources.

The city's Better Care plans have been incorporated into the CCG 5 year strategy and can be found in more detail on pages 19 and 56 of the 5 year plan.

Southampton's Better Care plan is also closely aligned to the JSNA and Joint Health and Wellbeing Strategy. It works to meet a number of the objectives and deliver many of the key actions set out in the Joint Health and Wellbeing Strategy, which was adopted by the Health and Wellbeing Board in March 2013, including to:

- Offer an annual health check to carers and promote support networks for carers across the City
- Review tele-care and tele-health services in the City, re-shape and re-launch these so that local people are more aware of the ways in which they can use technology to retain their independence
- Extend re-ablement services so that people can get help to regain their confidence and skills after an illness or mental health breakdown
- Promote healthy, active lifestyles through a dedicated team of Activity Coordinators
- Increasing the number of people who can say how best to spend the money allocated for their health and care, either through direct payments or personal health/care budgets
- Joining up health and social care services so that the number of assessments is reduced and a person's experience of moving between professionals is much smoother and less fragmented
- Developing a shared understanding of how best to support people to retain their independence and make changes to practice which improve the achievement of this objective
- Promotion of a focus on recovery rather than simply procedures for admission avoidance and/or hospital discharge when people need any form of secondary care
- To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions.
- Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia
- To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions.
- The development of extra-care services for people with long term conditions and those with dementia
- Launching a new approach to provision of aids and adaptations which encourage better access and information for individuals able to fund themselves and improves response times to those requiring equipment to maintain their independence
- Raising awareness amongst all care and health staff about appropriate responses for people with dementia, mental capacity issues including deprivation of liberty guidelines and protocols
- Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system
- Increase public awareness and discussion around death and dying
- Extend palliative care to other diseases besides cancer and ensure access to physical, psychological, social and spiritual care
- Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service)

The Better Care actions are also reflective of priorities in the recently revised City Council strategy 2014-17. These include:

- Prevention and early intervention with outcomes including encouraging active and healthy lifestyles and enabling more people to live independently in their own homes

- Protecting Vulnerable People including work with health to provide effective, seamless services to vulnerable adults
- Affordable housing
- City pride to encourage voluntary work and participation in the life of the city

The Better Care actions are linked to the overall City Strategy 2014-25 which has three key priorities of Healthier and Safer Communities, skills and employment and economic growth with equality. The focus within this includes keeping people healthy, protecting vulnerable people and reducing the negative impact of alcohol with expected outcomes being people staying healthy for longer and improving everyone's wellbeing and people experiencing less social isolation. The City strategy is led by Southampton Connect that brings together senior representatives from business, education , universities, statutory sector organisations, voluntary and community sector.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

A vibrant and sustainable primary care sector is pivotal to our Better Care plans and co-commissioning is therefore potentially a very useful enabler and is likely to have a significant impact on strategic planning over the next five years.

There is a recognised need for a clear strategic approach to supporting the development of general practice to create a model of primary care that is sustainable long into the future. The Phase 1 Report of 'A Call to Action for General Practice' describes a model of general practice that operates at greater scale and in greater collaboration with other providers, professionals, patients, carers and local communities. It also pledges to support more efficient ways of working and remove unnecessary bureaucratic burdens on general practice to free up time for delivery of more proactive, person-centred care. In both the CCG strategy and the Better Care Plan General Practice is recognised as a key enabler in the successful delivery of co-ordinated care.

The CCG has and is further developing a vision for a sustainable model of general practice in Southampton which meets the needs of society in the 21st century. This vision is a model which enables patients with increasingly complex problems to be cared for in the community; provides a wider range of services over a longer period of time; and increasingly will be providing proactive care in collaboration with other health and social care professionals, working across organisational boundaries to meet the needs of individual patients. This will require working in larger organisations, but these organisations must ensure that the element of personal continuing care, that is such an important aspect of the ethos of traditional general practice and a vital part of integrated person centred care, continues. Co-commissioning gives us an opportunity to accelerate progress on this redesign.

Practices are already looking ahead and beginning to make plans to create a more sustainable future for themselves, including; proposals for working together; for anticipating the changing role of general practice heralded by the new GMS contract agreements; and for enabling practices to develop their roles as part of the new model of integrated local teams. The CCG has identified resources that have already been made available through a local improvement scheme to support practices to undertake the organisational development necessary to respond to this strategic challenge. Allocated resources are being used flexibly by practices, both individually and together, to explore and develop sensible models that support delivery of the Better Care strategy and meet the needs of the localised population.

As a membership organisation, we are committed to supporting our practices on their evolutionary journey as they adapt in response to current pressures on their own primary care service and on the health care system as a whole. Financial pressures continue to increase, as do the needs and expectations of a growing population. These constraints drive a move towards integration and collaboration, both in terms of joint operational arrangements and service delivery in general practice and also bringing together primary and community services around clusters of practices in a neighbourhood.

Anticipating this direction of travel, in 2013, the CCG began developing a vision for a sustainable model of general practice in Southampton. Co-commissioning gives us an opportunity to accelerate progress. Southampton is one of the two most vulnerable areas for resilience of primary care in the Wessex area. Co-commissioning will allow us the flexibility to resource primary care in a way that will deliver responsible, sustainable general practice long into the future; a fundamental requirement for the success of Better Care.

The CCG has expressed an interest in delegated co-commissioning for local contracts, including enhanced services. The vision for the future of general practice is for locality-based clusters with fully integrated primary and community teams sharing a vision of holistic, person-centred care. Co-commissioning will make it easier to align general practice with the clusters which were designated after an extensive consultation with stakeholders and will be based on natural communities of approximately 50,000 patients.

We also expect to be able to use co-commissioning to stimulate and encourage use of care plans and alignment with Better Care. We recognise the need for system-wide transformation and efforts to review entire pathways of care are hampered whilst primary care is commissioned by a separate organisation.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The local definition is to ensure that resources are available to provide appropriate support for those who meet the current eligibility criteria and effective signposting for those who do not. The key focus for achieving this though, within the challenge of growing demand and increasing budgetary pressures, is to reduce the demand being made on social care. This is through the development of integrated approaches to identify need and intervene earlier as well as helping people regain their independence and through this reduce the need for ongoing care. For example helping older people to be independent for longer and delay the need for long term care services such as care homes.

Eligibility criteria for Social care support in Southampton is assessed for an adult aged 18 years or over, living in Southampton, who needs long term care because of difficulties related to older age, long term illness, disability or mental health problems or a carer who supports an adult with such needs. Eligibility is measured against a range of factors including:

- the risk to persons health and safety
- how much independence and choice they have

- how well the person can manage daily routines
- how far the person can get involved in family and community life

Priority for services is given to those residents whose needs have been assessed (through work with the individual and family or carer) as either critical or substantial, based on Department of Heath Guidance 2010. Those assessed as having either moderate or low needs are “sign posted” to other organisations and services where appropriate.

In addition though, we are maintaining services outside this where a short term piece of work may stop someone slipping into becoming critical and substantial – this means widening numbers who access effective reablement.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

City plans such as the Health and Wellbeing Strategy and Joint Commissioning strategy informed the priorities for use of the funding transfer from the NHS to Social care and use of Reablement money. Part of this was maintaining current eligibility criteria and this element will be maintained within the Local plan. There is especially investment into improving social care outcomes and widening access to reablement to help people support themselves and others in their communities, which has benefits for both health and social care. Within the overall Better Care model adult social care is transforming the customer journey. The vision behind this is “we assist people to find personal and practical support to lead full and active lives, maintain their safety, and have choice, control, independence and dignity”.

The journey will commence with improved single point of contact via single telephone number and improved web pages for initial screening, information and advice and guidance. An online knowledge hub and service directory will help people to be able to help themselves. This element is being developed within the local authority as a basis for a wider system model. The intention will be for increased access to reablement and the spending supports this element. This will be integrated with other rehabilitation services currently provided by health, for targeted support to increase independence. Through these approaches, demand for extended social care involvement for those who meet eligibility criteria will be reduced. The new model will refocus extended involvement from social care onto the regular reviewing of goals set via assessment and support planning.

This change is transformational for Southampton and is starting to show a change. For example in July 2014 64% of people who were supported through the reablement service did not need any further social care support at the end of their reablement period. This is a significant improvement compared to previous years.

Proposed local schemes and spending have also been developed that will further support the commitment to maintain eligibility, including responding to increasing demographic demand. These approaches include:

- maximise independence through improved integrated re-ablement and rehabilitation and responsive discharge
- access to telecare/telehealth services, to help people regain their independence and reduce the need for ongoing care
- supporting increased pace of roll out of personalisation and direct payments – including the market management and peer support development . This will create more choice and control for users and offer better value for money
- ensuring carers have access to appropriate resources and feel supported
- widen peer and community/voluntary sector support availability

The outcome of the social care transformation linked with the initiatives above will reduce demand for long term support or the level of support required.

The development of locality clusters will enable, through the use of proactive risk profiling, the identification of individuals at an early stage who may benefit from support.

There is already a strong commitment in Southampton to focus on outcomes for our population rather than for our organisations and this has been illustrated through proactive partnership working, such as regular joint meetings of the Council and CCG executive teams and the implementation of an Integrated Commissioning Unit. The intention is to build on the resource identified within the Better Care Fund to commit a greater combination of our health and care budgets into a pooled fund and base its use around the localities, people and outcomes, not institutions. This will protect social care services to achieve the outcomes outlined within the plan which support a reduction in demand to allow existing resources to be used more effectively for those who are eligible. This will include use of information sources to target more precisely our increasingly scarce resources and truly find out how many of our resources are ineffectively used at present.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The elements that have been included within the Better Care Fund that are supporting the Local Authority in the implementation of the Care Act in 2015/16 are:

Personalisation	£13,000
Carers assessment and support	£221,000
Information advice and support	£110,000
Quality	£22,000
Safe-guarding, (SSAB)	£36,000
Assessment and Eligibility	£226,000
Veterans	£11,000
Law Reforms	(£40,000)
Total	**£600,000**
IT, (Capital)	£231,000
Grand Total	**£831,000**

This allocation has been integrated within the various schemes outlined in this submission – specifically the carers and placement and packages schemes.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

In line with many other local authorities we are in the process of mapping all the elements of the Care Act, drawing on the draft guidance to establish which areas will continue as currently provided, require a degree of change or require considerable change management to be put in place.

Care Act Steering Group: In Southampton we will maintain oversight through the development of a Care Act Steering Group comprising representatives from Adult Social care, finance, legal and the Integrated Commissioning Unit. The group will invite updates from a range of identified responsible leads who have considered the different elements of the Act and accompanying guidance. Updates will be collated and shared with relevant governance forums.

Responsible Leads
A significant number of the areas set out in the Care Act and guidance documents are likely to be covered by current arrangements within the Council. However, each aspect needs to be checked against current practice and either assurance given to this effect, or appropriate actions put in place to ensure compliance. To undertake this work a number of responsible leads have been identified from within their area of specialism and mandated to undertake this work for their designated area. Responsible leads will be required to provide updates to the Care Act Steering Group on either level of compliance with the Act or progress towards compliance.

Impact modelling of Dilnott reforms
A modelling exercise has been completed which sets out the potential impacts in 2015 and 2016 showing worst and best case scenarios. The Surrey model (produced by Surrey County Council and ADASS South East) was used as a template and adapted for our region/local demographics. The 2015 impacts addressed are related to continued workforce demands from the new 2015 duties and the implementation of ASC funding reforms.

The model has been 'sense' tested by a group of subject area experts including Public Health, MIT team, Finance, Commissioners and Legal. The majority of results were found to be broadly accurate, and some areas were identified as requiring more accurate data. The South East Regional ADASS Care Act Implementation Lead has been clear that Southampton City Council is well advanced in its development of the modelling tool and has adapted it in a more sophisticated manner than she had previously encountered. However, we are now required to undertake a further modelling exercise using the Leicester modelling tool.

Local networks
Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) have formed a workforce development network meeting which links in with the regional Skills for Care and ADASS Care Act regional lead. These regional groups are tasked with development of common tools, systems and workforce/staff planning and development. Modest funding is available for development and the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) group is currently deciding how best to use this. SCC delegates support the development of common policies, tools and processes.

SCC Adult operational lead for care act implementation has initiated meetings of Paris (client data base) using local authorities in England and Wales in order to share common tools, processes and expertise.

Workforce development
Skills for Care have developed a programme which will ensure that all staff are prepared for the Care Act. Southampton are participating so that we will be in a position to roll out this programme from October 2014.

Bi-weekly Care Act Briefings covering specific subject areas are being produced by SCC Practice Support Officer and have been sent to all ASC staff to ensure that they are familiar with the Act and its' requirements in the interim.

Implications on workforce and capacity to deliver Care Act requirements will be monitored via the Care Act Steering Group.

Local impact
Through the Care Act Steering group and reports from Responsible leads, initial work has commenced on understanding where and what the impact will be.

