Appendix 1
Better Care Fund planning template– Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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 co-terminus. The only difference will be where non Southampton residents have chosen to register with a GP in Southampton.**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£924,000**
2015/16	**£16,851,000**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£59,226,200 (figure still under discussion)**

b) Authorisation and sign off

Signed on behalf of the Clinical	Southampton City CCG

Commissioning Group	
By	John Richards
Position	Chief Officer
Date	<date>

Signed on behalf of the Council	Southampton City Council
By	Dawn Baxendale
Position	Chief Executive
Date	<date>

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	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Southampton City has an established Integrated Person Centred Care Programme which is jointly led by Southampton City CCG and Southampton City Council and already has strong engagement from health and social care providers. The programme is overseen by the Vulnerable People Strategic Delivery Board which has representation from each of the local health providers (South Central Ambulance Service, Solent NHS Trust, University Hospital Southampton NHS Foundation Trust and Southern Health NHS Foundation Trust), the City Council Heads of Service and the Voluntary Sector (Southampton Voluntary Services). This Board has overseen the development of Southampton's Better Care Fund local plan which has been based on the work of the Integrated Person Centred Care Programme.

As part of the communication and engagement plan (attached with project initiation document) for developing the local plan, we have held three large stakeholder workshops, in addition to meetings and individual discussions with providers. The workshops were held on 16 November, 12 December and 17 January 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. They were used to develop and consult on our local plan.

In addition we have involved GP practices in the development of this plan through our locality meetings and TARGET (Time for audit, research, governance, education and training). The locality GP leads and lead GPs for integrated care have been part of the group developing the plan.

All providers have been asked to submit an impact assessment against our plan and we have also agreed our plan and discussed the implications at our System Chiefs meeting, which includes the Chief Executive of the City Council, Chief Officer for the CCG and the Chief Executives of each of the NHS provider trusts.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

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 are in development to ensure that we can continually update people about our progress. In February we will be holding a large stakeholder event in the City and we are currently developing plans with Southampton City Council to establish a citizens council.

e) 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
Project Initiation Document and Engagement Plan	Sets out the governance arrangements and processes for developing our Better Care Fund local plan, along with our plans for communication and engagement.
"Healthier Lives in a Healthier City" -	Southampton City's Health and Wellbeing

Southampton's Health and Wellbeing Strategy	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.
Principles for defining cluster teams	Sets out the principles that have been agreed by key stakeholders within Southampton for defining the local cluster teams. Over the coming months, we will be using these principles to co-produce our clusters and how they will operate with front line staff, public and service users.
Integrated Reablement/Rehabilitation Service – Project Initiation document	Outlines the plan of work we have in place 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 commissioning framework for carers, 2013	Sets out our plans for developing support for carers.
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 – draft strategic intent, 2013	Our strategy for personalisation in Southampton.
Southampton City Personalisation interim workforce learning and development plan, 2013	Sets out our short – medium term plans for developing the workforce to deliver a more personalised health and social care system.
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.
IM&T Project plan for integrated care, 2013	Sets out our IM&T plans to support our integrated care agenda.
Mapping of schemes against national and local metrics	Maps out the schemes we currently have in place or are planning for the coming year and how they contribute to delivery of the national and local metrics.

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Background

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. The overall population is forecast to rise by 4% between 2012 and 2019. The over 65s population is set to increase by 11% and the number of people over 85 years from 5400 to 6100 between 2012 and 2019. In contrast, the proportion of the population of working age is steadily declining. The number of people with long term conditions is 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. Analysis of ACG data with 12 practices shows that 85% of people aged over 65 have at least one chronic condition and 30% of them have more than four; By age 85 these have increased to 93% and 47% respectively. 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.

The changing needs of the population is 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 and Support Bill, are 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. This change is being met with a commensurate, if not more ambitious move within health, voluntary sector and social care practice to offer a fully personalised service for individuals. It requires a significant culture change across all parties including individuals, carers, providers and commissioners.

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.

Southampton City vision for better care

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 integrated person centred care work programme has the following areas of focus:

- 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
- Our services will focus more on prevention and early intervention

We have set our vision which describes where we want to get to:

