DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		BETTER CARE SOUTHAMPTON SUBMISSION UPDATE		
DATE OF DECISION:		1ST OCTOBER 2014		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION, INTEGRATED COMMISSIONING UNIT		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

Southampton submitted its initial Better Care Fund (BCF) local plan on 4 April 2014. Since then there have been some changes to the national policy framework underpinning Better Care and further national guidance has been issued by the Local Government Association and NHS England. Health and Wellbeing Board areas have been required to submit revised plans by 19 September 2014.

The revised BCF planning guidance and technical guidance documents set out what has changed in more detail. In summary, the previous £1bn Payment for Performance framework has been revised so that the proportion of the £1bn that is now linked to performance is dependent solely on an area's scale of ambition in setting a planned level of reduction in total emergency admissions (i.e. general and acute non-elective activity). Plans are also required to demonstrate evidence of robust finance and activity analytical modelling and to show strong provider and partner engagement and alignment to their plans.

This briefing provides an update on the status of Southampton's plan which was submitted on 19 September 2014.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board notes progress towards the implementation of Better Care Southampton

REASONS FOR REPORT RECOMMENDATIONS

1. As part of comprehensive spending review in summer of 2013 the Chancellor of the Exchequer announced that nationally a sum of £3.8 billion would be set aside for 2015/16 to ensure closer integration between health and social care. This funding was described as "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities. It should be noted that this is

not new money; the funding will be top sliced from existing budgets. Local authorities and the clinical commissioning group (CCGs) were required to submit a plan setting out how the pooled funding will be used to improve outcomes for patients, drive closer integration and identify the ways in which the national and local targets would be met.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. Each Health and Wellbeing Board in England is required to submit and deliver a plan developed jointly by the council and CCGs.

DETAIL (Including consultation carried out)

3

Summary of Southampton's Better Care Fund Plan

3.1 Better Care Southampton plan was approved by the Health and Wellbeing Board in March 2014, with strong stakeholder support. The revised plan follows the same direction of travel.

3.2 There is a strong case for change. 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%). 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. This is against a backdrop of rising need (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. There are increasing numbers of people living with long term conditions). 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 and Support Bill, are also requiring services to identify need earlier and respond to a national minimum eligibility threshold.

3.3 The 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.

3.4 Our overall aims are:

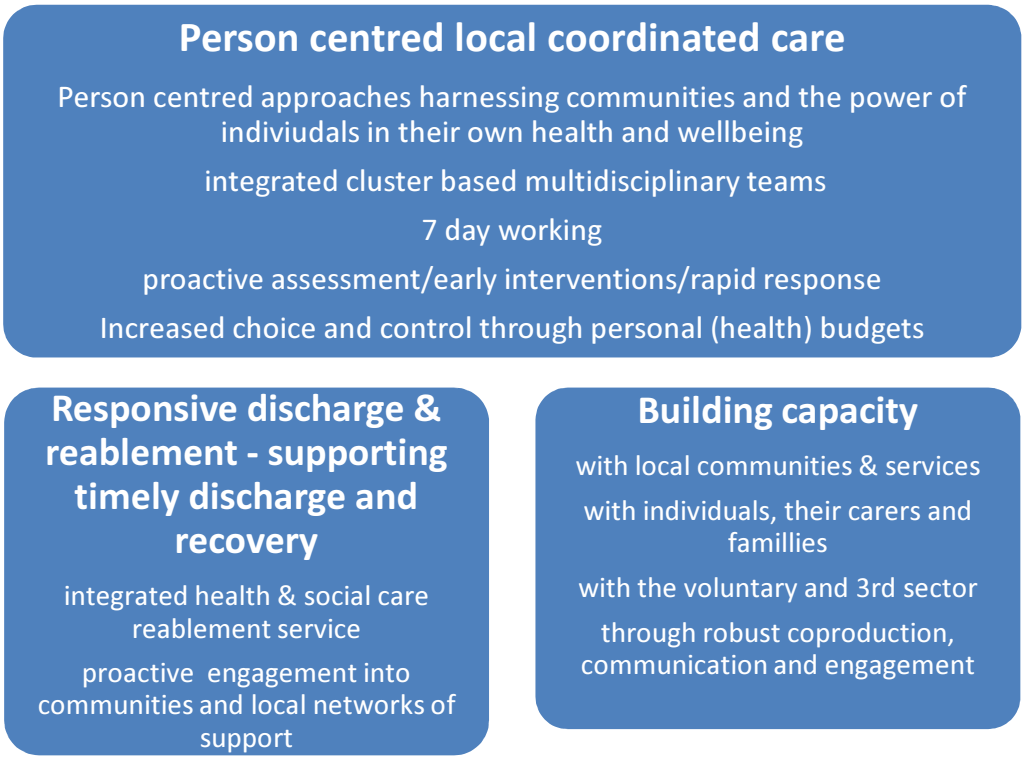
- Putting people at the **centre of their care**, meeting needs in a holistic way
- Providing the **right care, in the right place at the right time**, and enabling people to stay in their own homes for as long as possible
- Making **optimum use of the health and care resources** available in the community,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

3.5 **Underpinning these aims are the following national conditions:**

- protecting social care services
- 7 day services to support discharge from hospital
- data sharing
- Joint assessment and accountable lead professional for high risk populations

All of these elements have been developed within the plan. An element of funding will be available to protect social care 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

3.6 **Our approach to system redesign has 3 basic components:**



3.7 There are 6 main schemes:

- **Local person centred coordinated care** - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working – this will impact on those people most at risk of hospital admission or long term care who will benefit from case and disease management, roughly 5% of our population (around 12,000 people), but also support those at more moderate risk (35,500 people)

who would benefit from supported self-care. The majority of this target group will be older people (65+) and those with multiple long term conditions.