- ***Financial***: through two modelling exercises and working with other authorities we are developing a more robust understanding of what the financial impact will be in both April 15

and April 16. Findings from this work have been presented to Corporate management for consideration and agreement to undertake further checks. This work includes establishing a proposal for using the anticipated funds allocated by the government for 2015-16

- ***Other resources:*** additional resources will need to be recruited to respond to the increased demand for assessments and it is noted that a number of authorities have already started working with agencies to ensure resources will be available. Locally it is agreed to commence discussions with relevant agencies to identify the necessary increased workforce.

- ***Delegation:*** Work will commence shortly on preparing an options appraisal on the delegation of assessment and/or other functions once the new power is available to the council. This will include carer assessments and setting up care accounts.

- ***Systems and process:*** There are numerous implications for existing systems and processes, primarily across Adults but also affecting Finance, Business Support, Children's and other services. In all cases, existing arrangements will need to be reviewed to ensure they are compliant; in a significant proportion change and development will then be required.

- ***Legal:*** Beyond the legal requirement to implement the Act, there are several other potential impacts on Legal teams:
  - Potential increase in appeals
  - Increase in demand on legal teams supporting the deferred payments process
  - Understanding any legal implications, should a decision be taken to delegate any functions to other organisations.

- ***Services:*** A number of service areas will be impacted, the full extent of this will be, in part, dependent on other decisions, e.g. delegation of powers, but the following are within scope for change:
  - Information & Advice will be delivered using an online approach supported by a range of community based services and aligned to the Local offer.
  - Procurement of a new advocacy service is underway, which will retain the option of extension to cover developments within the Care Act and the Children & Family Act.

Care & Support planning, along with other areas of service delivery are being incorporated within a wider transformation programme within the Council.

v) Please specify the level of resource that will be dedicated to carer-specific support

£813k will be dedicated to carer specific support from the Better Care pooled fund and will be spread across a broad range of service areas.

Identification, advice and support for adult carers combines both CCG and SCC funding to a total annual value of £253k. This service supports the early and wide reaching identification of carers resulting in increased provision of information, advice and support – further information is contained in Annex 1, Detailed Scheme: Carers

A further £91k is being jointly invested by the CCG and City Council in a Young Carer service which will provide timely and effective support to young carers and their families.

Integral to all NHS held contracts is the requirement to identify and signpost carers into appropriate services. Further work will be undertaken to establish the value of this element of service delivery and consider the most appropriate approach for identifying carers in health

settings and ensuring they gain access to information, advice, support and assessment as relevant to their circumstances.

The CCG also makes a contribution to a number of other carer based services, notably respite and short breaks. These are incorporated into relevant section 75 and section 256 arrangements. We are currently undertaking a piece of work to establish the funding levels involved in all the NHS areas of service delivery with a view to informing future commissioning intentions in line with Better Care requirements.

The Local authority is currently exploring the options for providing carer assessments and meeting eligible needs. This work includes consideration of delegated powers to 3rd sector agencies, online access to self-assessment and use of direct payments. This work will inform the use of the remaining allocated carer funding within the Better Care Fund.

Impact on Carer experience of these developments

Carers will find information, advice and support readily available in a greater number of settings. More carers will receive support whether online, through volunteer or buddy schemes or directly through the new service.

The carer is expected to experience improved mental health (as shown by study into informal carers of first time stroke survivors by C Simon & Kendrick 2009), as a result of being provided with access to social support. Also, when provided with access to emotional support and training, it will significantly delay the need for the person receiving care from going into residential care (MS Mittelham 1196).

Impact on patient outcomes

Currently it is estimated that carers save the UK economy £119 billion a year in care costs. This equates to £18,473 per year for every carer in the UK. Supporting carers is a vital element in maintaining this input into the health and social care economy. A study concluded that 20% of the over 75 year olds they tracked were admitted to hospital because of the breakdown of a single carer on whom that person was mainly dependent (Study in Surrey 1998). The changes set out above will contribute to carers planning for a change in their circumstances and avoiding both a breakdown for themselves (the carer) and reducing the impact on the person they care for.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

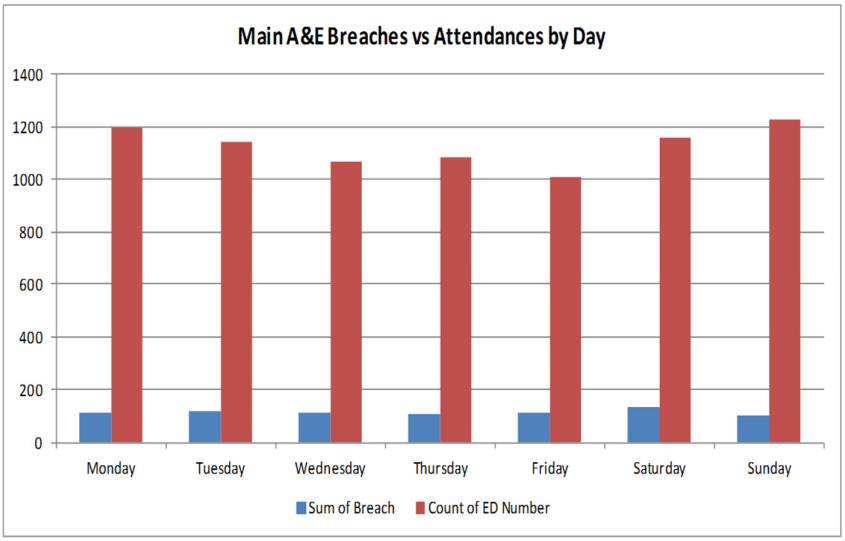
The level of funding available for the protection of Social Care and for the implementation of the Care Act has been unaffected by the re-submission.

The risk of not achieving the level of admission reductions alters the value of total funding that can be planned to be used effectively to reduce costs across the system. In turn this could potentially reduce the ability to fund greater levels of preventative social care activity for the benefit of the overall Health and Social Care system.

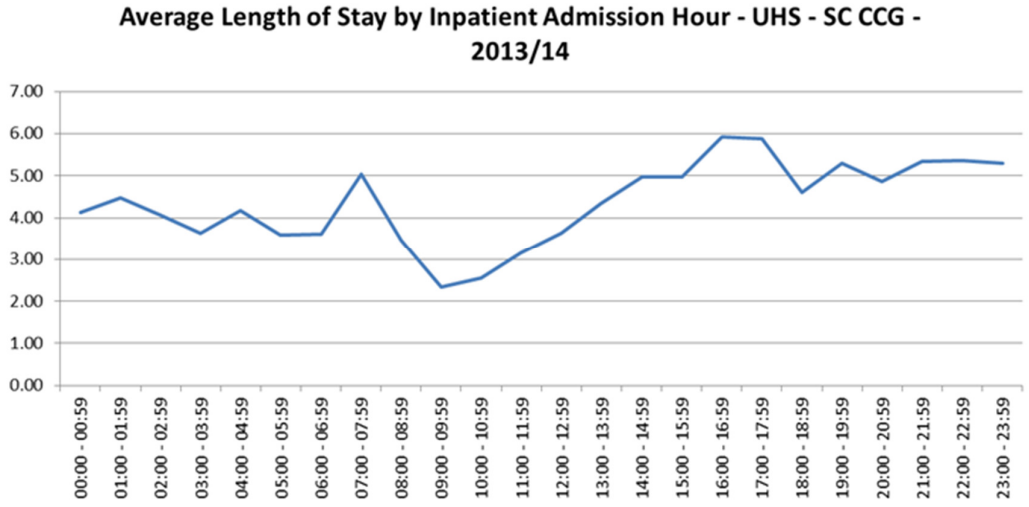
b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Need for health and social care is not limited to specific days/times of the week. Although some services like hospitals are open every day, services at weekends are often reduced. The limited availability of some services across the health and care system at weekends can have a detrimental impact on outcomes for people. Local data shows that ED attendances are generally higher at weekends and early evening.



Discharges are lower over the weekend and data suggests that patients admitted later in the day have longer lengths of stay.



Locally we are committed to delivering the clinical standards for 7 day services (7DS) contained in the Service Development and Improvement Plan section of the NHS local contract. Our contracts for 2014/15 already include an expectation of providers that they will

begin scoping work and readiness planning in preparation for the standards and requirements that will emerge from the national Forum on 7 day working.

Social Care are currently reviewing their out of hours provision to increase 7 day availability and this will be further strengthened through the integrated rehabilitation and reablement model – Scheme Two.

Our plans for 7 day working are outlined below:

Year 1 (2014/15)

- All NHS providers contracts have a clause which allows for in year service reconfiguration to take place which is in line with the implementation of Better Care
- Map existing services 24/7capacity and demand identifying gaps and opportunities to redeploy resources to maximise effectiveness.
- Review of processes to embed 7 day discharge into community bed capacity
- Review of community nursing capacity and demand to ensure resources are appropriately targeted to meet peak times of demand and linked into primary care and Out of Hours urgent care provision.
- Consider which of the 7DS clinical standards should move into the quality section of 2015/16 contracts.

Year 2 (2015/16)

- Review current access routes to services to streamline entry and management of referrals for both health and social care.
- 7 day ward rounds and establishing a pull system by community staff to support early discharge.

Year 3 (2016/17)

- Full implementation of 7 day working and audit of processes to ensure that care is provided on the basis of right time, right place, right workforce.
- Ensure all 7DS clinical standards are included in the quality section of the contract.

Key risks relating to the move to 7 day services include:

- Access to reablement services are not maximised due to risk averse culture in inpatient settings
- Reduction in bed based capacity and shift in resources to community solutions is unable to cope with surges in demand.
- Recruitment of skilled social staff becoming difficult as the local economy improves and reduces pool of potential workers.
- Nursing staff find model of working unattractive due to increased requirement to work unsocial hours and perform social care tasks alongside health duties.
- Hand off arrangements remain difficult between discharge, reablement, cluster and long term care management teams.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number is seen as a key factor in promoting greater information sharing between Social Care and Health.

All health services use the NHS number as the primary identifier in correspondence and Adult Social Care is using the NHS Number as the primary identifier, with 83% of known individuals

having this recorded. By using the NHS Number Adult Social Care services are able to link data with health information though the Hampshire Health Repository (HHR). The Council has achieved NHS Information Governance approval to share data.

In June 2014, Southampton City Council completed a pilot project linking PARIS, the Social Care records system, to the NHS Personal Demographics Service (PDS). A full scale deployment is now planned. The PDS module of PARIS will enable Social Care records to be synchronised with the NHS demographics held for a person. The synchronisation process automatically downloads the person's NHS number into PARIS.
The PDS matching (and retrieval of NHS number) process is started when a client record is opened (and there are changes at either end i.e. a record is not synchronised, and when a new client record is created. This ensures that NHS number capture takes place as early in the care management pathway as possible.

A core principle of the Better Care agenda is to deliver integrated care, single person centred care plans and seamless service delivery coordinated through a single lead professional. A key enabler for this to be achieved is to have IT based systems which share information which is relevant to the person and clinician's needs in order to inform decisions and deliver care. Currently Southampton and surrounding areas benefit from having access to the Hampshire Health Record (HHR). The HHR gathers patient information from health providers (primary care, acute, community and specialist health providers and from social care). Over the past few years the HHR has developed technically and now has the capability to share information and care plans electronically with anyone who has authority to view with consent from the individual patient. In addition through the Common Assessment Framework 2 programme (CAF2) a patient portal has been developed through the "Say it once" project. The" Say it Once" project has delivered a mechanism for patients to share practical information about themselves.
There is some evidence to show that the sharing of data using the HHR can reduce length of stay in hospital. The table below shows the length of stay per spell on those occasions where there has been no attempt to view the patient's information on HHR compared to those occasions where records were viewed.

Preliminary findings (not validated)

HHR and Inpatient length of stay

HHR View Status	Number of Spells	Average Length of Stay per Spell (days)
No Attempt To View	52123	3.5
Record Viewed	17695	10.3
Unsuccessful View	1557	12

All health providers including primary care services have agreed to implement "single sign on" to the HHR for clinicians. Single sign on means that a clinician types in one security password and authority is automatically given to access a number of IT clinical systems. Clinical staff at Southampton General Hospital have significantly increased the use of the HHR due to this approach.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

It is planned that HHR during 2014/15 will under undergo a significant upgrade. This will provide greater functionality to push and pull data, to allow user specific views, so that pertinent

data is seen first, to improve patient access to their health records, to allow data to be imported from patient purchased Apps and to improve the general experience and navigation of using the HHR system. These improvements are being taken forward by all partners to the HHR across Hampshire. A prioritisation exercise is due to take place in the coming months to identify which HHR development opportunities to accelerate and to agree the programme plan for the coming years.

Discussion has commenced with independent social care providers (nursing, residential and domiciliary care) to allow them access to the HHR and support them to move towards electronic care records which are integrated with statutory provision.