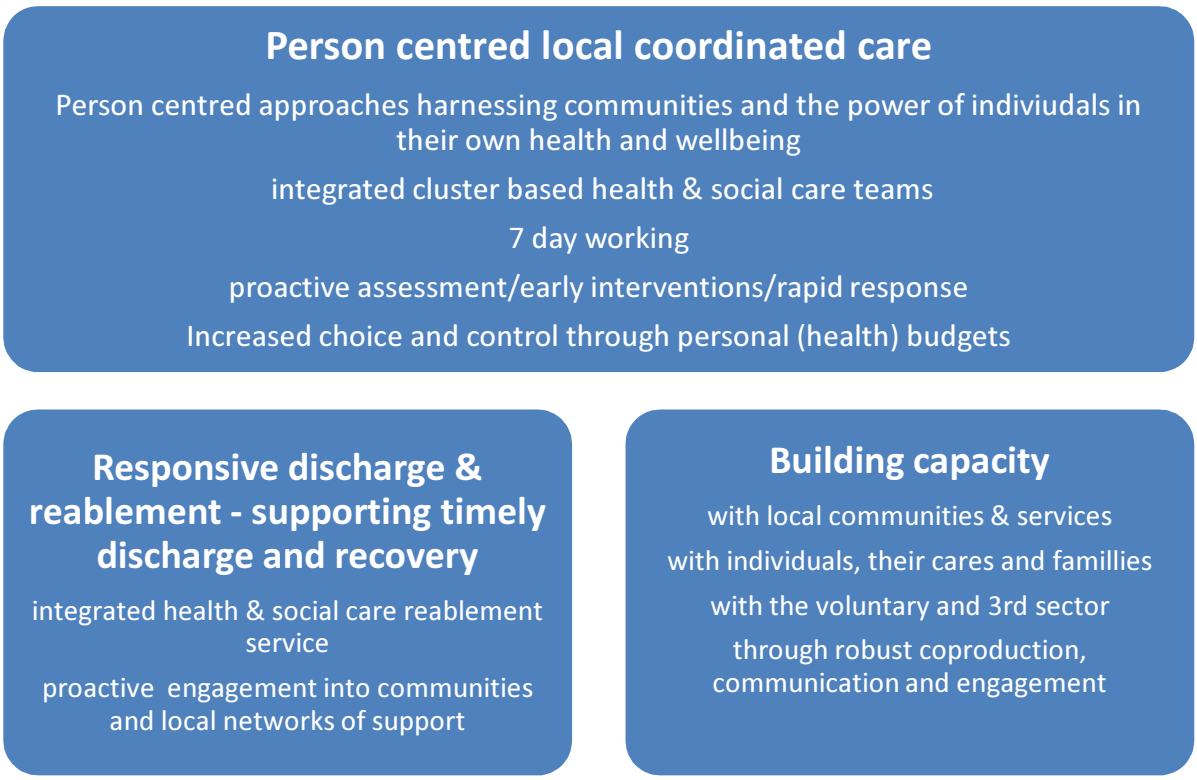
Health and social care working together with you and your community for a healthy Southampton

We have adopted 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 TLAP to develop this approach within the city.

Our approach for system redesign has 3 basic components:



The core principles underpinning the 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** – Direct payments and personal health budgets will be the default method of delivering care so 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 your 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. 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.

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), social care staff, housing workers and the voluntary sector and will inreach 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. We will be working with our local practices, frontline staff and communities over the coming months to determine the most sensible cluster configurations. Specialist services will also reconfigure to actively work within the clusters and some outpatient clinics currently located in the hospital will be delivered locally. 2014/15 will be a period of transition, enabling staff to get to know each other and their local cluster area. A key focus in this year will be to foster amongst staff a sense of identity and knowledge of the geographical area in which they work. This will include identification of need in each area through the pooling of intelligence from each host agency and beginning to jointly identify those people most at risk who may benefit from early preventative planning or intensive care management. 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 QOF 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.
  - **Primary care development programme** to expand capacity and support development of new models of working.
  - **Introduction a common trusted assessment and planning tool across health and social care** (building on the comprehensive geriatric assessment and 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.
  - **A single management structure** with strong leadership. It is intended to identify early on locality/cluster managers to lead the development of each locality/cluster.
  - **Joint workforce development / development of core generic skills,** eg. person centred planning, risk profiling, self management, care coordination, brief intervention skills , working with those with dementia integrated care leadership. 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 will be 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, eg. 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.

- **Introduction of a single point of access for integrated health and social care.** This will include easy access city wide to good quality user friendly information that allows people to assess their own needs and choose the best solutions for themselves, when necessary, with help from trustworthy community based support. It will be staffed by people with the knowledge, skills and information to help people self manage and seek solutions for themselves or recognise the need to refer on for further assessment and intervention. During 2014/15 consideration will be given to the delivery model for this, including mapping existing points of contact and their functions, and consideration of the levels at which the unified point of access should operate (city wide or cluster level or both).The intention is to implement this during 2015/16.

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:
    - City Care First Support 7 day reablement service
    - Brownhill House (City Council reablement residential provision) and the RSH wards (managed by Solent NHS Trust)
    - Health and social care therapies
    - Telecare and telehealth
    - Joint Rapid Response admission avoidance/discharge support service, providing 24/7 crisis response to patients in their own settings

- 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 new 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, 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 elements of the team 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.

Building capacity

This includes:

- **Increased support for carers -** The Council and CCG are pooling available resources to re-commission direct support services during 2013 so that they are in place and ready to commence in spring 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). The new service will continue to work closely with the Local Authority as it continues to deliver carers' assessments, and progress any new requirements emerging in the proposed Care & Support Bill and the Children and Families Bill. 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 include community and primary care settings. 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 and increasing access to personal health budgets for those eligible for continuing health care (from 2014) and those with long term conditions (from 2015). We will be developing our workforce to promote the philosophy of personalisation, implementing in 2014/15 a CQUIN scheme as part of all our NHS provider 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. In 2014/15 we will also be making changes to our finance systems that support the delivery of a personalised health and social care environment.

