

DECISION-MAKER:	HEALTH AND WELLBEING BOARD		
SUBJECT:	BETTER CARE SOUTHAMPTON IMPLEMENTATION		
DATE OF DECISION:	25TH MARCH 2015		
REPORT OF:	DIRECTOR OF QUALITY AND INTEGRATION, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP (CCG)		
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STATEMENT OF CONFIDENTIALITY			
None			

BRIEF SUMMARY

Over the last 12 months extensive work has been undertaken by the City Council working in partnership with Southampton City CCG and other stakeholders to develop Southampton's Better Care Plan, under the leadership of the Health and Wellbeing Board. The final plan was signed off by the Health and Wellbeing Board, Chief Executive of the City Council and Chief Operating Officer of the CCG on 19 September 2014 and submitted to Ministers. This has been approved following the Nationally Consistent Assurance Review which identified no areas of high risk within the plan and means that Southampton can now progress with full implementation of its plan. This includes the establishment of a Better Care pooled fund by 1 April 2015.

This report summarises some of the progress towards implementation of Better Care Southampton.

RECOMMENDATIONS :

- (i) To note the progress with the implementation of Better Care Southampton.
- (ii) To support the progress by the Council and Southampton City CCG with finalisation of S75 of the National Health Service Act 2006 Partnership Agreement Pooled Fund, noting Southampton's ambition to achieve integration at scale

REASONS FOR REPORT RECOMMENDATIONS

- 1 From 1 April 2015 Local Authorities and CCGs are required to establish a pooled fund under Section 75 of the NHS Act 2006 for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authority.

- 2 Southampton City has taken a more holistic approach to health and social care and proposes to fund and commission it in that way. The ambition is to encompass all services that fit within the scope of the Better Care model, eventually bringing together approximately £132m into the pooled fund. Approval to proceed with the pooled fund has been given by Health and Wellbeing Board, Full Council and Clinical Commissioning group Governing body.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

- 3 To pool only the minimum - this has been rejected on the basis that Southampton's Better Care Plan seeks to achieve a fully integrated model of health and social care. In order to achieve this ambitious transformation, it is considered necessary to bring together all of those health and social care resources associated with this vision and commission services in a fully integrated way, which is focussed on people's outcomes and needs in their entirety, as opposed to their health or social care in isolation.

DETAIL (Including consultation carried out)

Implementation of Better Care Southampton

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

The overall aims 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.

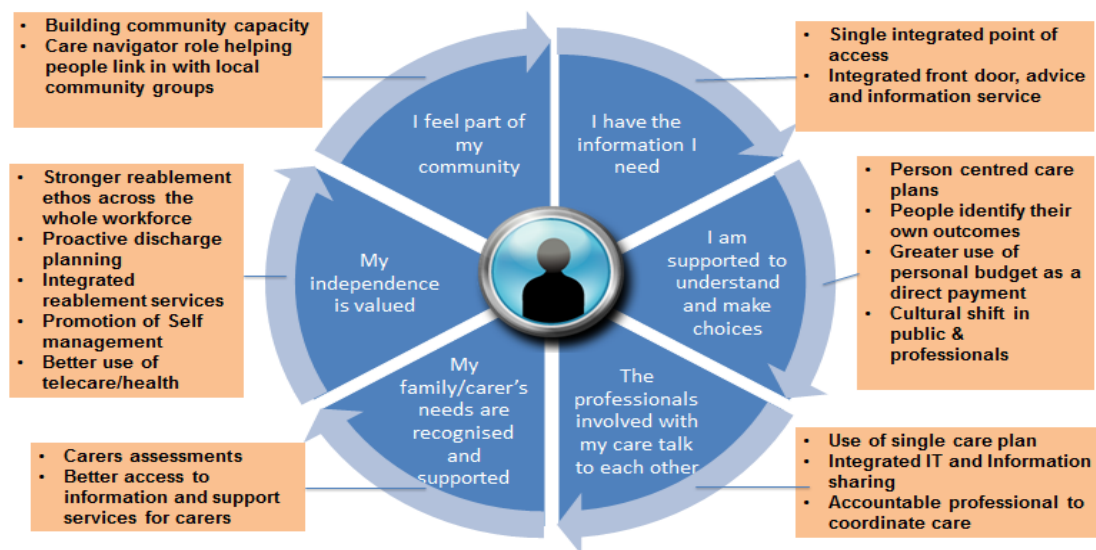
- 5 Southampton's plan has the following main schemes and work is in progress with each:

1. Local person centred coordinated care (clusters) - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, and 7 day working.
2. 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 deterioration, as well as supporting people's recovery and reablement following a period of illness.