- **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 reviewing how specialist teams focussed on specific long term conditions can better support the more holistic model of local person centred coordinated care we are aiming to implement.

- **Integrated discharge, reablement and rehabilitation** service, including greater use of tele care/tele health. 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. The scheme will particularly focus on reducing long term admissions to residential and nursing homes and preventing delayed transfers of care.

- **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.

- **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. 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.

- **Developing the market for placements and packages** – 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.

4. **Progress**

There is already significant momentum in delivering the Better Care programme.

- We have consulted on and agreed 6 local cluster areas, based around GP practice populations, through which integrated care will be delivered.
- Pilot of elderly care nurse role to support primary care in work with patients over 75 years of age
- Significant work has been done across the system on reviewing

discharge processes. The trusted assessor model is being rolled out within reach coordinators and discharge facilitators being trained to assess, restart and set up simple packages. Discharge to assess is also being implemented with 12 beds commissioned in the nursing home sector to support this.

- A concept paper for a more integrated model of rehabilitation and reablement is currently being consulted on.
- Additional information, advice and support services for carers have been commissioned and have gone live in September 2014.
- The domiciliary care tender is progressing with new contracts due to go live in February 2015.

5. **Targets**

Southampton's Better Care plan seeks to achieve the following:

- **Reduce unplanned hospital admissions** – as agreed at the last Health and Wellbeing board meeting we aim to reduce our number of unplanned hospital admissions by 2% year on year over the next 5 years (3% when population growth is factored in). The payment for performance element of the Better Care fund is based on this reduction. The national planning assumption is that this will be in the region of a 3.5% reduction in 2015/16 against the previous year (with no allowance for population growth). The rationale for a lower target is that, 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, 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 such as the Emergency Care Intensive Support Team (ECIST) review which concluded that, despite some successes, there had been an over-reliance on schemes to avoid admission and insufficient emphasis on improving discharge planning and ongoing care in the community.
- Significantly **reduce permanent admissions to residential and nursing homes** - Our aim is to achieve a 7.1% reduction in admissions in per capita terms over 2014/15; 9.7% over 2015/16 and sustain and improve on this in subsequent years.
- **Increase the percentage of older people still at home 91 days post discharge into reablement services** - we are already performing well on this metric (87%) and are aiming to sustain this level of good performance in 2014/15, increasing to 90% in 2015/16 whilst acknowledging an increasingly complex population.
- Significantly **reduce delayed transfers of care** - Delayed transfers of care (DTOC) are 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 and to further reduce delayed transfers in 15/16 by an additional 3 per day. This will return levels of DTOC to the 13/14 position, an approximate 10% reduction.
- **Reduce injuries due to falls** - our aim is to reduce the number of injuries due to falls requiring hospitalisation per week by 12.5% by the

end of 2014/15 and sustain and improve on this in subsequent years.

6. **Consultation and Governance**

6.1 There has been significant consultation over the last 10 months in the development of the Better Care plan with a broad range of stakeholders. Key to the success of Southampton's Better Care plan is strong engagement and co-production of the model. Health Provider organisations have had to confirm detailed and meaningful provider involvement in the development of the plan, demonstrate clear alignment between the overarching BCF plan and the provider plans and demonstrate a shared understanding of the critical path to successful delivery

6.2 The Integrated Care Board, with broad stakeholder membership oversees the development and implementation of Southampton's Better Care plan. The Board reports to the Integrated Commissioning Board with member, clinician and senior officer representation from both the Council and CCG. 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.

7. **Next steps**

• Revised submission had to be made by 19th September.

• 22nd September to 3rd October a desktop review of plans will be undertaken nationally focused on overall review of narrative of plan; analytical review of data, trends and targets and financial review of calculations and financial projections

• The combination of the feedback from Area Team and Local Government regional peers, and the outcome of the desktop review, will form the basis of the assurance process ahead of plans being recommended to Ministers for sign-off.

• Moderation exercise will be completed by 10th October

• Final presentation and recommendations to Sir Bob Kerslake, Simon Stevens and Ministers 17th October

RESOURCE IMPLICATIONS

Capital/Revenue

8. 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.

Organisation	Contribution to pooled fund (£000) 2014/15	Contribution to pooled fund (£000) 2015/16
Southampton City Council	924	56,008
Southampton City CCG Minimum Contribution		15,325
Southampton City CCG additional contribution	1,286	59,786
TOTAL	**2,210**	**131,119**

9. A draft Section 75 agreement is being complied. The finalised pooled fund agreement will progress through appropriate organisational approval. It is not

required until 2015/16.

Property/Other

10. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. NHS England Publications Gateway Ref. No.00314

Other Legal Implications:

12. None

POLICY FRAMEWORK IMPLICATIONS

13. Align with Health and Wellbeing Strategy and Council's Policy Framework Plans

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

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)
1.	None	