- **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 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:

- **Devolution of an element (to be defined) of the Better Care fund to cluster teams to incentivise the development of local solutions.** Further work will be undertaken during 2014/15 to determine the size of this budget and how it will be managed at a local level. It is envisaged that the devolved fund will be used for aspects such as personalised care packages and community development.
- **Introduction of a care/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. During the early part of 2014/15, our intention is to further define this role with a view to appointing the first care/support navigators during this shadow 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.

- **Ensuring the right capacity in community support services -** over the coming months we will be reviewing capacity within community support services (including domiciliary care, residential and nursing home provision and day services) with a view to refreshing our demand and capacity plan to support the integrated care model. This will need to take into account profiling of future needs and changing demographic factors. For example 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. 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 the development of a market development team which forms part of the Integrated Commissioning Unit.
- 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.

What difference will this make to patients and service users

For patients and service users, the changes we are making will mean:

- **I have access to easy to understand information which is consistent, accurate, accessible and up to date.** People will have easier access to information about the help available to them in their local communities through their local team and care 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 have as much control of planning my care and support as I want. I am supported to understand my choices and to set and achieve my goals.** People will be involved as equal partners in their care. They will draw up their care plan with professionals 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 have access to a range of support that helps me live the life I want and feel part of a community.** People will have the opportunity to be linked into local voluntary sector schemes and community groups by their care coordinator, which enable them to develop a network of support and share experiences. People will be able to access a local time bank which will enable them to make a contribution to their local community and develop wider friendships.
- **After a set-back, my independence is valued and I am given the help I need to stay at or get back home.** 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.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

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 wherever safe and appropriate to stay in their own homes

- 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 empowered and supported to manage their own conditions	Outcomes for people are improved A sustainable health and social care system. Needs are met Health inequalities will be reduced	• 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 • Increased community capacity and utilisation
	Use of new technologies is maximised, including telecare and telehealth		
	People will be appropriately signposted to local voluntary sector and community support.		
To intervene earlier in order to secure better	People's health and wellbeing are maintained for longer		• Greater number of

outcomes	People are able to be 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		anticipatory care plans developed following risk stratification • Earlier identification and support for people with dementia • Fewer falls

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

To deliver its vision, Southampton City has already embarked on a system wide change programme (the Integrated person centred care programme) and therefore has a lot to build on. Success requires substantial change in the way services are provided and staff work with people, local communities as well as with 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 projected to be made in the acute hospital sector will release money to be reinvested in the integrated out of hospital model.

1. PERSON CENTRED LOCAL COORDINATED CARE

We will use the Better Care Fund for:

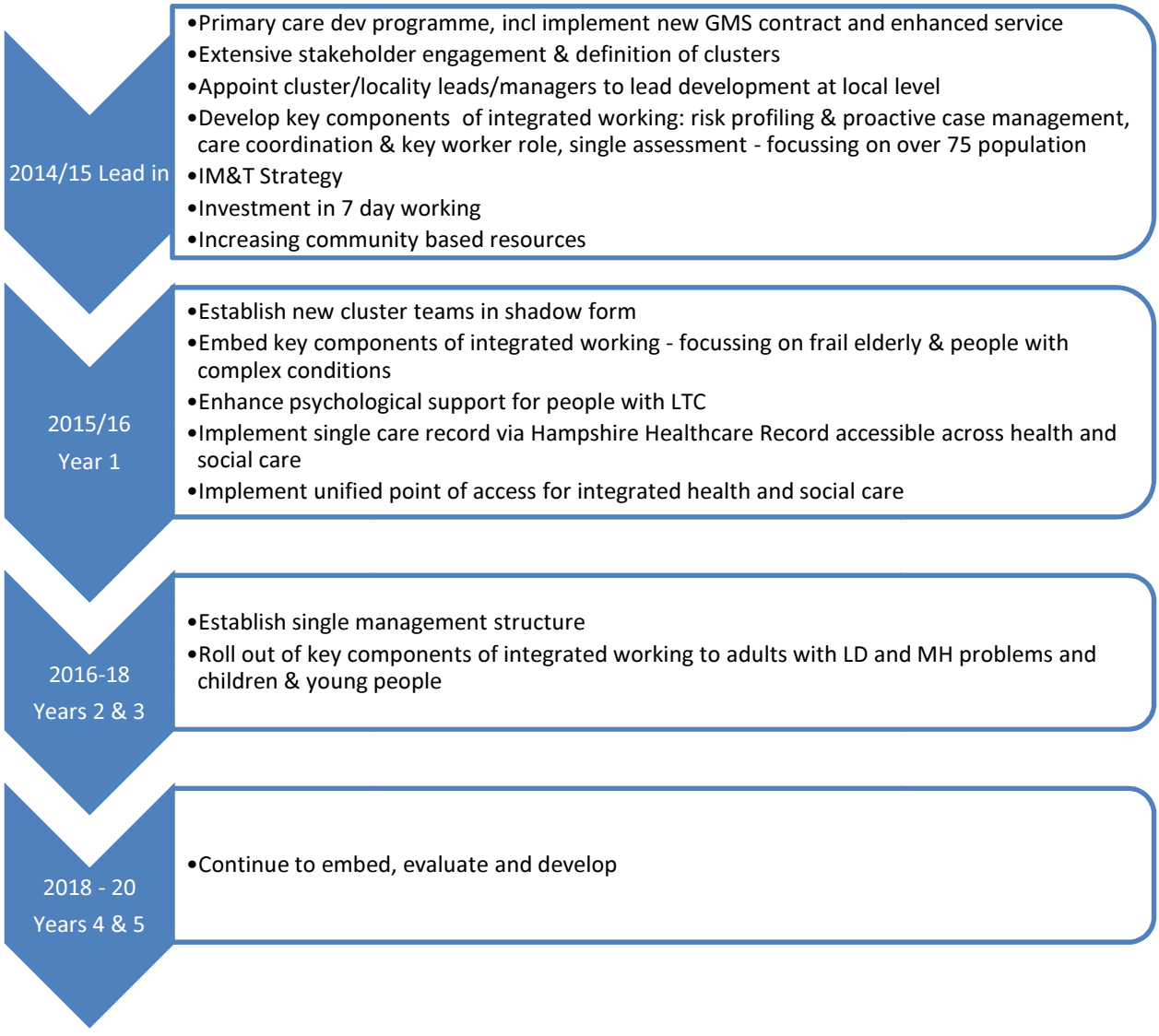
- Reconfiguration of health and social care into integrated cluster based health & social care teams under a single management structure, based on GP practice populations (teams to include community nurses, therapists, geriatricians, MH nurses, primary care, social care, housing and voluntary sector) – focussing initially on over 75s, extending to all adults with complex LTCs in 15/16, and then to adults with LD and MH problems and children with special needs/disabilities.
- 7 day working within teams
- Development of a personalised care promoting workforce across all services
- Adoption of Personal Health Budgets and Personal Budgets as the primary 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
- Increased use of technology for delivery of services and support.

Key success factors and dependencies for this part of our strategy include:

- Good robust engagement and coproduction with all stakeholders
- Workforce development
- Primary care development and GPs signing up to new enhanced service for patients with complex needs
- 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
- Strong leadership
- Increasing community resources

Implementation timeline for this component of our strategy



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

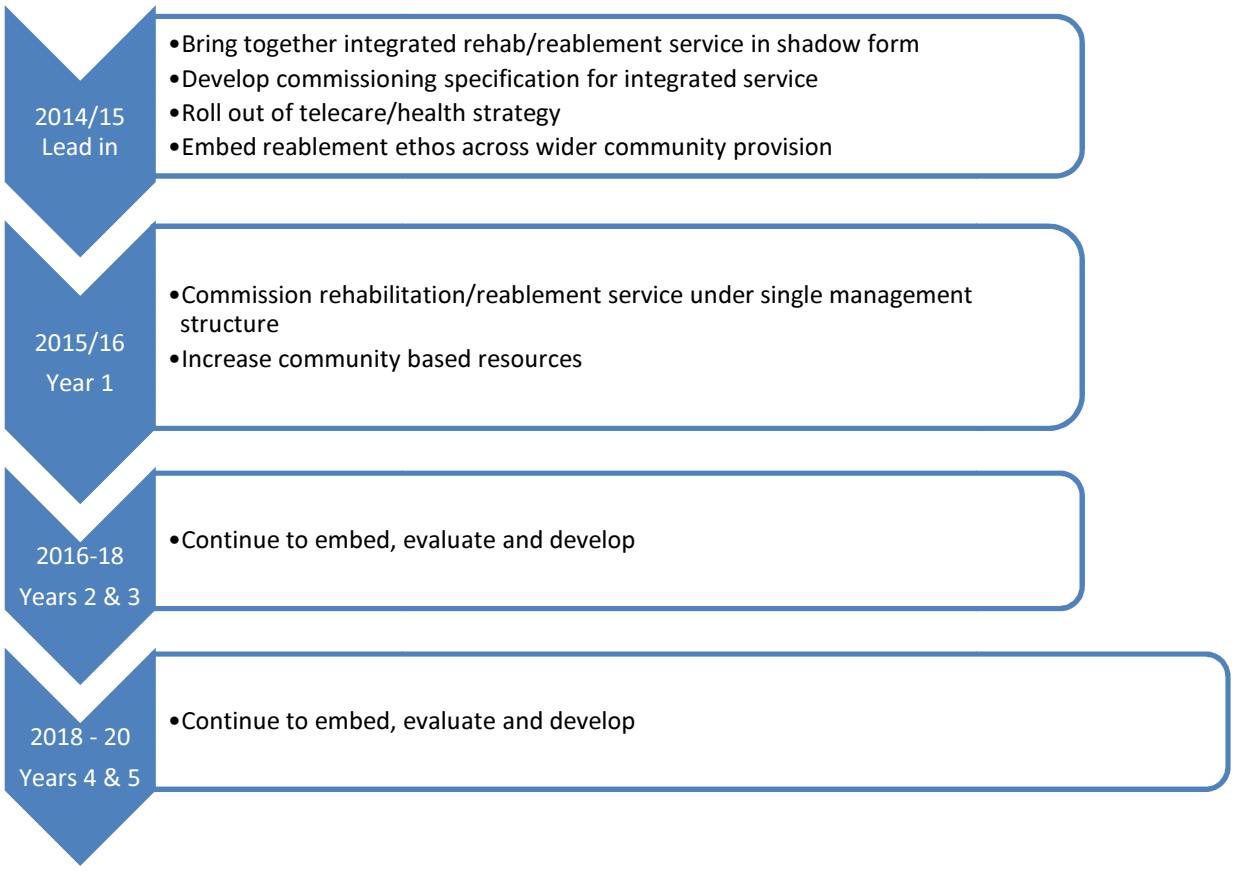
We will use the Better Care Fund for:

- Redesign of an integrated health and social care rehabilitation/reablement service bringing together City Care First Support, Brownhill House, RSH wards, Health and social care therapies, Telecare and telehealth, Joint Rapid Response admission avoidance/discharge support service.
- Ensure 7 day availability across service
- More proactive response to meeting straight forward needs
- Reablement culture built into wider community provision, eg. domiciliary care, nursing and residential providers
- Reablement function built into local cluster teams
- Increased use of self management approaches
- Increased use of technology for delivery of services and support.
- Improved focus on helping people plan to return to employment

Key success factors and dependencies for this part of our strategy include:

- Strong leadership
- Buy in and engagement of front line staff and workforce development
- Culture change to build reablement ethos into wider community services, e.g domiciliary care

Implementation timeline for this component of our strategy



3. BUILDING CAPACITY

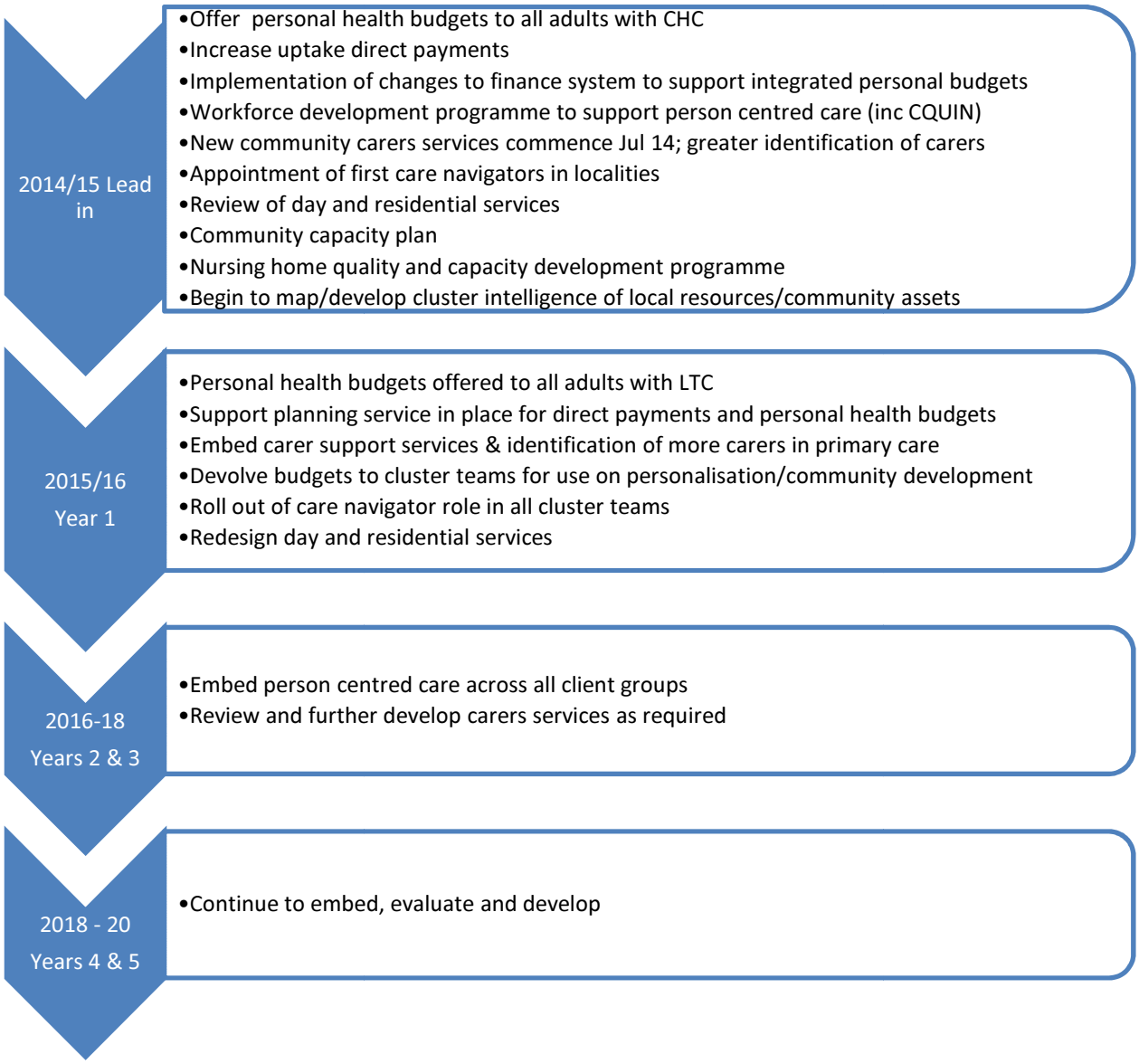
We will use the Better Care Fund for:

- Development of 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
- 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)
- Devolution of an element (to be defined) of the Southampton Better Care fund to cluster teams to incentivise local solutions
- Community coproduced JSNA mapping of community assets and need
- Provision of an integrated health and social care information, advice and guidance service, linked to single point of access
- Development of markets and communities to provide an active and vibrant environment for social enterprise, micro enterprises and self help mechanisms to flourish
- Increased support for carers through new jointly commissioned support services, underpinned through better information for carers, greater identification within community services and increasing assessments
- Implementation of 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.
- Work to help individuals understand and maximise opportunities for developing social capital through peer support, mentoring, time banking, local networks and community integration
- Greater encouragement and support for self management and person centred care planning through community and early contact points
- Refreshed demand and capacity plan for community support (nursing homes, residential homes, day care)
- Quality and capacity development programme with local nursing homes

Key success factors and dependencies for this part of our strategy include:

- Patient, user, carer co-production, engagement and buy in to the model.
- Good access to meaningful, accurate, up to date information.
- Finance systems capable of supporting integrated personal budgets.
- Primary care engagement and development.
- Development of capacity in social care to increase carer assessments.
- Workforce development and culture change in relation to person centred care.
- Robust market development.

Implementation timeline for this component of our strategy



Alignment with JSNA and Joint Health and Wellbeing Strategy:
The Better Care Plan 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. In 2014/15 and 2015/16 the Plan will help to deliver a number of the actions set out in the living and ageing well theme of our Health and Wellbeing Strategy, in particular the following :

- 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)
- Have timely bereavement counselling available

As the work develops into 2015/16 and the focus extends beyond elderly people and individuals with complex long-term conditions, the Better Care Plan will widen to support actions in the building resilience and using preventative measures to achieve better health and wellbeing and best start in life themes. The capacity building component of the strategy will embed resilience and prevention into communities, the existing council-led transformation programme will bring together housing with health and social care to address the housing outcomes identified in the Strategy, and the extension of Better Care principles across the whole life course will address key actions in the best start in life theme.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Achieving our plans will require a significant investment in primary and community care and reduced activity in the acute sector.

For University Hospital Southampton, our main acute hospital provider, our plans will mean:

- More outpatient activity delivered outside the hospital on an outreach basis
- A more joint approach to working between secondary, primary and community care to manage risk in the community

- A more specialist advisory role to the community.
- Reduction in beds

We are projecting a X% reduction in avoidable admissions and a x% reduction in excess bed days in 2014/15 with a further x% reduction and x% reduction respectively in 2015/16. This equates to x beds and a £x reduction in spend in the acute sector.

We expect our plans to improve performance against NHS service delivery targets through:
- Much more proactive approach from the community to discharge patients, enabling more timely discharge, and the hospital to better manage capacity and reduce delayed transfers of care.
- More coordinated, preventative community provision, operating 7 days a week, preventing avoidable admission and 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.

The risk to our plans is that the extent of the change in out of hospital services does not happen or does not deliver the benefits expected in order to deliver the reduction in activity we are projecting. If we do not deliver the outcomes expected, then there will be a financial pressure on the local health system.

This will be managed through monthly monitoring of activity levels, daily review of delayed discharges through our Integrated Discharge Bureau and real time information in the urgent care dashboard to identify early warnings of non delivery. In the event of non delivery, cross system plans, with clear targets and milestones, will then be developed to deal with any pressures.
To support this we intend to shift to outcome based contracts with a risk sharing approach so providers are all actively committed to the achievement of the targets.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