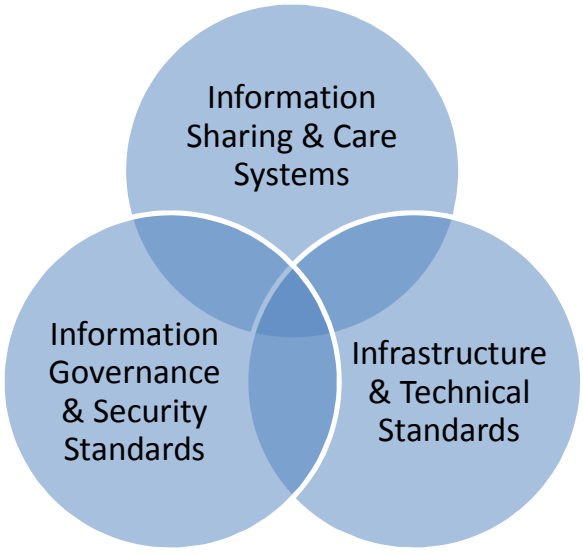
Southampton City Council is PSN (Public Sector Network) compliant level 2.

The Council has also achieved GCSX and N3 compliance with the ability to connect to the NHS spine.

Solent NHS Trust and Southern Health NHS Foundation Trust are currently not fully compliant (National BT system Rio),or able to share real time currently. However they are looking to re-procure by Oct 2015 to become fully compliant.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The HHR governance arrangements have been reviewed following the formation of CCG's across Hampshire. There is a strong emphasis on clinical / carer and patient led delivery of Interoperability Information Sharing Programmes. We believe this is the right way to decide what information needs to be shared and how systems should look and feel to do this. The new governance arrangements for the HHR has resulted in the formation of 3 groups (below) being formed representing patients, clinicians from data providers and users, IT technical experts and information governance leads from health and social care. These groups report to the HHR Board which reports directly back to partner CCG's.



The CCG achieved Level 2 in IG Toolkit status (submission of 31 March 2014). An action plan has been developed to gain level 3 by 2016, however takes each element of the toolkit and identifies progress, gaps and controls each year. An interim submission will be undertaken in October 2014.

The CCG and health local health providers have taken on board the requirements set out in Caldicott 2 and have undertaken the following:

- Caldicott Guardian and SIRO in place with appropriate training.
- Quarterly reports to Board and monthly briefings to the Caldicott Guardian on the status of the action plan including how we will mitigate against any risks.
- Examined existing arrangements, policies, protocols, procedures and training materials which are currently being refreshed.
- Clearly explaining to patients and public how their personal information will be used including updating the Privacy Notice.
- Commissioners access to patient identifiable data (PID) has been restricted and can only be used once consent has been gained.
- Mandatory e-learning have been completed by all staff (this has to be undertaken yearly).
- Information Governance arrangements are included as part of our induction programme
- All activities comply with the Information Governance Framework

The CCG and City Council are also working closely on IG issues that have arisen due to the establishment of the Integrated Commissioning Unit. We have also attended a national seminar to try and seek clarity on some of these issues and are looking at working with a law firm to take this work forward.

The overarching information sharing agreement which is in place for the HHR is currently being between commissioners and providers to support all of this work.

The City Council has achieved level 2 IG Toolkit status and have in place an improvement plan. A Caldicott Guardian and SIRO for Social Care with appropriate training are in place. The IG activity will be reported quarterly to the Council's Information Management Board and Council Management Team following review of existing terms of reference. A complete review is underway with regard to how the Council shares PID with its partners and work is ongoing to further assure procedures with regard to the main PID recording systems utilised within the Council. E-learning is in place covering 4 modules with a specific module designed for staff who regularly come into contact with PID. A review of consent to share documents and privacy notices is underway in light of the transformation work being undertaken as part of the People Directorate. Measures to ensure that direct care teams are better able to share information appropriately according to Caldicott 2 principles is being action planned.

Solent NHS Trust and Southern Health NHS Foundation Trust have achieved level 2 and are moving towards level 3 compliance.

University Hospital Southampton Trust is aiming to achieve level 2, moving towards level 3 compliance.

The CCG has reviewed the contracts it has with providers of healthcare to ensure that health data will be shared within information governance frameworks and that providers have a commitment to deliver interoperability changes to their clinical IT systems.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

In accordance with the Proactive Care Programme, 2% of the population are identified as at high risk of hospital admission. Tools used to identify these patients include the ACG tool, frailty indicators, long term conditions registers, end of life register, clinical knowledge and judgement, care home residents, co-morbidities and the CCG's urgent care dashboard.

Work is underway to include information from the housing sector and establish a data feed into the ACG tool from the ambulance trust, social care and 3rd sector in order to enhance the intelligence available for risk stratification.

The CCG has procured access to the Adjusted Clinical Group tool in partnership with other CCG's in the South Central area to enable primary care and integrated care teams to risk stratify the population. Partner CCGs are in the process of procuring a new tool which will provide greater functionality and take into account social care data and risk factors. This new tool which will be IG compliant will be available from April 2015.

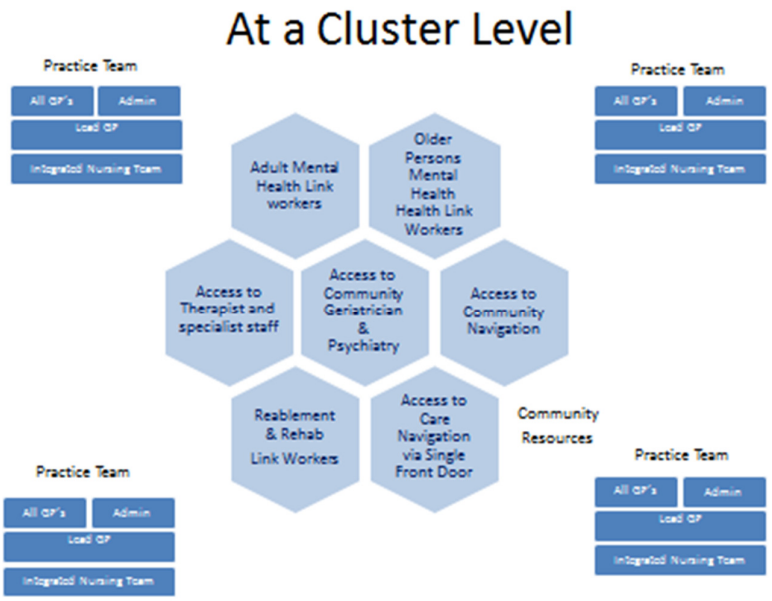
In addition to focussing on the top 2% of the population most at risk of hospital admission, the Better Care model we are implementing will also seek to identify a further 3% of the population just below this level where more proactive assessment, care planning and support will prevent their escalation to high risk. It is believed that the greatest dividends will be gained from focussing lower down in the risk stratification pyramid, where there is more opportunity to maintain people's independence, change behaviours and achieve strong engagement.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

All GP practices in the City are signed up to the Proactive Care Programme and working to deliver the specification. This includes risk assessment, development of care plans based on the Proactive Care guidance and identification of lead professional.

GP practices are at the heart of Southampton's Better Care model which in turn is supporting practices in delivering their responsibilities under the DES.

The relationship between the cluster teams described in Section 2c Changes to Service Delivery (person centred local coordinated care) and GP Practice teams is illustrated below.



The core functions of the cluster team have been agreed as follows:

- To work with and support the GP practice teams in the cluster to:
  - identify people at risk of deterioration such that they would need admission/ long term care
  - comprehensively assess need through an assessment which is:-
    - Person Centred
    - Comprehensive (Comprehensive Geriatric Assessment) – encompassing physical, medical, social needs, function, daily living/psychological – wellbeing
    - Formulation of needs/issues – causes/factors/links
  - develop care plans which are anticipatory and goal orientated
  - coordinate care – supporting the GP practice in providing a single lead professional for each service user
  - manage crises/change in care needs
  - facilitate discharge from acute care
  - facilitate access to aids, adaptations, telecare/health to promote independence
- To promote self-management
- To sign post to community resources within the local area

Key principles of cluster working have been agreed with all stakeholders:

- Interactions with patients and service users will be person centred and needs led – this means that people will feel empowered and supported where necessary to find their own solutions to their needs and manage their own conditions and circumstances. People's responsibility for their own health and care will be respected.
- Staff will respect each other's professionalism and trust each other's assessments, without the need to duplicate.
- Teams will work in a more inter-professional way, recognising that individuals have core skills and expertise but at the same time promoting a common, holistic approach.
- A recovery and reablement focus will be built into all interactions with people.
- Decisions will be based on the needs of the person as opposed to our organisations.

The CCG has agreed to fund the development of an automated care plan using existing data collated in the HHR. The data that is pertinent to urgent care staff (Out of Hours doctors, ambulance crews, clinicians in ED), will be shared in a user friendly format to aid them in making appropriate clinical decisions. It has been found that using paper versions of the care

plans reduces the need for conveyances and admissions to acute care and increases the likelihood of patients being supported with community solutions. This care plan will be in place by December 2014.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

1% at March 2014 (per Risk Profiling DES)
2% at September 2014 (per Proactive Care Programme)
£5 per head funding to identify top 5% of patients at risk who are over 75 years of age.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

We have a continuous programme of patient/service user and public engagement in developing our plans for the Better Care Fund. Engagement and participation activity to date has involved 3 stakeholder workshops plus presentations at:

- Service user focus group
- Service users forum (Consult and Challenge)
- Patients Forum
- Older Persons Forum focus group
- Communications and Engagement reference group
- Pensioners Forum
- Equality Reference group
- Healthwatch
- Carers Strategic group

Service user and public insight has also been gained from a number of other sources e.g. complaints and patient experience data, NHS Choices, local services survey (online), Call to Action survey (online), carers network event and the stroke 'Have your say' event.

Our vision is based on what people have told us is important to them. Through the above consultation and engagement routes, we know what people want is more choice and control, good quality services and for their care to be planned with them and their families/carers and coordinated by a key worker or case coordinator to simplify communication and provide consistency. They tell us that good information and advice along with good communication are key. They want us to make better use of IT and technologies such as telecare/telehealth as well as computer and mobile phone support. The people we talked to also highlighted the important role of the voluntary sector and the need to make staff in statutory services more aware of what is out there in the community. One key point that came out of several

consultations was how much people value NHS services and the principles of the NHS constitution and so we are mindful of the need to ensure we protect and build on what is good.

We have worked with people to come up with our vision statement "**Health and social care working together with you and your community for a healthy Southampton"** and will be working with them over the coming weeks to produce a user friendly summary of our plan. We are encouraging people to comment on our plan and give us their views via a number of routes, e.g. on line, e-mail, social media, website. Web pages have been developed with our Better Care branding and can be found on the CCG website to ensure that we can continually update people about our progress. On 11 March 2014 we held a large public and other stakeholders event in the City which involved further discussion on our Better Care Fund plans and the CCG and Southampton City Council are currently developing plans to establish a citizens' council.

Healthwatch is represented on the Integrated Care Board and Interargency Operational Group and have been supporting the work we are doing to co-produce different elements of the model, specifically the development of the Community Navigation function.

We have also worked with the CCG's Equality Reference Group to develop our indicator for patient/service user experience, seeking service user views about the most appropriate metric.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Southampton City CCG commissions NHS care from the following main providers:

- Care UK (Elective and GP Out of Hours care).
- Solent NHS Trust (for general community and child and adolescent mental health services)
- South Central Ambulance Service NHS Foundation Trust
- Southern Health NHS Foundation Trust (adult mental health services)
- University Hospital Southampton NHS Trust (which incorporates our main acute Hospital)

NHS provider engagement has been strong in the development of our Better Care plans. The Integrated Care Board which oversees our programme has representation from each of the local health providers (Primary care, South Central Ambulance Service, Solent NHS Trust, University Hospital Southampton NHS Foundation Trust and Southern Health NHS Foundation Trust), along with the City Council Heads of Service, Public Health and the Voluntary Sector (Southampton Voluntary Services).

In developing our vision back in the latter part of 2013/2014, we held three large stakeholder workshops, in addition to meetings and individual discussions with providers. The workshops were held on 16 November 2013, 12 December 2013 and 17 January 2014 and involved a wide range of stakeholders from all of the local health providers, primary care, voluntary sector groups, City Council housing and social care. The workshops were led by the Director of Public Health, CCG GP clinical lead for integrated care and chair of the Health and Wellbeing Board who is the Cabinet Member with the portfolio for Health & Adult Social Care.

All providers have presented an impact assessment against our plan to the Integrated Care Board and we have also agreed our plan and discussed the implications at "System Chiefs", a

forum which brings together the City Council Director of People, Chief Officer for the CCG and the Chief Executives of each of the NHS provider trusts.

More recently we have undertaken further reviews of discharge processes from acute care, supported by ECIST, the resulting action plans from which are changing significantly how care is planned and organised in the City and have influenced our Organisational Resilience and Capacity Plan. This has been described in more detail in Section 2.