3. Community solutions and prevention - this scheme is aimed at building on and developing local community assets and supporting people and families to find their own solutions.
4. 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.
5. Developing the market for placements and packages and further integrating approaches – this includes work 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.

Appendix 1 outlines the progress of work within the Better Care newsletter. This is used to communicate progress to a wide range of stakeholders

- 6 The diagram below illustrates what the system will look like from the perspective of an individual and the work in progress to achieve this:



7 Cluster Development

Development of integrated care in Southampton is focused around six cluster areas. To support implementation, leadership groups are now working in all six, formed from community health providers, adult social care, supported housing and voluntary sector organisations. These groups have developed a cluster specific implementation plan, resulting in six plans now being in place to underpin the city wide approach. These early plans include real time actions towards integrating care for the frail elderly and people with complex needs as a result of having a number of long term conditions.

The primary areas of focus are as follows:

- Integration of care planning between community and primary care providers (cluster 5).
- Development of cluster need and service profiles (city wide – starting in cluster 3, 4 and 5).
- Focus around the specific registered practice population, where extraordinary need identified (cluster 4 and 6).
- Development of shared agreement of those most vulnerable in each cluster, providing a primary focus for integrated care development (city wide – starting in cluster 1, 2 and 4).

Over the coming 3 months the city wide group will be in the process of engaging with a wider group of services, i.e. those more primary supporting adult population. These will include: learning disability services; adult mental health services; substance misuse services; and IAPT (Improving Access to Psychological Therapy). This will initially start from a city wide view before moving into cluster development discussions.

8 **Integrated rehabilitation and reablement**

The aim is to integrate resources that facilitate rapid crisis response, timely hospital discharge and preventative and recovery focused rehabilitation and reablement. This will be achieved through working alongside families/carers and community clusters to:

- undertake community rehabilitation and falls prevention activity.
- assess and coordinate safe discharge of people from hospital back into their communities.
- collectively intervene early and rapidly responding to crisis situations in a coordinated and flexible manner thus helping to avoid unnecessary acute hospital, residential and nursing home care or complex home packages.

A new service specification is in place and service providers are working together to integrate services with a completion date by July 2015.

9 **Community solutions and prevention**

The Community Solutions group oversees and coordinates the delivery of increased community involvement to support the Better Care agenda. The work plan for the coming year includes:

- mapping community resources at a cluster level against identified needs. Community leaders will be encouraged to upload information about their group on either Placebook, SID (Southampton Information Directory) or the Knowledge Hub.
- Community Navigation pilots have commenced Falls Exercise Classes due to commence developed by a consortium led by Age UK and involving Solent University (Sports Sciences), Active Options and Southampton City Housing .
- Southampton is involved in piloting Person Centred Planning for people

with long term conditions. £20,000 has been awarded by NHS England Patients In Control Programme. Age UK is starting to lead the work linking into a small number of GP practices. Early outcomes from the work will be reported in March 2015.

- Nicholstown Surgery in partnership with Age UK have been developing links with local ethnic minority groups to explore how individuals can be supported to self-manage their long term condition (see project evaluation).
- Southampton is involved in a national pilot scheme designed to change the way services are commissioned and delivered, with the involvement of local residents. The Our Place scheme which is underway in the Shirley and Freemantle area has started to engage the community to understand their concerns and priorities. One of the key areas identified is the need to improve the health and wellbeing of older people in the community.

As part of the development of clusters and integrated team developments, a coproduction process is being proposed, which will involve users, carers and voluntary sector organisations, together with statutory services. The aim is to review information emerging regarding the needs of the population in a cluster area, identify common priorities and develop a cross community/organisation action plan which will be delivered and supported by the cluster leadership teams; information which will be used is as follows:

10 **Market Development**

New domiciliary care contracts will come into place on the 1st April increasing reliability and quality of these packages of care.