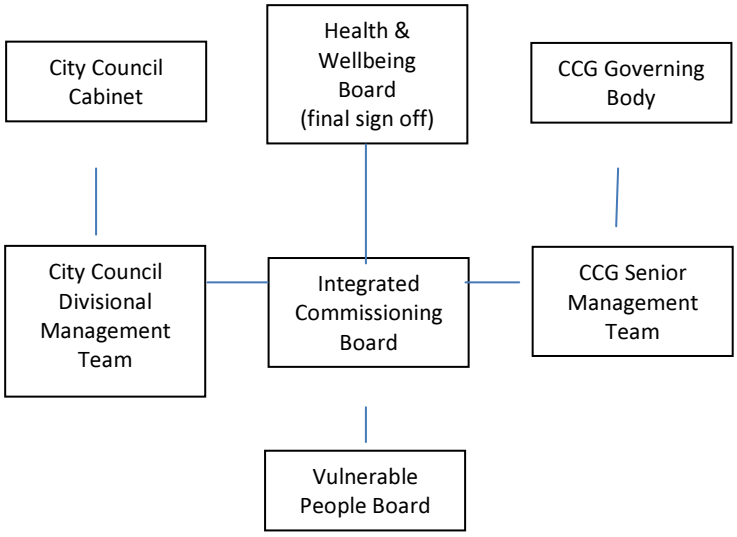
Development of Southampton's integrated care plan has been coordinated by the city's integrated commissioning unit through its Vulnerable People workstream. The Vulnerable People Strategic Delivery Board was set up two years ago to oversee the development and implementation of the strategy. This includes taking a system-wide view of outcomes and service provision for vulnerable 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 Vulnerable People programme are recognised and considered and that the aims, objectives and actions of the vulnerable people programme are properly communicated across the system.

Membership of the Vulnerable People Strategic Delivery Board includes CCG clinical and commissioning leads for integrated care, Public Health consultant, Senior Social Care leads, Community and Acute health provider leads, Voluntary sector representative and Housing.

The Board reports 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, Chief Finance Officers and lead Directors.

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 governance arrangements will continue to oversee the implementation of our local plan and are illustrated below:



At a more operational level we are considering the option of establishing an integrated management board during 2014/15 to oversee the implementation of the new service delivery arrangements. This board, reporting to the Vulnerable People Board, will include senior managers and professional/clinical leads from each NHS provider organisation, the Local Authority and primary care and will be responsible for implementing the cluster teams. The intention is to devolve operational management along with some budget to a locality or cluster level (to be defined over the coming months).

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.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

An element of the local definition is ensuring that resources are available to provide appropriate support for those who meet current eligibility criteria and effective signposting for those who are 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.

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.

Please explain how local social care services will be protected within your plans.

City plans such as the Health and Wellbeing Strategy and Joint Commissioning strategy informed the priorities used to inform the use of the funding transfer from the NHS to Social care. Part of this was maintaining current eligibility criteria and this element will be maintained within the Local plan. However the focus was also on a number of areas intended to reduce demand. These approaches will be sustained within the model:

- maximise independence through improved re-ablement and 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 market management and peer support development
- ensure carers feel supported
- Widen peer and community/voluntary sector support availability

The intention is to build on the resource identified within the Better Care Fund and existing pooled budgets to commit a greater combination of our health and care budgets into a pooled fund and base its use around the localities and people, 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.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Seven-day health and social care is a key principle of our integrated care model and will be developed as a priority over the next 5 years. It is recognised that only with 7 day working can

the outcomes of our local plan be realised and funding be released from the acute hospital sector.

Many of our community health and social care services are already providing a 7 day service (e.g. reablement, rapid response). During 2013/14, system leaders from across the City Council and local NHS have made a strong commitment to further developing 7 day working in the community through use of Winter pressure monies and a Change and resilience fund created by all organisations to bring about transformational change. This has included making investment in:

- expanding the integrated discharge bureau to cover the 7 day period
- 7 day working in inpatient therapy rehabilitation team with a view to increasing bed occupancy in community beds to 95%, reducing community length of stay to 17 days and increasing flow from acute hospital wards
- increasing the hours of the already 7 day community emergency department support team to operate later into the evening in order to support earlier discharge of patients who can be appropriately managed in the community before they are admitted to a ward.

Further development of 7 day working remains a priority.

Priorities include:

- implementation of GMS contract and improved primary care access with extended hours in each locality
- ensuring availability of 7 day social care assessment to support timely discharge and transfers
- 7 day access to geriatrician for advice to community teams and ambulance service
- extension of equipment service availability to Saturday afternoons and Sundays

A detailed plan for 7 day services will be developed during 2014/15 as part of our capacity modelling for implementation from 2015/16 onwards.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.

Adult Social Care are using NHS Number as the primary identifier, with 83% of known individuals having this recorded. By using 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.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

We are committed to using the NHS number as the primary identifier for correspondence and will continue to promote this.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

The Council has also achieved GCFX 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 confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott2.

The CCG has achieved IG toolkit level 2.

The City Council has achieved level 2 IG Toolkit status, with plans in place to gain level 3 by 2016.

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.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Southampton City CCG has been implementing a risk profiling tool (the ACG tool) across all its GP practices to identify patients with conditions that make them 50% more likely to be admitted to hospital in the coming 12 months. The ACG tool upgrade which is planned for the New Year will predict those patients at risk of emergency hospital admission within the next 6 and 12 months. This data can be filtered by age group.