During May and June of 2014 we held 3 locality workshops across the city which were well attended by all NHS providers alongside community groups, primary care, social care and housing and were used to consult on our Better Care clusters and consider how our processes could be simplified and better coordinated.

ii) primary care providers

Southampton City CCG has 33 constituent member GP practices. The CCG has a number of clinical GP leads who provide leadership to strategy and planning and play a significant part in engaging the member practices. The Chair of the Integrated Care Board is the CCG lead GP for integrated care and the board is also attended by two other of the CCG clinical GP leads. One of these leads also sits in an advisory capacity on the Operational Group responsible for operational delivery of our Better Care Programme and has clinically led a project involving two practices, social care, health providers and the local community to pilot elements of our Better Care model (in particular risk stratification, integrated care planning and community navigation). The other has been piloting a model of self management in partnership with a voluntary sector provider in his inner city practice and is also a member of the Better Care Commissioning task and finish group advising on alternative contractual models and approaches.

Practices have been engaged in the development of our plans through locality meetings and also TARGET which is a forum which meets quarterly and provides time out for audit, research, governance, education and training.

In developing our plans for cluster working, we consulted with all GP practices through the locality workshops (mentioned above) as well as by individual letter and made a number of changes to the proposed cluster configuration as a result of their feedback.

As already mentioned, we are piloting 3 different approaches to increasing practice based nursing capacity using the Everyone Counts £5 per head initiative, following discussion with GPs at locality and city level.

Practices are working hard to deliver the Proactive Care Programme and to build stronger relationships within their locality clusters to support delivery of the £5/head proposals. A city-wide GP federation is also in development.

iii) social care and providers from the voluntary and community sector

Social Care and the voluntary and community sector are also represented on the Integrated Care Board and have played an active part in all the workshops mentioned above. Social care is also part of the System Chiefs group mentioned above.

The integrated commissioning unit works across both the CCG and City Council reporting to the Integrated Commissioning Board which comprises the Chief Executives and Chief Finance Officers of the City Council and CCG, the Director of People in the City Council, the Director of Public Health, the Director of Quality and Integration for the CCG and City Council, the GP Clinical Chair and HWB Chair who is also the Cabinet member with responsibility for health and social care.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

Better Care Southampton is focussed on a balanced approach across the breath of integrated care with ambitious targets to:

- Reduce avoidable emergency admissions where we benchmark poorly including better management of frailty including falls avoidance
- Better reablement outcomes (ensuring reablement is more effective in restoring independence and thereby also reducing repeat admissions)
- Impact on reducing length of stay, specifically reduced DTOC (quicker discharge from hospital into agreed packages of care)
- Reduced nursing and residential home admissions (thereby ensuring that NH/RH capacity is more readily available for those who need it)

Throughout 2013, it became clearer that sustained very high levels of bed occupancy (in excess of 95%) were creating difficulty in admitting patients in urgent need, and creating unacceptable risks to the safety and quality of patient care across the hospital. We are starting to see a decline in the number of A&E attendances and there is some evidence that the growth in emergency admissions has been stemmed. There is renewed determination across the whole system to build on progress, to sustain efforts to alleviate these problems and to support the hospital in every way possible. However, performance against the 95% standard remains less than acceptable and this is important because this standard is a key indicator of challenges across the entire system: failure to safely and effectively discharge people leads to significant pressure on elective capacity which in turn means that meeting other crucial national standards (such as referral to treatment times and waiting times for cancer) becomes challenging.

Better care provides us with an opportunity to really focus on tackling patient flow through the system (which has been shown to be a key pressure in the current system – see Case for Change) at the same time as maintaining our QIPP focus on reducing NEL admissions. We will continue to focus on reducing NEL admissions through:

- Alternatives to ED attendance (which has not grown in 2013/14) including the newly commissioned enhanced MIU service
- Improved treatment pathways from ED that will reduce the need for admission including
    - the community assessment facility for frail elderly introduced in 2014/15 and
    - new chest pain and abdominal pain protocols introduced in 2014/15 to reduce very short stay admissions (which have hitherto) been responsible for 80% of the NEL admission growth).

However, we see Better Care as a prime opportunity to focus on improving patient flow through the system and reducing pressure in social care. This is reflected in our activity plans and

targets (a 2% reduction between 2014/15 and 2015/16 in NEL admissions) and in our schemes.

Unplanned admissions/Non elective (NEL) admissions

The contribution of Better Care to reducing NEL admissions is focused upon tackling avoidable emergency admissions. This will be a result of better proactive care of people with long term conditions so that they are less likely to have an acute episode requiring admission to hospital, together with more proactive integrated care in the community and improved effectiveness of reablement so they are not readmitted.

Our plan is based on a 2% reduction (before growth) in NEL admissions between 2014/15 and 2015/16. Without growth factored in, this equates to 570 admissions. With growth factored in at approx 1%, this would equate to 850 admissions or a 3% reduction. In actual numbers this amounts to between 2 and 3 less admissions a day.

In summary our rationale for choosing a target lower than the 3.5% national expectation is set out below:

- NEL growth in 2013/14 was limited to 2.7% in Southampton, a high proportion of this growth being in very short stay admissions. NEL growth is not the principal driver of increased cost in the local system, rather we are focussed on tackling length of stay and hence discharge and onward care, as well as avoiding emergency admissions.
- Forecast NEL growth in 2015/16 due to demographic factors is 1%
- Planned changes of 3% gross to this forecast result from a combination of 1% reduction due to 'QIPP' (which in this context is shorthand for productivity improvements in the acute pathway and alternatives to acute admission) and 2% reduction due to Better Care initiatives such as better reablement, falls prevention and elderly care nursing in community teams.
- Thus, the net NEL reduction against the plan baseline will be 2% (compared to the national expectation of 3.5%).

The key schemes that focus on achieving this are:

- focussed work on specific LTC pathways – specifically in relation to diabetes and COPD
- local person centred coordinated care – offering a more proactive approach targeting those individuals most at risk of admission
- integrated rehab and reablement service – focused on promoting recovery and maintaining people's independence

In financial terms this reduction equates to approx. £849,000 (without growth).

Delayed Transfers of Care (DTOC)

Delayed tranfers of care remain high in Southampton and we have seen significant growth in the beginning of 2014/15 compared to 2013/14. Our plan for 2014/15 is therefore to hold this growth for the remainder of the year at the 2013/14 level. This is a very ambitious target, particularly as the 13/14 figures are artificially low due to norovirus last Winter which meant fewer people were admitted. However we have an ambitious plan this winter which focuses on improving discharge pathways and stronger rehab and reablement. Significant investment is being made to support this. The key schemes include:

- implementation of trusted assessor

- discharge to assess – 12 additional beds
- increased rehab and reablement capacity

In order to achieve our 14/15 plan we will need to reduce DTOC by 5 per day over the remainder of this year from the Q1 and 2 position. On average around 10 Southampton City patients are discharged from Section 2s or 5s each day – this will mean an increase to 15.

Moving forward, our plans are to further reduce DTOC in 15/16 by an additional 3 per day. This will return levels of DTOC to the 13/14 position, an approximate 10% reduction. The main schemes for achieving this additional reduction is our rehab and reablement scheme and placement and packages scheme which will bring together health and social care resources to improve efficiency and capacity.

Impact on income for acute sector

From a provider income perspective, NEL admissions are currently paid for at the marginal rate (30%) so any reduction in real terms will have a beneficial financial impact.

Implications for the acute sector of our plans – new ways of working

There has been extensive engagement from all providers in the development of our plans and agreement of our targets (as demonstrated in Annex 2).

For University Hospitals Southampton, our main acute hospital provider, our plans will require:

- Stronger joint working between secondary, primary and community care to manage risk in the community
- More outpatient activity delivered outside of the hospital
- A more specialist advisory role to the community.

Impact on delivery targets

We expect our plans to improve performance against NHS service delivery targets through:

- a more proactive, pull approach from the community to discharge patients. This will enable more timely discharge and support the hospital to better manage capacity and reduce delayed transfers of care.
- More coordinated, preventative community provision, operating 7 days a week. This will reduce avoidable admissions, thereby reducing pressures on the urgent care system
- Better information available to the hospital on admission (through access to the patient's care plan) supporting assessment and coordination of care.
- Safer levels of capacity for elective activity as a result of improved functioning of the urgent care system

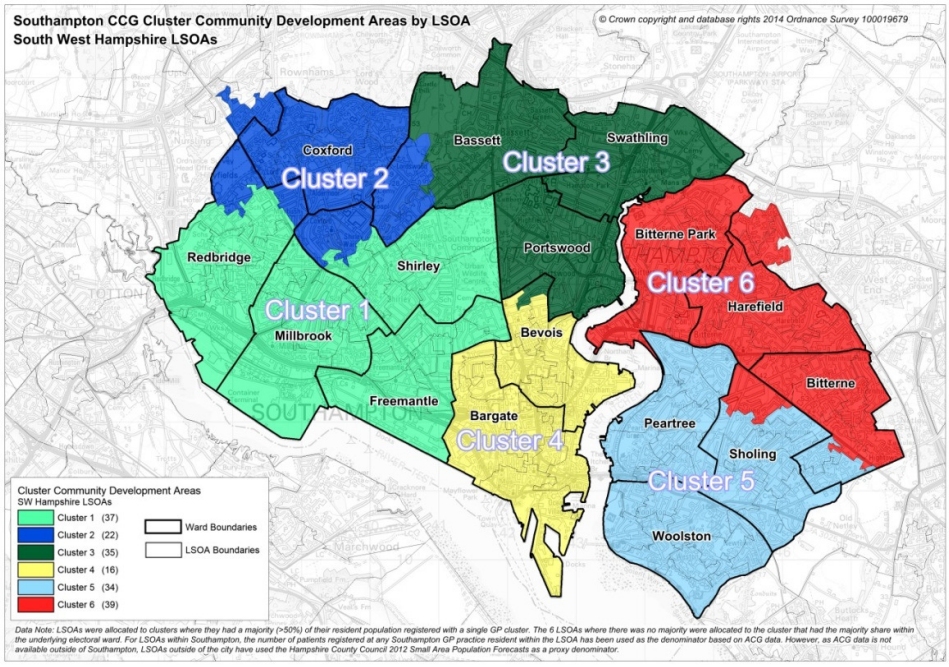
This will improve performance in the following areas:

- Sustainable delivery of Emergency Department (ED) Performance including the Clinical Quality Indicators for ED
- Reduction in very short stay admissions to Clinical Decision Unit (CDU)
- Safer Occupancy levels and a reduction in levels of medical outliers.
- Improvements in Length of Stay and a smoother patient flow through the hospital
- A reduction in the levels of 'on the day' cancellations due to non-clinical reasons
- Sustainable delivery of Referral to Treatment (RTT) standards
- Reduction of delayed transfers of care
- Reduction in levels of unplanned readmissions

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1.
Scheme name
Local person centred coordinated care (Integrated Cluster Team Working)
What is the strategic objective of this scheme?
Over the next 5 years, our vision is to completely transform the delivery of care in Southampton through our jointly led CCG and City Council Better Care programme so that it is fully integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, empowered and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention. The development of integrated working in clusters is a key building block in the new system. These clusters will bring together community nurses, geriatricians, MH workers, primary care, housing and voluntary sector with strong links to social care to work in an integrated way around local people and communities. The clusters will be based on GP practice registered populations. The clusters are intended to be generic in their scope, although initially they will focus on over 75s and adults with complex long term conditions (LTCs). After consultation, the following 6 clusters have emerged:    The intention is to implement the cluster model during 2014/15 with a view to all 6 clusters being up and running in some form by the end of the year.
Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Core functions of the cluster team

The following functions have been identified:

- To work with and support the GP practice teams in the cluster to:
  - identify people at risk of deterioration such that they would need admission/ long term care
  - comprehensively assess need through an assessment which is person centred, comprehensive (encompassing physical, medical, social needs, function, daily living/psychological) and provides a clear picture of needs/issues.
  - develop care plans which are anticipatory and goal orientated
  - coordinate care – supporting the GP practice in providing a single lead professional for each service user
  - manage crises/change in care needs
  - facilitate discharge from acute care
  - facilitate access to aids, adaptations, telecare/health to promote independence
- Promotion of self-management
- Early intervention/prevention
- Sign posting to community resources within local area

Target groups

The clusters will target two groups: those people within the highest risk groups for hospital admission or long term residential/nursing care who account for around 5% of our population (around 12,000 people) and 34% (9,400) of total emergency hospital admissions and those people within the moderate needs group who would benefit from supported self care who account for approximately 15% of our population (35,000 people) and 25.5% of total emergency admissions (7,000). Both these groups will be mainly frail elderly people and people with multiple long term conditions.

The Better Care Operational Group is undertaking further work to scope the needs of these cohorts in order to inform workforce planning and development. However, it is envisaged that the clusters will comprise the following staff:

- community nurses and matrons
- Older people's MH link workers
- Community/acute geriatricians
- Housing staff
- Local voluntary sector
- links to Care Managers and Social Workers
- links with the Fire Brigade
- links to domiciliary care providers

In terms of community nursing, the intention is to develop a much more integrated nursing model around each practice where the community nurses will work in an integrated way with practice nurses and other practice based staff, allocating work between them which maximises the key skills of each discipline.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The model is being developed with existing providers (described in the previous sections) and is being implemented by the Interagency Operational Group described in Section 4b. A

transformation manager with significant operational experience has recently been seconded from Southern Healthcare to champion change and project manage across organisations.