11 **Performance**

Southampton's Better Care Plan has been designed to achieve the following key targets:

- To reduce unplanned hospital admissions - by 2% year on year over the next 5 years (2014 – 2019). Rate per 100,000 population.
- To reduce permanent admissions to residential and nursing homes - by 12.3% in per capita terms over 2014/15 and sustain and improve on this in subsequent years, bringing Southampton in line first with its statistical neighbours and then the national average. *65 years and over, per 100,000 population* To reduce readmissions by increasing the percentage of older people still at home 91 days post discharge into reablement services - to achieve 90% in 2015/16.
- To reduce delayed transfers of care and therefore excess bed days - by 3 per day in 15/16 which equates to an approximate 10% reduction. *Delayed days, per 100,000 population, average per month, aged 18+.*
- To reduce injuries due to falls - by 12.5% by the end of 2014/15 and sustain and improve on this in subsequent years. *65 years and over.*

Year to date progress is that performance is on target for the reduction in non-elective admissions and permanent admissions to residential and nursing homes Please see Appendix 2.

12 **Development of the Pooled Fund**

Southampton City's Better Care Fund Plan seeks to pool all budgets associated with health and social care services for older people and those with long term conditions to deliver a fully integrated provision centred around the needs of individuals. Pooling these budgets at scale will minimise overlap/gaps in service delivery, increase efficiency, improve value for money and ensure that services are designed to meet the needs of service users. It will enable radical redesign of services around the user regardless of whether their needs are mainly social or health.

The Integrated Commissioning Board (ICB) of the City Council and CCG which oversees all integrated commissioning arrangements between the two organisations has been overseeing the development of the pooled fund, in consultation with City Council and CCG legal representatives and finance. The Board have reviewed the Section 75 agreement and this will be finalised before 31st March 2015. The Partnership Agreement has duration of 3 years with a 3 month notice period for variation, unless otherwise agreed by the ICB. The ICB will oversee the effective management and performance of the overall Partnership Agreement and each of the individual Schemes within it on behalf of the CCG and City Council.

RESOURCE IMPLICATIONS

Capital/Revenue

- 13 The minimum requirement for the Better Care Fund in 2015/16 is £15.325M Revenue and £1.526M Capital. The majority is existing funding sources included within either the Council or CCG 2014/15 budget. This funding is not new to the Health and Social Care system. However, under the conditions of the Better Care Fund, additional funding of £600,000 from within the pool will be provided to help meet the new responsibilities of the Council required by the Care Act 2014. This funding will come from the existing NHS resource and will therefore be a pressure to the CCG.
- 14 It is planned to place three of the five schemes into the pool from 1st April 2015. These schemes will incorporate approximately a further £45m of funding from the Council and the CCG bringing the total planned pool for 2015/16 to £61m. Currently £3.4m of the additional £45m is within an existing joint funding arrangement between SCC and SCCCG under a S75, S76 or S256 agreement. The funding for the first three schemes entering into a pooled fund arrangement will be Council £5.3m, (9%) and CCG £55.5m (91%). It should be noted that all figures in this report are based on 2014/15 budgeted levels for both the Council and CCG. The equivalent budgets for 2015/16, except for the minimum BCF provision, may vary subject to the relevant budget approvals for each organisation.
- 15 It should be noted that it is the commissioning budgets for services that are being pooled and that the services themselves and the associated staff will remain managed and employed as they are currently. Therefore the recommendations in this report have no TUPE implications.

Property/Other

- 16 The proposal should not have any property implications as it relates to commissioning functions. Any changes made to any service funded through the pooled fund which may have property implications will be subject to a separate report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

- 17 Section 75 of the National Health Service Act 2006
The pooled fund agreement will cover governance and technical aspects including accountability, financial reporting and the handling of overspends, underspends and savings requirements.

Other Legal Implications:

- 18 The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to encourage and support integrated working.

POLICY FRAMEWORK IMPLICATIONS

- 19 The decision sought is wholly consistent with the Council's Health and Wellbeing Strategy and other policy framework strategies and plans.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All
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SUPPORTING DOCUMENTATION

Appendices

1.	Southampton City Better Care Plan
2.	Pooled budgets and the Better Care Fund Guidance, October 2014 (The Chartered Institute of Public Finance and Accountancy)

Documents In Members' Rooms

1.	None
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Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes
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Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
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1.	None	
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