All practices have signed up to the DES in 2013/14, have established the 1% of their registered populations most at risk of hospital admission and are working towards ensuring that all of these patients have a care plan with a named lead professional as a requirement of the DES. In addition to the DES, the CCG has also implemented a local Quality Improvement Scheme to monitor care outcomes.

The CCG's community health provider, Solent NHS Trust, is working with practices to establish

joint care planning through the community nursing cluster model. This has been incentivised over 2012/13 and 2013/14 through the local CQUIN.

All patients identified at high risk and being case managed have their care overseen by a community matron. Approximately 300 care plans, and approximately 700 less detailed ambulance anticipatory care plans are now in place and being rolled out for all case managed patients to avoid inappropriate conveyance to hospital. When called, the ambulance service can check the AACP and contact community services, thereby avoiding an unnecessary hospital admission. A CQUIN is also in place with University Hospital Southampton Trust, the CCG's acute hospital provider, to incentivise the use of anticipatory care plans in the assessment of patients presenting in the Medicine for Older People specialty.

Work is underway to establish a joint health and social care risk profiling and care planning process. This is being trialled within one neighbourhood (Demonstrator site) covering 18,000 patients, with two GP practices, community health services, older people's mental health services, social services, housing, community and voluntary providers. All partners have worked together to identify approximately 60 of the most at risk individuals in the neighbourhood for joint care planning and case management. With the support of Southampton University, the key aspects being trialled in the Demonstrator site (i.e. integrated care planning, risk stratification and the lead professional model of working) are being evaluated. Our plan is to roll these out to other areas across the city as we implement the cluster teams during 2014/15 and 2015/16.

Initially the roll out will focus on the 2% of people with complex conditions, most at risk of hospital admission, building on the 1% at risk identified during 2013/14 through the DES.

In future years (2016/17 onwards) we will roll this out to adults with learning disabilities, mental health problems and children and young people with complex needs.

4) RISKS

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

Risk	Risk rating	Mitigating Actions
Failure to achieve the cultural change required to make this happen	MEDIUM	Strong leadership from all partners through Vulnerable People Strategic Delivery Board and integration management board. Robust stakeholder engagement programme and involvement in developing the model. Roll out of cluster/locality working during 2014/15 through workshops, co-location, joint working, prior to formalisation of cluster/locality teams. Workforce development programme during 2014/15 focussing on key elements of the model, e.g joint assessment and care planning, care coordination/key worker role, self management and other person centred care approaches
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	HIGH	Robust activity and financial modelling, supported by whole system capacity planning tools. Strong project management and performance monitoring throughout.
Demand for services increases beyond expectation putting additional pressure on system, increasing costs	HIGH	Thorough impact assessment to support plans: - implications of Care and Support Bill - demographic profiling
Failure to establish infrastructure soon enough to support integrated working, eg. IT systems, single telephone number, finance systems	MEDIUM	Strong focus of work during 2014/15 to be on developing infrastructure to support integrated working. Robust project plan and management. High level attention to infrastructure requirements at CCG and City Council Board level.
Unable to get buy in from GP practices to the scale of change required	MEDIUM	Extensive primary care engagement programme. GP clinical and locality leads to provide strong leadership. Strong bottom up approach to development of detail of the model.
Primary care unable to make the change required due to lack of capacity or resistance to change	HIGH	Investment in organisation development programme for primary care during 2014/15. Strong clinical leadership through GP programme and locality leads.
Unable to get buy in from political leaders to scale of change	MEDIUM	Political leaders involved at each stage of local plan development. Councillor lead for programme development.
Contractual barriers, eg. unable to secure change fast enough because of contract notice requirements	MEDIUM	Outline specification for future model to be issued before 31 March 2014 to give providers 12 months notice prior to 2015 full roll out of model. Contractual levers used during 2014/15 to incentivise culture and organisational change required, eg. person centred care CQUIN.
Failure to incentivise providers to overcome	LOW	Senior leadership from all provider

Risk	Risk rating	Mitigating Actions
organisational boundaries		organisations on Vulnerable People Strategic Delivery Board. Extensive consultation and engagement programme with all providers, including front line staff. Establishment of Operational Partnership Board to implement model.
Implementing change at scale may destablise existing providers	MEDIUM	Impact assessments completed by all main providers against the new model of integrated care. Risks to individual providers to be monitored throughout implementation.
Public do not have same level of confidence in community services as they do in acute hospital services and opt for ED as first port of call	MEDIUM	Strong Public and patient engagement programme.
Shortage of good quality providers in the market to meet need for home care	MEDIUM	Joint domiciliary care tender to expand choice and confidence in the market. Investment in new Associate Director post for market development within the Integrated commissioning unit to specifically focus on market development.
Inability to recruit to key posts in out of hospital model, eg. geriatricians	MEDIUM	Whole system wide recruitment targeting key posts, eg. therapies, geriatricians. Introduction of new innovative roles, e.g. joint posts working across agencies, hospital and community, joint training opportunities, rotations