It is planned that within each cluster staff will remain managed by their host organisation/service. However each cluster will have its own identified, named staff.

Coordination of the model will be key to ensuring that each cluster is working effectively, staff are working together effectively (duplication and gaps are reduced) and needs are being met.

To make the model work it is proposed that each GP practice identifies a "link GP" for the cluster (this role could be rotated within the practice). The role of the link GP would be to:

- Become familiar with what resources/skills/expertise are available in the wider cluster
- Act as a conduit of information back to the practice
- Attend cluster team learning and development events to represent primary care

In each cluster there will be a cluster management team made up of a nominated lead GP for the cluster (this role could rotate amongst the link GPs mentioned above), a representative from each statutory organisation and the nominated coordinator for that cluster.

The role of the management team for each cluster will be:

- Overseeing the effective running of the cluster – ensuring processes and staff are functioning effectively
- Development of a cluster development plan
- Workforce planning
- Capacity planning
- Identification and following up any opportunities for improving the model
- Overseeing key performance indicators and trends eg. numbers emergency admissions, permanent admissions to residential/nursing homes
- Identifying population need and planning to meet that need

The role of the cluster coordinator will be:

- Accountability for delivering against key targets
- Coordination and administration of the management team
- Relationship management within the cluster
- Single point of contact for any issues around integrated working in the cluster
- Identification and Escalation of any key issues around operation of the model
- Coordination and administration of the virtual wards

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Three consultation workshops with staff involving the voluntary sector have taken place involving over 200 individuals. Additional consultation also took place with primary care and other staff groups. In addition to this a range of user and voluntary sector forums have been involved in shaping the strategy and its implementation.

The following evidence base has been consulted:

- Kings Fund resources on integrated care "Making it Happen"
- ICASE Integrated Care and Support Exchange
- Nuffield Trust resources on integrated care and risk stratification
- National Voices, Principles for Integrated Care

- Think Local Act Personal
- The Health Foundation, Person Centred Care
- Helen Sanderson Associates Person Centred Planning
- Royal College of General Practitioners, Integration of Care
- Kaiser Permanente, Integrated Health Care and Population Management
- Emergency and Urgent Care Intensive Support Team (ECIST)

The CCG and City Council have also made strong links with other leading sites (Torquay, Greenwich, Leeds) to learn more about their experiences and learning.

The model we are implementing has also been piloted in one neighbourhood (comprising two GP practices, social care, community nursing, older people's mental health services, as well as local voluntary and community groups) specifically in relation to integrated risk stratification, care planning and community navigation. Another pilot in the inner city has been testing out models of promoting self management with a voluntary sector partner. This has been clinically led and is an attempt to implement House of Care at a local level, developing the processes for enabling proactive supported self management, building an understanding of different roles and identifying potential tools and methods

We are also working with Southampton University to evaluate our model and are in the process of developing an evaluation proposal for sign off by our Integrated Care Board.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment shown against this Scheme in Part 2 of our submission is the existing collective spend across the CCG and City Council on services which will make up our local person centred integrated care model, in addition to some additional investment we are making in practice based nursing. The intention is to use the pooled fund to redesign and develop services in a way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The cluster model is expected to impact on all the Better Care targets, most notably:

Fewer avoidable hospital admissions

- Through proactive multiagency risk stratification tools which bring together a breadth of information to identify those people most at risk of deterioration and intervene earlier, maintaining and promoting independence
- Through better use of case management and shared care planning to better manage people at home
- Through a stronger focus on prevention, including falls prevention

It is estimated that the high risk groups account for around 9,400 admissions and we are aiming to prevent approximately 200 (approx. 2%) of these over the next 12 months through a combination of this scheme and the more responsive proactive discharge, rehabilitation and reablement model described below. This scheme also focuses on the medium risk group who would benefit from supportive self care and it is estimated that this group accounts for approximately 7,000 admissions of which we are aiming to prevent 400 (5-6%) through this scheme.

Fewer admissions to long term care, eg. residential or nursing homes

- Through better case management and shared care planning
- Through a stronger reablement ethos
- Through more proactive discharge planning, ensuring that people are only in hospital for as long as they clinically need to be and that their independence is promoted

Fewer delayed discharges from hospital

- Through improved discharge processes which begin to plan for discharge at the point of admission or as soon as possible thereafter and proactively "pull" patients through the system, which will include any assessments for long term care taking place in a community setting
- Through strong joint working between acute and community teams
- Through a stronger more proactive recovery and reablement focus which commences as soon as the patient is clinically fit

Better service user experience

- Through more person centred approaches and self-management which empower people to design and manage their own care/condition
- Through better information about local resources
- Through people feeling less isolated
- Through reduced duplication

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The interagency Operational Group is in the process of developing a set of key performance metrics for each of the outcomes identified above.

Below is a summary of the thinking so far:

- Fewer avoidable hospital admissions
  Suggested KPIs
  - Reduction NEL admissions
  - Reduction NEL admissions of case managed patients
  - Reduction A&E attendances
  - Reduction A&E attendances of case managed patients
  - Reduction injuries due to falls
  - Reduction ambulance attendances for patients who have fallen
  - % of Case managed patients who have received a falls assessment and review in past 12 months
  - Reduction in readmissions within 91 days of discharge

- Fewer admissions to long term care, eg. residential or nursing homes
  Suggested KPIs
  - Reduction permanent admissions to residential and nursing care

- Fewer delayed discharges from hospital
  Suggested KPIs
  - Reduction in excess bed days
  - Reduction in delayed transfers of care

- Better service user experience
  Suggested KPIs
  - % of case managed patients reporting positively to statement "I feel confident in managing my long term condition"

- % of case manage patients reporting positively to statement "I have planned and feel in control of my life and future"
- number of patients in each cluster with shared care plan in place

The intention, having agreed the indicators, is to produce regular performance reports for each of the clusters.

What are the key success factors for implementation of this scheme?

- Co-design, production and Community Development – we have a very positive relationship with Healthwatch who are supporting us on both this scheme and the Community Development Scheme and sit on the Integrated Care Board and Operational Group. We also have support from Think Local Act Personal (TLAP).
- Ability to evaluate and continuously learn from the work we are doing – we have already in place critical friend academic support from Wessex AHSN and Wessex CLAHRC
- Good robust engagement and coproduction with all stakeholders – see our communication and Engagement Plan for how we are taking this forward.
- Workforce development – a workforce development plan is being developed in 14/15 to underpin the change in culture and new ways of working (including trusted assessor model, person centred planning, motivational skills) required by the cluster model
- Primary care development and GPs signing up to new enhanced service for unplanned admissions – all 33 GP practices have signed up to the new Proactive Care programme.
- Identification of suitable accommodation within each cluster area to provide a team base – the Operational Group is currently mapping premises by cluster to enable a decision about bases to be made.
- Information sharing agreements and interoperable IT across health and social care settings – we are working with our Commissioning Support Unit to develop the appropriate information sharing agreements, templates and IT interoperability. Work is underway to produce a shared care plan prototype using the Hampshire Care Record which will be available for roll out by December 2014.
- Strong leadership – this is provided through the Integrated Care Board which includes leaders from across the health and social care system, as well as the voluntary and community sector, and oversees our Better Care work programme. Leadership is also strong through our Health and Wellbeing Board.

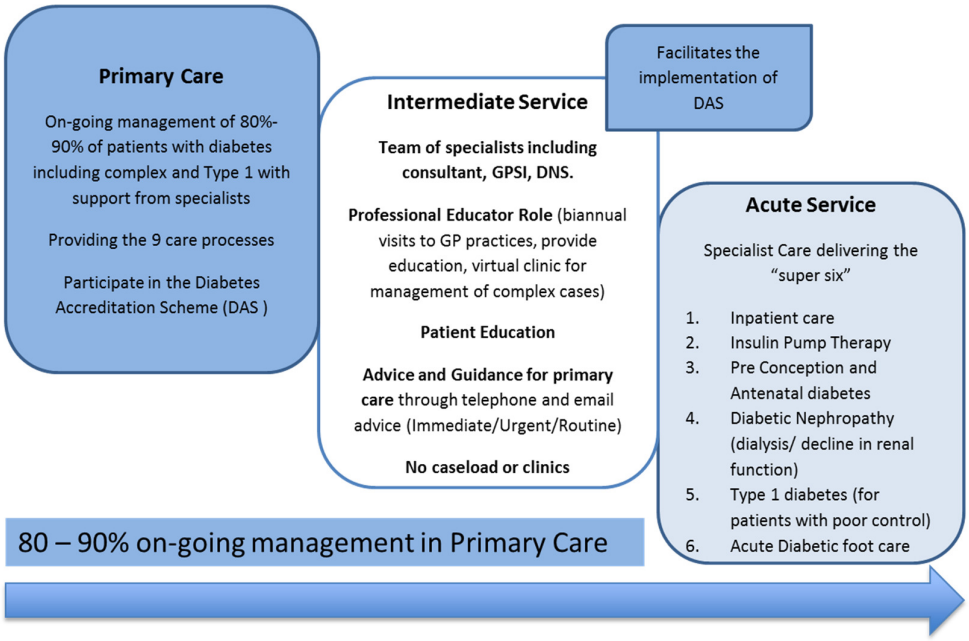
Scheme ref no.
1b.
Scheme name
Long term conditions pathways – supporting local person centred coordinated care
What is the strategic objective of this scheme?
This scheme supports the model of local person centred coordinated care described in Scheme 1. It includes focussed work that we are doing around specific conditions, particularly COPD and diabetes, to support people to remain well and independent in their own homes and communities, with a strong focus on supported self care, as well as the provision of expert support to the cluster teams who will be working in a more holistic way.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

We have been developing an integrated approach to long term condition (LTC) services. We have made significant changes to community COPD Services, developed a new diabetes care model which is currently undergoing implementation and are reviewing services which support heart failure and neurological long term conditions with a view to developing commissioning intentions and implementing service changes which will deliver improved outcomes for patients.

The consistent approach/strategy for LTCs services is delivery of care closer to home in community settings, supported by specialist knowledge through integration, with primary care leading the majority of people's care.

The ICU is developing its LTC strategy during 2014/15 to consolidate the work which has been undertaken to date and to inform a 3 year plan for further improvement in the care of people with LTCs in the city.

Diabetes
In Southampton there are 11,545 adults with diabetes (over 90% receive their care in primary care). The model of care for people with Diabetes is as follows:



We are undertaking specific work with general practice to improve the quality of care, using the NICE 9 key processes of care and have developed a GP diabetes accreditation scheme which we are currently rolling out:

Standards of Diabetes Care - narra

PC - Diabetes Accreditation Scheme

Foot care has been identified as a particular priority for development given the very high rate of amputations in Southampton. This will involve better integration between the community podiatry team and the acute diabetes service in the management of active foot disease and ulceration. The proposed model of care, developed by primary care and endorsed by the providers is as follows.

PC Integrated Diabetes Footcare Pr

A business case to enable the delivery of this new model is currently being developed.

COPD

4810 people in Southampton have COPD. In our case for change, we have identified that respiratory admissions make up 10% of all unplanned hospital admissions. The Southampton City Integrated COPD service is provided by a multidisciplinary team of combined UHS Foundation Trust and Solent NHS Trust staff. The Pathway has a lead Clinician (a Consultant In Respiratory Care), and an operational manager with a clinical knowledge base (an 8a Allied Health Professional (AHP) or Nurse). The service provides both community based consultant and nurse led clinics and home visits to provide admission avoidance and 30 day post discharge support, pulmonary rehabilitation and patient education, and primary care education and support. Because of its integrate nature it has excellent links with the acute respiratory service to enable support for post discharge care, and the Home Oxygen Assessment Service.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The majority of LTC services are currently commissioned solely by Southampton City CCG and on a service by service basis, incorporated within the acute and community NHS contract with providers. Main providers are Solent NHS Trust and University Southampton Hospitals NHS FT.

The integrated COPD Service is a service commissioned jointly from both providers, and is currently undergoing a review regarding meeting the outcomes and objectives set when the service was implemented 2 years ago. It is anticipated that from this review the current contracting method could be improved and other options, for example an alliance contract may be appropriate for this service. If successful it may be used for other LTC services.

Diabetes Intermediate service is commissioned from Solent NHS Trust as a lead provider, and there are sub – contracting arrangements with other providers to support in its delivery.

The Heart Failure service and specialist nurse service for neurological LTCs (Parkinson's, epilepsy and MS) are currently under review, they are currently commissioned from Solent NHST Trust with sub-contracting arrangements in place for the heart failure service.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

For all service developments national evidence is reviewed including:

- Appropriate NICE guidance and clinical standards
- Atlas of Variation
- Public Health Observatory publications
- Parliamentary briefings
- NHS England House of Care model and associated toolkit

In diabetes scheme we have also used local evidence over the last two years to drive the improvements required including:

- Initial Stakeholder Event to identify areas for improvement in 2012
- Findings from 3 GP Locality Projects:
  - West : Integrated Diabetes Foot Care Service
  - East : Self -Management
  - Central: Enhancement of Professional Education in Diabetes
- GP Practice Stock Take in May 2013
- Patient questionnaire
- Insulin Pump patient forums
- Engagement and patient representation from Diabetes UK

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment shown against this Scheme in Part 2 of our submission is the existing spend within the CCG on services targeted at people with specific long term conditions (e.g. diabetes, COPD, heart failure, neurological conditions. By pooling this funding within the Better Care pooled fund, we intend to redesign and develop services in a much more integrated way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme will particularly contribute to achieving the following Better Care targets:

- reduction in emergency admissions – we are expecting the integrated pathway of care we have developed to reduce COPD emergency admissions by 135 and diabetes admissions by 120 (these figures include growth unlike the figures in Part 2 of our Plan)
- reduction in delayed transfers of care
- improved patient experience – this scheme specifically impacts on our chosen target to increase the percentage of people who feel supported to manage their long term conditions

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We will measure the specific impact of this scheme on the Better Care targets above through the following set of specific metrics:

- Reduction in emergency admissions
  - COPD impact to be measured specifically through a reduction in HRG DZ21A to DZ21K admissions - Threshold for 15/16 is 25% reduction on 12/13 baseline actual baseline plus 5% growth

- plus increase in number of patients discharged from Pulmonary Rehab course to have completed nine out of twelve sessions – target is 60%
- plus increase in patients who have completed Pulmonary Rehab showing an increased exercise tolerance – target is 60%

- Reduction in delayed transfers of care
  - COPD impact to be measured specifically through a reduction in excess bed days against HRGs DZ21A to DZ21K – target is 20% against 12/13 baseline plus 5% growth

- Improved patient experience
  - COPD impact to be measured through patients completing the Quality of Life Indicator at the completion of the programme – target is 60%
  - plus all patients seen by the COPD service to have a management plan and an appropriate self-management plan

Quarterly review meetings with the service providers are in place to review performance against the outcome measures/quality indicators.

What are the key success factors for implementation of this scheme?

- good clinical engagement – this is achieved through GPs as clinical commissioners leading the development of service models and driving forward the service model implementations, alongside clinicians delivering community and secondary care.

- Patient engagement – this is achieved through having patient representatives included within project groups/review meetings. We have engaged patients groups (for example through attendance at patient group meetings and events, surveys etc) to highlight areas of improvement and concerns, testing proposed new models and care planning.

Scheme ref no.
2.
Scheme name
Integrated discharge, reablement and rehabilitation
What is the strategic objective of this scheme?
The strategic objectives of this scheme are:- • To support individuals to live independently for as long as possible within their own communities • To provide integrated community facing rehabilitation and reablement services that are effective, timely, person centred and are responsive and flexible enough to: ✓ Reduce the number of avoidable admissions to acute services ✓ To reduce the number of delayed discharges of care from hospital
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme will establish an Integrated Out of Hospital Service that brings together a number of existing functions (currently provided separately across agencies) including rehabilitation and reablement, community bed based provision and rapid response into a single integrated service which will: • Offer a crisis response function – to be able to respond to a crisis situation in the community and when appropriate target health, social care and voluntary resources to keep that person within their home or somewhere close to home whilst further support is planned. • Operate a service that is able to discharge people out of hospital at the point that their acute episode has ceased – and using a "Discharge to Assess" approach to then respond to that person's needs in a person centred manner within a community setting. • Link with the "community clusters" to work with people who are identified as potentially at high risk of an acute episode – offering information, advice and guidance or in some instances direct intervention e.g. equipment/therapies, falls prevention. (There will be a pathway for people who have fallen to ensure that all fallers are followed up and an appropriate management/rehabilitation plan is devised, including use of medication and referral to exercise classes to improve core strength and balance.) Interventions are generally likely to be goal orientated and time limited however the focus of the service will be person centred and needs led. The service will use a Multi-disciplinary Team (MDT) methodology to undertake both generalist and specialist activity as appropriate utilising the skills and experience of a range of professionals including: • Occupational therapists and occupational therapy assistants • Physiotherapists • Consultants in integrated medicine and older people • Community and inpatient nursing staff • Community and residential care staff • Community support workers • OPMH support workers • Reablement Care Managers There would also need to be explicit links/support from other services/process e.g. :- • Housing • The "Risk Stratification" process and Care Navigation provision

- Advocacy Services
- Carer Support Services
- Continuing Healthcare Team

The service is designed to support adults aged over 18 years, however, based on current service usage, a growing elderly population with one or more long term conditions and increasingly complex social circumstances, the expectation is that the majority of service users will be over 65 years. The target group will be those in the high risk category shown in the Case for Change section – approximately 5% of the population accounting for 24.8% of total unplanned admissions. We estimate that the service will receive around 2,250 patients a year through hospital discharge and 3,500 patients a year from the community. Over time, we expect the ratio of people coming into the service from the community as opposed to the hospital to grow as the system moves to a more preventative proactive focus.

The preferred option will always be to deliver the service within the community, when necessary using nursing and care staff overnight; however if this is not possible the service will have bed based options in the community if required.

Supporting the model, we plan to develop an integrated telecare and telehealth service that builds on local intelligence and demographics. Target groups will include

- Over 85's
- Case managed patients with long term conditions
- Carers
- People with Dementia
- People who have fallen and so are at risk of future falls

The service will be developed through a staged process that develops from an existing and established community alarm service, through competitor negotiations and procurement to provide an integrated model of telecare and telehealth embedded within assessments and care planning.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The functions which the integrated service will bring together are currently provided by the City Council (in house provision) and Solent NHS Trust. The CCG commissions health provision and makes a significant contribution to the City Council reablement service through the reablement budget.

The concept paper for the new model is currently out to consultation and a detailed business case is in development. This will explore future provider arrangements which may include integrated provision via a pooled budget or a single provider model. The new service will be jointly commissioned by the City Council and CCG through the ICU as part of the Better Care pooled fund arrangements.

The project has an agreed Project Initiation Document which includes:-

- Key actions and agreed timescales
- An established project group with provider and commissioning representation for each aspect of the project (which includes all of the above provider leads.
- Risk Management Plan
- Communication and Engagement Plan

With regard to telecare/telehealth, a business case is being progressed by the ICU for the identified target groups. The new service will include existing provider of Community Alarm while developing new business across wider social care and health settings.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The scheme has been informed by:

- "Better Care Workshops" held over the past year which have given a particularly strong steer that our reablement and rehabilitation services should be more joined up, our processes should be simplified and our planning should be coordinated.
- the knowledge and experience of clinicians and practitioners from a range of services in the form of a "Task and Finish Group" to support the process of designing the scheme.
- the ECIST review of hospital admission and discharge processes out of which there are a number of clear messages which have been incorporated into our thinking:
  - Use community resources where possible to manage crisis through rapid coordinated crisis response and timely follow up planning.
  - Once people are admitted to hospital begin the discharge process at the earliest point possible using "trusted Assessor" approaches and engaging moving on services as soon as possible.
  - Once an acute episode is complete and there is no longer a need to remain in hospital patients should be discharged preferably home or to a community resource using whatever support is necessary to do so (including overnight nursing support) with further assessment of need taking place in the community ("Discharge to Assess").
- A cross agency Occupational Therapy Review undertaken in 2012 that identified many concerns in relation to duplication, communication issues and haphazard processes. The recommendations from this review have been incorporated into this scheme in relation to having shared management and shared processes including a single point of access.
- Social Care Institute for Excellence Research briefing 36 (April 2014) Reablement: a cost effective route to better outcomes identified improvement in outcomes and probability of cost effectiveness. The focus on the need for suitably trained care workers has been explicitly incorporated and the role of Occupational therapy skills.
- The King's Fund convened working group of community providers which explored the steps that are required to change community services in ways that will help create the transformation needed (Nigel Evans – Kings Fund "Community Services – How They Can Transform Care" February 2014). The report that was produced highlighted a number of areas that are reflected within this scheme:-
  - Complexity should be removed with simple patterns of multidisciplinary service delivery developed linking primary care and geographical areas with community and hospital based services.
  - Services need to be capable of very rapid response and to work with hospitals to speed up discharge. The ability to access community beds for short stays is seen as important.
  - Significant numbers of patients occupying hospital beds could be cared for in other settings but only if suitable services are available and can be accessed easily.
  - Community services need to reach out into communities more effectively harnessing the power of the wider community to support people in their own homes.

Telecare and telehealth has a growing evidence base from national schemes including 3 million lives and Kings Fund. Recognising there is a broad range of evidence, both in support of and against the use of telecare and telehealth, the local approach has been to use local intelligence to understand the areas where the greatest benefit can be achieved. Feedback from pilots, professionals and individuals has helped to inform the design of the new service.

Modelling based on reducing pressure continues to inform the assumptions about impact and outcomes.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment shown against this Scheme in Part 2 of our submission is the existing spend within the CCG and City Council on provision delivering rehabilitation, reablement, community rapid response and discharge facilitation. By pooling this funding within the Better Care pooled fund, we intend to redesign and develop services in a much more integrated way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme will make a significant contribution to the following Better Care targets:

- reduction in unplanned admissions – through supporting people to maintain their independence at home in their local community and intervening earlier. People who could benefit from rehabilitation and reablement services will be identified as early as possible through risk stratification and early crisis response and in so doing will reduce future risk of crisis.
- reduction in permanent admissions – through supporting people to maintain their independence at home in their community and intervening earlier
- reduction in delayed transfers of care – through supporting timely discharge and recovery. Our plan is to reduce DTOC in 15/16 by around 3 per day from the 14/15 position.
- improved service user experience – through supporting people to set and achieve their own goals and providing confidence and peace of mind through developments like telecare and telehealth
- reduction in readmissions within 91 days after discharge into reablement services
- reduction in injuries due to falls – through the development of a new falls pathway that ensures that every person who has been injured from falling is followed up and has a falls prevention plan

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following metrics will be used specifically to measure the impact of this scheme:

- reduction in unplanned admissions
    - % referrals to rehab and reablement service coming from community as opposed to hospital discharge (a higher percentage would suggest a greater focus on early intervention/prevention)
- reduction in permanent admissions
    - % referrals to rehab and reablement service coming from community as opposed to hospital discharge (a higher percentage would suggest a greater focus on early intervention/prevention)
    - evidence of improved/maintenance of function at end of reablement/rehab (measure to be developed)
- reduction in delayed transfers of care
    - reduction % delayed transfers where prime reason recorded to be awaiting equipment (this has reduced from 2% to 1% over the last 4 years)
    - Integrated Discharge Bureau daily average discharges (increasing this from 10 to 15)

- % Section 5 Patients discharged within targeted time limits (target is 60% within 3 days)
- reduce number of patients discharged from UHS with length of stay > 30 days

- improved service user experience
  - direct feedback from patients who have used rehab and reablement services (measures to be developed)
- reduction in readmissions within 91 days after discharge into reablement services
  - evidence of improved/maintenance of function at end of reablement/rehab (measure to be developed)
- reduction in injuries due to falls
  - Number of patients in receipt of comprehensive falls assessment
  - Number of patients participating in evidence based exercise programmes.
  - Physical outcome measures at the start and the end of the exercise programmes to be reported quarterly. These outcome measures will be measures that correlate to falls risk therefore improvement in outcome measures reported should correlate to lower falls risk for patients.

What are the key success factors for implementation of this scheme?

- Culture change to build reablement ethos into wider community services, e.g. domiciliary care
- Good robust engagement and coproduction with all stakeholders – see our Communication and Engagement Plan for how we are taking this forward.
- Strong leadership – this is provided through the Integrated Care Board which includes leaders from across the health and social care system, as well as the voluntary and community sector, and oversees our Better Care work programme.
- A diverse and sufficient community market for meeting people's long term needs which promotes a reablement ethos – this scheme is closely linked to Scheme 3C.
- Good systems for identifying and targeting those people early enough to maximise positive outcomes of rehabilitation and reablement – this requires good risk stratification processes and close working with the cluster teams described in team one.
- Commissioning for outcomes instead of outputs and stand alone tasks

Scheme ref no.
3
Scheme name
Community development (including self management and development of a community navigation function)
What is the strategic objective of this scheme?
The objective is to build capacity with and within local communities and create a future health and social care system within Southampton where local communities are equal partners in all planning, strategic thinking and decision making. It requires changing the way we work together with local communities as well as recognising, valuing and working with existing groups and activities. The aim is to build capacity (part of our plan for protecting social care services) and also to shift towards a culture which helps people to find their own solutions, drawing on their own strengths and those of the people around them and feel part of a bigger community network. Tackling loneliness is also a key part of this agenda, recognising the significant proportion of older people who live on their own in Southampton (see Case for Change section).
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme builds on the work already happening in the community. We will continue to work with communities and providers to develop the local markets to maximise local capacity to support health and wellbeing of communities, including local action to reduce loneliness and social isolation and provide exercise classes as part of our falls pathway that we are developing. This will also include proactive support through voluntary sector partners to attract and maximise alternative funding opportunities (e.g. Big Lottery, Trust funds) into local communities of identity (e.g. ethnicity, diagnosis, neighbourhoods). We will review existing provision, building on existing developments like “Time Banks” and contracts to explore opportunities for out-sourcing areas of work/activity to the community and voluntary sector, at the same time as exploring different models of working with the community and voluntary sector which facilitate innovation and growth. Community development is drawn together through a cross sector Community Development group, sponsored by the HWB’s involvement in a draft framework with TLAP to Develop the Power of strong inclusive communities. A particular area of development which is key to our Better Care model involves the Community Navigation function which has been implemented successfully across the country. Community navigation is about supporting people in their local communities to maintain their health and wellbeing, manage their own conditions and access community resources, directly linking people to activities/community resources e.g. leisure, employment, education, welfare rights, housing, friendship schemes, time banking schemes and volunteering. The community navigator will link people into support networks (e.g. health trainers, Steps to Wellbeing) which will help them to develop a plan to manage and improve their health and wellbeing and support them to achieve their personal goals. They will provide a point of contact to access universal services and also actively follow up people to check out that their needs are being met and identify if additional support is required. They will also be in a good position to identify gaps in support and to provide a rich resource of information for commissioners and community groups/voluntary sector providers. The target group for community navigation are people who are both frequent attenders to primary care and or urgent care services, who are not eligible for coordinated care, but have an identified significant underlying unmet need and people who have been identified by the cluster teams as being at moderate risk of deterioration in their health and wellbeing. Generally this

will be the same group of people likely to benefit from supported self care who account for approximately 15% of our population (35,000 people) and 25.5% of total emergency admissions (7,000) as identified above in Scheme One. The community navigator will receive referrals from primary care and cluster teams.

At an individual level we will continue to work in way that helps individuals understand and maximise opportunities for developing their own social capital. A particular area of development is Person Centred Planning with patients who have Long Term Conditions. We are rolling out a scheme which is aiming initially to provide support to 60 patients to develop person centred plans (PCP). These plans will explore areas such as hopes, dreams and fears of the individual, what a good day and a bad day looks like, what's working and what's not working, people's gifts, talents and capacities. Again this will focus on the 15% moderate risk cohort identified above.

People will develop their person centred plan with key individuals (people who they want to help them plan and make the plan come to life) and be facilitated by a skilled volunteer. Assisting people to develop a person centred plan helps them to take control over their own health. It is planned that care plans will be accessible to patients and professionals involved in their care via the Hampshire Health Repository (mentioned above in Section 7c). These plans will inform health and social care professionals and commissioners about how best to deliver care and what needs to be in place to achieve person centred care.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The community development group (mentioned above) reports to the Integrated Care Board and builds on and works with a number of existing initiatives including the community development workers (CDWs) network. The role of the community development group is to:

- to identify priority areas for development
- to map existing community assets against specific needs/priorities
- to introduce the community navigation role
- to attract and maximise alternative funding/support opportunities.
- to support coproduction with voluntary organisations and communities
- to support Better Care communications and engagement
- to evaluate and review initiatives

The community navigation function is being developed through a process of co-production, involving clinicians, cluster staff, voluntary organisations, community leaders and other interested stakeholders. It is envisaged that the function will be delivered by the community and voluntary sector and we are planning to write to potential providers in October 2014 to ask for expressions of interest in moving this forward. A stakeholder event will be held in October 2014. The CCG is providing pump priming funding initially for one year (with a potential extension) to support the sector in setting up and delivering this initiative but the intention is that this will become self funding. The Integrated Commissioning Unit market development function will offer practical support and advice to voluntary organisations in seeking external funding.

In terms of the person centred planning scheme, we are working with a range of voluntary sector organisations and community groups including: Age UK, Alzheimer's Society, Marie Currie, Carers Together, Healthwatch, Woolston Timebank, and a number of faith groups. Currently mapping work is underway to identify the range of community resources available and help prioritise the focus of future community development. The plan is to go back to this network to identify suitable individuals who could be offered PCP facilitator training and support.

The aim is to provide training and support to 20 patients, family members or volunteers (from community groups or voluntary sector organisations) from the demonstrator site to develop their skills in person centred planning, for these individuals to support at least one people to develop a person centred plan following and during the training.

We will invite 10 of the individuals trained to become "Train the Trainers", so they can pass on their growing expertise and experience to others from across the City.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The TLAP draft framework for HWBs states

> "There is compelling evidence that better health and wellbeing can be achieved through developing stronger and more inclusive communities and re-designing and tailoring public services so that professional expertise complements people's own lived experience"

This evidence is provided from proactive agencies such as NESTA, Kings Fund, TLAP, Expert Patients programme and LSE (Martin Knapp).

The community navigation function or similar function has been tested in a number of areas, most notably Torbay, Greenwich and Cornwall. In developing our plans we have established close links with experts from Torbay and have also visiting Greenwich to find out about what they are doing.

The learning from the local pilot of our Better Care model referenced in Scheme One as well as feedback from the Better Care workshops we held in November, January and during April/May highlighted the need for community navigation in Southampton which will support the progression of the Better Care agenda.

With regard to person centred planning, this approach has been well tested with people who have learning disabilities. There is research evidence that even the most excluded and disempowered individuals in society are able to use person centred planning to gain increased control and ownership of their care. By developing a person centred plan individuals will be in a strong position to engage in self management, shared decision making and personal budgets.

The ICU is working closely with academics from the University of Southampton in conjunction with the Wessex CLAHRC (Collaborations for Leadership in Applied Health Research and Care) and the Wessex Health Academic Health Sciences Network. The evaluation is gathering qualitative and quantative data, which is linked to an Agile approach to project delivery so that a PDSA (Plan, Do, Study, Act) cycle can be followed on a 3 month basis. By adopting this approach early lessons learned can be consolidated and new innovative methods adopted both engaging professionals and patients.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

We have badged existing collective spend across the CCG and City Council in the voluntary and community sector relating to the Better Care model against this scheme, in addition to some additional investment we are making in the community navigation and person centred planning developments. The intention is to use the pooled fund to redesign and develop services in a way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme supports the delivery of local person centred coordinated care described in Scheme One and so it is difficult to quantify separately the specific impact in relation to the Better Care targets. The scheme seeks to support individuals to have and maintain for as long as possible a healthy, meaningful life located with the community of their choice being able to actively self manage their conditions. As such it will support the delivery of the following:

- reducing permanent admissions to residential and nursing care
- reducing emergency hospital admissions
- improving patient experience – people feel supported to manage their long term condition

Specifically this will be achieved through:

- Helping people to access through their local communities and networks support and activities that are meaningful to them, give them a sense of purpose, provide friendships and reduce loneliness and isolation
- Enabling people to adopt behaviours to support their health and wellbeing and enable them to overcome blocking factors (income, caring roles, self-esteem, stress and anxiety) which previously resulted in need to access services.
- Reducing the dependency on clinical services for non-clinical problems by offering alternative services to individuals who may be seeking social and emotional support.
- Delaying the need for social care eligible services.
- Increasing compliance with appropriate interventions which will subsequently reduce waste in the health/social care system - reducing attendance at primary care and other health care settings (ED/Ambulance calls & conveyance).

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We are still working through ways of measuring the specific impact of this scheme but are considering the following measures and metrics:

- Number of community groups and activities across the city supporting the target group
- Number of referrals from primary care and cluster teams to voluntary organisations via community navigation
- % of voluntary organisations reporting positively to statement "We are feel we are contributing positively to achieving the Better care agenda" (via survey)
- Samples patients to measure capacity to self-manage using PAM scores collected on a longitudinal basis.
- Reduction in attendance at primary care for non clinical problems

We are working with Healthwatch to explore the development of a patient survey, specifically linked to our local Better Care metric “percentage of people who feel supported to manage their long term conditions”.

What are the key success factors for implementation of this scheme?

- Engagement of community representatives in strategic planning and service developments (coproduction)
- Delivery of the Community development group work plan, through joint working and ownership by Integrated Care Board
- Contributing to the TLAP framework for developing strong and inclusive communities with evidence based case studies.

- Ability to attract funding from external sources to meet gaps identified within local communities but not met by statutory funding.

Scheme ref no.

3b

Scheme name

Supporting carers

What is the strategic objective of this scheme?

To build and develop capacity by identifying an increased number of carers and providing them with information, advice and support to help them maintain their caring role.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Council and CCG are pooling available resources and have recommissioned new adult and young carer services from September 2014. These services will streamline current provision while expanding the identification, advice, information and support provided to the increasing number of unpaid carers. This work will be ambitious in its remit and work with young, adult and older carers in appropriate ways.

Services will be asked to meet the critical areas set out nationally and locally, in particular supporting those with caring responsibilities to identify themselves at an early stage, providing accessible and meaningful information through website, literature, face to face contact and wider technical communication channels, recognizing carers in their own right, maximising the education, employment, income and benefits of carers and building community capacity to improve the wellbeing of carers (and those cared for).

In particular the scheme will deliver against a number of key themes set out in the revised 2010 national carer strategy:

- supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages;
- enabling those with caring responsibilities to fulfil their educational and employment potential;
- personalised support both for carers and those they support, enabling them to have a family and community life; and
- supporting carers to remain mentally and physically well.

The new service will continue to work closely with the Local Authority as it continues to deliver carers' assessments, and progress the requirements within the Care Act and Children & Families Act. It is planned to substantially increase the number of adult carers identified from April 2014, rising from under 3,000 to over 5,000 by March 2015 and engage more young carers in appropriate support.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The scope and reach of the new service was developed from a joint strategic carers strategy for Southampton. This was used to inform the Carer Commissioning Framework in 2013 and underpins the basis for jointly commissioning the adult and young carers service.

The integrated commissioning unit (ICU) worked on the procurement of the new service, under relevant governance processes for both CCG and City Council. The service was commissioned through a legal procurement process, resulting in a local voluntary sector provider being awarded the contract. The City Council is the lead commissioner for the service. Regular contract monitoring by the ICU will ensure performance, outcomes and quality are achieved.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The basis for this scheme and service was drawn from national and local evidence base. The design also went through consultation with local carers.

National evidence shows that good robust and comprehensive support for carers will be essential as the health and social care system deals with the challenge of meeting increasing need with less resource (Dept of Health, Carers at the Heart of 21st Century).

Key but not exclusive national evidence and drivers are set out in:

- National Carers Strategy 2008 and Revised National Carers Strategy 2010; and
- Making it Real for Carers.
- Commissioning for carers: Key Principles for Clinical Commissioning Groups (carers Trust 2013)
- RCGP Commissioning for Carers 2013

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

NB. This scheme includes the additional £221k investment into carers assessment and support being made for implementation of the Care Act, in addition to the existing £600k ringfenced budget for carers and other areas of spend on carers, e.g. short breaks

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme like the Community Development Scheme supports the delivery of local person centred coordinated care described in Scheme One and so it is difficult to quantify separately the specific impact in relation to the Better Care targets. The scheme seeks to support carers in their caring role and thereby will contribute towards achieving a number of the Better Care targets, in particular reducing permanent admissions and improving patient experience.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The contract holds a range of performance and outcome measures which will inform the wider developments within integrated care and carer services.

We will monitor the number of carers (including new carers) identified, engaged and provided with the range of services jointly commissioned. Through a steady yet significant increase in the numbers engaged and provided with the relevant information, advice and support and surveys we expect to see an increase year on year in the number of carers (as a percentage of all carers engaged in the service) reporting that they feel better equipped to continue caring where it is appropriate for them to do so, who feel engagement with the service has resulted in a positive benefit to their life and has helped them maintain and safeguard their own education, employment, income and benefits.

What are the key success factors for implementation of this scheme?

- strong engagement with key care and health settings to achieve greater identification of carers and signposting to assessment and support

Scheme ref no.
3c
Scheme name
Placements and packages
What is the strategic objective of this scheme?
The strategic objectives of this scheme are: • Ensuring people have the right care and support at the right time • Ensuring care and support packages are tailored to the unique needs of the individual and their carers • Enabling people to exercise choice in how care and support is provided • Maximising the use of Direct Payments (DPs) and Personal Health Budgets (PHBs) • Working with local markets to develop flexible and innovative approaches to the provision and delivery of care and support and which support the above objectives
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The city council and CCG are committed to delivering services in a personalised way and maximising the use of DPs and PHBs. This will build on successful local pilots. At the heart of our vision is the view that tailoring care and support to the unique needs and assets of the individual will improve outcomes – individuals know best about what will work for them. Assessment and delivery of care and support will be holistic and we will consider physical and mental health needs together. This will be supported by the whole Better Care programme and the complementary effect of the individual schemes including those focusing on improving access to information and the development of integrated assessments. This scheme will focus on ensuring the quality, availability and diversity of packages and placements. To support this we will: • Implement processes across the city council and CCG which support the take up of direct payments. This will include in-house processes such as finance and payments but also include developments such as pre-payments cards and Individual Service Fund providers (ISF). We already have a Direct Payments Support Service and can build on the lessons learnt from them. We are looking to integrate CHC and Adult Social Care assessment and review processes, using the Care Bill to support this e.g. by removing the restrictions on who can do social care assessments. The team focus would be on personalisation and the ongoing roll out of personal budgets and personal health budgets. • Implement a market development strategy that increases diversity and flexibility of services. This will include increasing access to Personal Assistants, shifting the balance between care and support provided in the home and that provided in residential settings and improving access to accommodation and community support. • We are already reviewing a range of services, including day care and residential services for all care groups and respite provision, and are looking to develop more flexible models of care and support. This will involve a shift away from block purchased contracts towards more individual arrangements. Where we continue to block purchase we will build in arrangements which support personalised approaches and make this contractual – we are already including this in a current re-tender of our domiciliary care framework. We are looking to develop services which better support prevention,

including enabling people to remain living at home and to support carers, contributing to preventing unnecessary hospital admissions and admissions to care homes. In terms of residential care, we are committed to reduce the use of residential care services by providing better alternatives in the community, and increasing options for care in people's own homes. This includes the development of housing with care and support, four schemes of which have already been developed in the city since 2008, with a further scheme planned, which will provide a further 30 housing with care and support places, as part of a wider development of accommodation for older people. It also includes a greater range of realistic options for supporting people to stay in their own homes, and to have greater options to take on and to spend their personal budget on supported access to mainstream and community-based services.

- Work with staff across the system to support a cultural shift towards an asset based approach which gives more choice and control to individuals.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Delivery of this scheme is being progressed by the ICU. Detailed project initiation documents (PIDs) are in place for the day care, residential, respite and domiciliary care reviews with clearly identified actions, leads and timeframes. All procurement and contracting will be undertaken within the procedures of the two agencies within the relevant governance arrangements. All reviews will be subject to public consultation and will result in option appraisals and recommendations which will be agreed through the governance structures described above.

For domiciliary care we are out to tender and will have new contracts in place by February 2015 to support the model described above. The ICU currently manages a number of separate contracts for domiciliary care. Snapshot data provided in July 2013 identifies that the domiciliary care market within Southampton currently provides care for approximately 1,810 people in any given week (1,750 SCC and 60 SCCCG). There are currently up to 75 providers (65 spot purchased and 10 framework providers contracted) working in the city and delivering care packages on behalf of SCC and the CCG. 48% of domiciliary care is currently spot purchased – the tender aims to reduce this significantly so that the majority of domiciliary care is purchased through the framework to a set specification for quality and price.

The new domiciliary care framework will be managed through the ICU's Care Placement Service. The design of the model of provision to be delivered through the framework agreement is proposed to deliver improvement through:

- Greater flexibility and capacity, whilst still maintaining the geographical focus which recognises the issue of travel time.
- Clearer quality standards and performance indicators (KPIs) linked to contract terms and conditions which will support the drive for quality.
- A more streamlined systems approach as outlined in the service specification with a strong emphasis on promoting personalisation and independence
- A requirement to deliver outcome based support using flexible care plans that shift away from minute by minute calls.
- A more generic approach focussing on need rather than diagnosis

Day care is currently provided in house and through block contracts with external providers or individual packages of support. There are 39 external day care providers. Block contracts are with Age Concern, Headway Southampton, SCA Community Care Services Ltd and provide for 175 users over 65, 20 under 65 years. Internal provision is provided through four centres to 287 users. Provision tends to be based around the needs of specific client groups particularly adults with learning disabilities, physical disabilities, severe and enduring mental health needs

and older people. It is envisaged that future provision will include a wider range of private day service provision purchased through individual care packages or personal budgets. Again this will be purchased through the ICU's Care Placement Service.

Residential care is currently provided in house (through four residential care homes for older people, three of which are dementia long-stay, residential care settings (with some respite). In addition, Brownhill House (a rehabilitation unit) also provides a crisis response and respite facility. Current in-house services account for 11% of placements in all homes - The average for the city's neighbouring authorities is 5%. This figure equates to a total of approximately 21% of placements made by the City in residential care settings.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is evidence to show that personal budgets improve the experience of patients and clients. An evaluation of the pilot programme for personal health budgets suggested that:

- Personal health budgets were cost-effective relative to conventional service delivery – though cost neutral overall, there were some savings for people with the most complex needs.
- People with higher levels of need benefited most regardless of diagnosis, similarly high-value personal health budgets (over £1,000 a year) were found to be more cost-effective than low-value budgets.
- Personal health budgets were found to be effective for both mental and physical health conditions and the net benefits of personal health budgets for Continuing Health Care and mental health were tentatively found to be greater than for other patient groups.
- Most people appreciated the increased choice, control and flexibility that personal health budgets afforded and many chose to use their budget on treatments and services outside NHS provision, including through employing personal assistants

A subsequent survey of personal health budget holders showed that:

- Over 70% of personal health budget holders reported their budget having a positive impact on their independence
- Over 60% of personal health budget holders reported their budget having a positive impact on their physical health (68.8%), getting the support they wanted (68.3%), being supported with dignity and respect (67.9%), being in control of their support (67.7%), being in control over the important things in life (67.2%), and on their mental wellbeing (63.9%).
- Over 50% of personal health budget holders reported their budget having a positive impact on the long-term condition for which they held the budget (59.4%), feeling safe in and outside the home (58.2%), their relationships with people paid to support them (53.1%), and their relationships with members of their family (50.8%).

Local pilots of the use of DPs and PHBs have demonstrated a shift in the way care is delivered, for example in a local pilot we saw a shift from residential to community based alcohol treatment. People also valued feeling more in control. Issues raised included concern about managing the practical arrangements, the availability of services and impact on carers.

There is evidence to show that personal budgets, choice and control improve individual outcomes, quality of life, user satisfaction (Valuing People, Care Act legislation).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

This scheme includes the remainder of the additional investment being made for implementation of the Care Act: £379,000 (excluding the £231k investment for IT which is shown under infrastructure).

It should be noted that the rest of the funding shown against this scheme relates to existing collective spend across the CCG and City Council on placements and packages. The intention is to use the pooled fund to redesign and develop services in a way that supports the delivery of our Better Care vision. However, as we develop our model and further test our assumptions and ideas, we may well flex investment between the schemes and so the figures identified against each scheme in Part 2, Tab 3. HWB Expenditure Plan may change over time.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme will particularly impact on the reduction in permanent admissions to residential and nursing care and reduction in delayed transfers of care, where lack of capacity and flexibility in the market has led to delays in discharge processes and sometimes over-reliance on residential solutions.

Our Case for Change has already outlined that delayed transfers of care are high in Southampton and this is a key priority for us. An analysis of hospital bed days lost as a result of delayed transfers of care over the last 4 years is showing that:

- family choice of residential/nursing home accounts for around 40% of bed days lost
- and awaiting a care package in own home accounts for around 7.5% of bed days lost

Although this data is a subjective judgement made by staff, it does suggest that there is a strong need to improve capacity, flexibility and responsiveness of community support.

This scheme, working alongside the model of local person centred coordinated care and a more proactive integrated rehabilitation and reablement provision, aims to achieve the reductions in permanent admissions and delayed transfers identified in Part 2 of this submission. It will do this by:

- increasing capacity and flexibility
- supporting a greater take-up of direct payments and personal health budgets leading to a greater focus of personalised approaches in all placement and packages
- encouraging greater use of community based resources as an alternative to the more traditional building based models
- a reduction in block funded care in favour of individual approaches
- higher levels of satisfaction from service users and carers

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We will develop a monitoring framework to track the impact against identified outcomes in order to ensure these are delivered and to enable early identification of any additional risks and opportunities.

This will be overseen by the Integrated Care Board who are responsible for monitoring the system wide impact of the Better care Programme.

Information from the take-up of direct payments and personal health budgets will be used to inform future commissioning intentions and will be incorporated into our market development strategies. We will use this intelligence to stimulate the services people tell us they need.

We will use service user and carer feedback to address the practical arrangements supporting the take up of options including looking for efficient ways to make payments and monitor quality.

Co-production approaches to service redesign are, and will continue to be used to inform service models and specifications.

Successful take up of individual payments will inform decisions relating to procurement – whether to continue block purchase arrangements for example.

Specific metrics will include:

- % domiciliary care purchased outside the framework
- reduction in minute by minute calls for domiciliary care
- increased uptake of direct payments
- reduction in hospital bed days lost as a result of delayed transfers of care related to awaiting a care package at home or family choice of residential care.

What are the key success factors for implementation of this scheme?

- A shift in culture on the part of professional staff and service users and carers to support self-directed approaches
- Practical arrangements for take up of direct payments and personal health budgets that are easily understood by all
- Accessible information people need to make choices
- A diverse marketplace able to meet and respond to the choices people wish to make

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Southampton City Health & Wellbeing Board
Name of Provider organisation	University Hospital Southampton, NHSFT
Name of Provider CEO	Fiona Dalton
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	28, 431*
	2014/15 Plan	28,335 *
	2015/16 Plan	27,768 *
	14/15 Change compared to 13/14 outturn	-0.3% (excluding any adjustment for growth)
	15/16 Change compared to planned 14/15 outturn	-2% (excluding any adjustment for growth)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	380 (includes 1% growth)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	850 (includes1% growth)

* Please note that the above figures are the total number of NEL FFCES (general and acute) **for all providers** for the **Southampton City resident population** (which will be slightly different to the Southampton City CCG population). It is based on provider MAR returns. UHSFT accounts for about 94% of this, the remainder being activity at other hospitals in neighbouring Trust.

For Provider to populate:

Guidance notes: A good provider commentary will:

- Confirm detailed and meaningful provider involvement in the development of the plans, from the major acute providers locally
- Demonstrate clear alignment between the overarching BCF plan and the provider plans
- Provide triangulation to provide reassurance that the projected reductions in planned emergency activity are feasible

- Confirm that providers are implementing their own risk management and action plans to respond to the planned change in activity
- Demonstrate a shared understanding of the critical path to successful delivery
- Articulate local risks and cross reference with the risk log in Section 4

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust understands the rationale used by SCCCG in terms of reduction. Our partner has forecast 1% growth to be reduced via QIPP and 2% baseline reduction to be delivered via Better Care schemes. The Trust reviewed growth as part of the Annual Planning Review and during the years leading up to 2013/14 experienced an annual growth rate of circa 6% growth for NEL admissions. During 2013/14 growth was circa 3%. On this basis the Trust included a 1% reduction for 2015/16 in its 5 Year Strategic Plan submitted to Monitor in relation to Better Care. The remaining 2% growth is above baseline contract.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	The difference between the Trust and CCG projections is highlighted because the Trust has to plan to meet the expected demand that it forecasts and match capacity to that. The CCG planned reductions are more ambitious than the plans included within our Monitor submission, but we welcome the ambition of the health and social care community in attempting to make a radical change. Our Monitor plans, which were developed prior to the development of the CCG initiatives, therefore now reflect a risk that those initiatives may not be delivered as quickly as the CCG expects and that underlying growth could return to pre 2013/14 levels. However, this should not be misinterpreted as a divergence from the CCG plans. Indeed as they are delivered the benefit of the delivery of these schemes will be reflected in the next iteration of our plans. If the SCCG ambition was realised, there would initially be a positive impact on the hospital with less capacity pressures, improved operational performance and reduced financial pressures of unplanned bed openings and agency usage. In the longer term, if these ambitions were realised, we would have to reconfigure the hospital and would be relying on the health care community's commitment to the further centralisation of regional services to maintain a viable high quality organisation. The Trust recognises the CCG schemes and is committed as a local health economy partner to the aims and rational of them. The Trust supports their aims of reducing emergency admissions and more importantly reducing length of stay once a patient has actually been admitted: *Scheme 1 – Local Person Centred Co-ordinated Care & Long-term Conditions Pathways* *The Trust is committed to person centred care and creating seamless pathways across organisational agencies.*

		Reducing non-elective admissions will improve patient flow through the system and reduce pressure in social care, in order that more planned management of demand can be achieved. This will reduce stress in the current system and deliver efficiencies for all partners including Trust length of stay. The focus on elderly is significant as these are the growing pressure in the population in terms of demand, which have long lengths of stay. *Scheme 2 – Responsive Discharge & Reablement – Supporting Timely Discharge & Recovery* *This scheme is a priority for the Trust and links to the local ECIST Plan within the local health economy (LHE) to change the focus of demand management to discharge (back door). This is critical in terms of patient flow, occupancy and Trust performance together with the management of capacity. The Trust has had an overall total of between 130 to 170 delayed transfers over recent times per day. SCCG is committing to reduce these by circa 5 per day then further 3 per day for their related activity.* *Scheme 3 –Building Capacity* *Critical scheme to align demand and capacity across the LHE, transformation of personalised health budgets, sign-posting and carer support, which impacts risk stratification of patients in terms of keeping at home or need for step-up/step down care.* In the long term the successful delivery of the Better Care initiatives will ensure that Trust activity reduces and this will be reflected in the projections we make each year.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes, the Trust considers different scenarios when planning the size and demand requirements of the organisation, in context with both the local and national priorities. It has to make a balanced judgement on the pace of change and delivery of any planned reductions in activity. The Trust also provides specialist regional services, R&D and education when future proofing the hospital.