ANNEX B

Southampton Better Care Plan

July 2015

National Context

- £3.8 billion 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 (Chancellor of the Exchequer announcement 2013)
- To support and accelerate local integration of health and care services through joint commissioning & partnership working
- Facilitate the provision of:
  - more joined up care for patients with complex needs through service transformation
  - increased care in the community
- Help address demographic pressures in adult social care

Nationally set targets

- To reduce **unplanned hospital admissions** - by 2% year on year over the next 5 years (2014 – 2019).
- 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.
- 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.
- To reduce injuries due to **falls** - by 12.5% by the end of 2014/15 and sustain and improve on this in subsequent years.

Southampton's case for change

- **Increasing older population** - over 65s population due to increase by 11% and the number of people over 85 years from 5400 to 6100 between 2012 and 2019.
- **More people living with two or more long term conditions** - 85% of people 65+ have at least 1 chronic condition and 30% have more than 4; By age 85 this has increased to 93% and 47% respectively (ACG analysis).
- **Loneliness** - 11,283 households consist of older people living alone with increased risk of loneliness and associated poor physical and mental health.
- **Changing expectations** - People are used to expressing far greater choice and control over their needs and aspirations
- **Legislation and reduced resources** – requires a major transformation of services to continue to meet need and deliver requirements of Care Bill

What it can feel like

- People do things to me without asking
- I never know when people are going to turn up or what they are going to do
- I have to repeat myself a lot of times to different people – they don't seem to speak to each other or know what each other is doing
- I don't know who is in charge of my care
- I have never been asked what I want from my care
- I don't feel listened to
- I don't know where to go or who to ask if I need more help when things start to go wrong

We need to respond to the challenge and improve people's experience of care and the outcomes they achieve through transforming the way care is provided locally.

Southampton's approach

- **Individuals at the heart of their own care**
  - Empowered and supported by integrated local services & communities
- **Focus on prevention and early intervention**
  - Integrated risk profiling
  - Proactive person centred planning to target services.
- **Build community capacity**
  - Working with defined neighbourhoods
  - Supporting vulnerable people
- **Help people to retain and regain their independence**

Putting the person at the centre:

- **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** – service users can decide how the money allocated for their care should be spent
- **You, not your illness** - the approach to care will be holistic and not focussed around diseases or conditions

Key principles:

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

Southampton's 3 building blocks

Person centred local coordinated care

Person centred approaches harnessing communities and the power of indiviudals in their own health and wellbeing

integrated cluster based health & social care teams

7 day working

proactive assessment/early interventions/rapid response

Increased choice and control through personal (health) budgets

Responsive discharge & reablement - supporting timely discharge and recovery

integrated health & social care reablement service

proactive engagement into communities and local networks of support

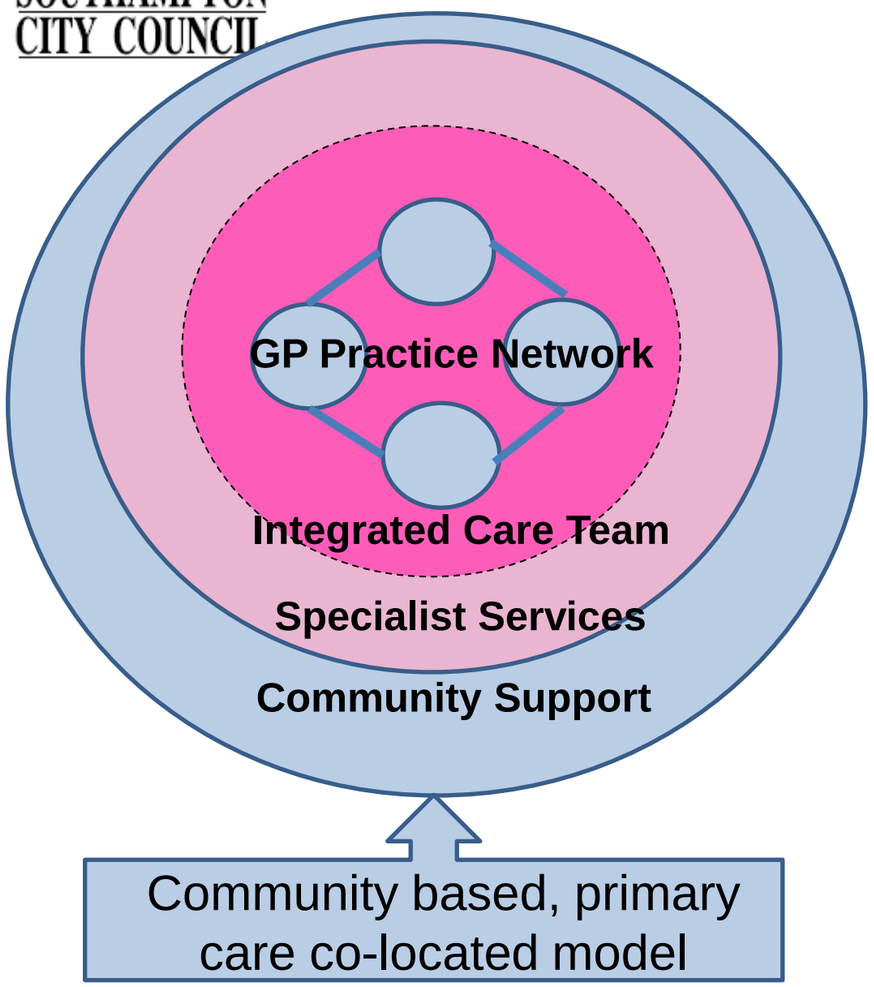
Building capacity

with local communities & services

with individuals, their cares and famillies

with the voluntary and 3rd sector

through robust coproduction, communication and engagement



Community based, primary care co-located model

Our approach:

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

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

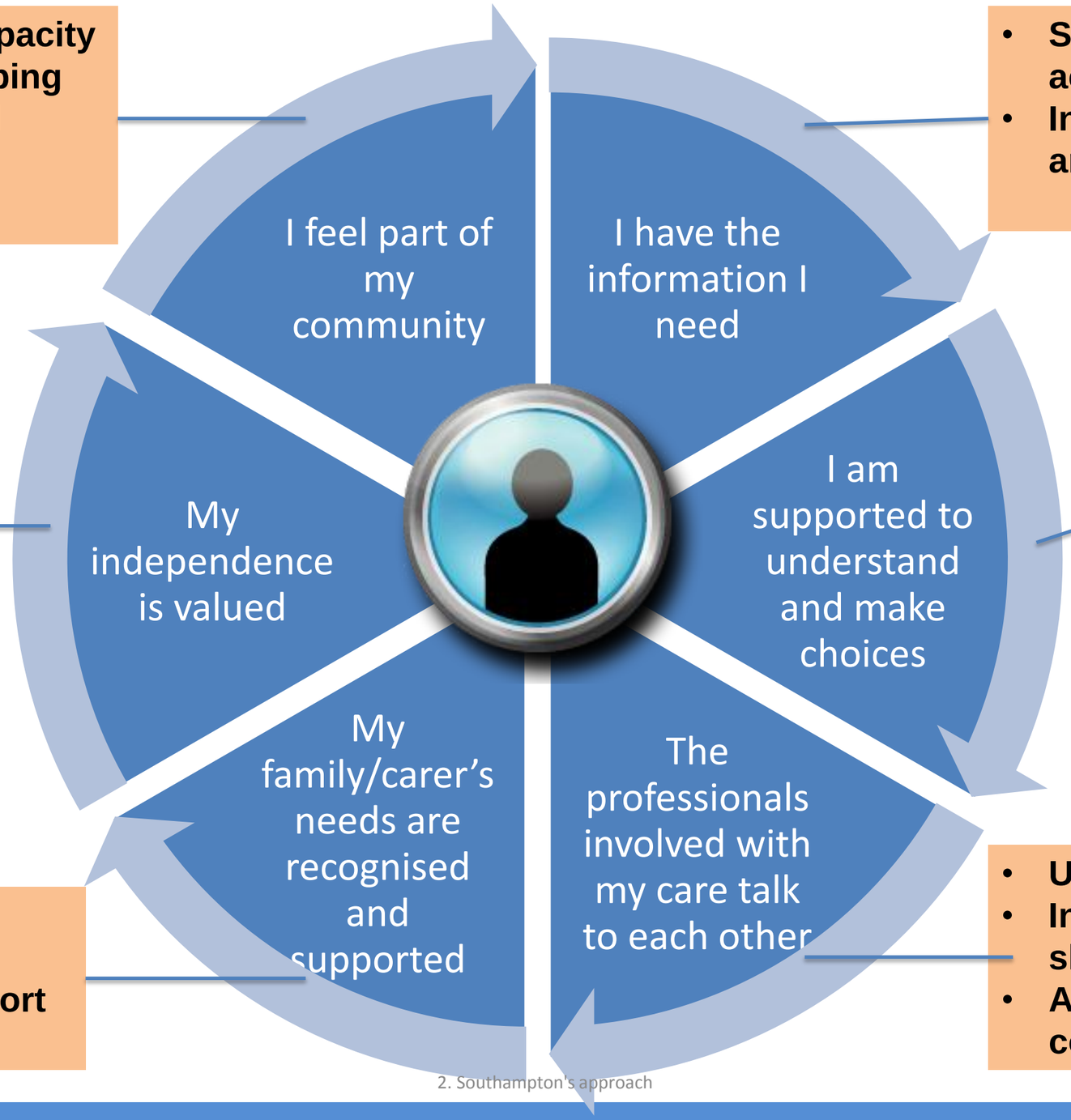
cluster teams | cluster teams | cluster teams | cluster teams | cluster teams | cluster teams

Wrap around Community Support

What difference will it make for people

- **Building community capacity**
- **Care navigator role helping people link in with local community groups**

- **Single integrated point of access**
- **Integrated front door, advice and information service**



- **Stronger reablement ethos across the whole workforce**
- **Proactive discharge planning**
- **Integrated reablement services**
- **Promotion of Self management**
- **Better use of telecare/health**

- **Person centred care plans**
- **People identify their own outcomes**
- **Greater use of personal budget as a direct payment**
- **Cultural shift in public & professionals**

- **Carers assessments**
- **Better access to information and support services for carers**

- **Use of single care plan**
- **Integrated IT and Information sharing**
- **Accountable professional to coordinate care**

National requirement to establish a Pooled Fund

- A must do - 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.
- Southampton's minimum value = £15.325m revenue and £1.526m capital.

How a pooled fund can help us deliver

- 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.
- Enable faster shared decision making, effective use of resources and economies scale.
- Enable radical redesign of services around the user regardless of whether their needs are mainly social or health.
- Enable greater transparency of spend – governance of a pooled fund requires all budgets to be clearly identified and monitored by both partners.
- Provide greater flexibility to move resources quickly to where they are required to meet need.

And in addition…

- 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
- 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.

Progress to date

- Establishment of 6 cluster/locality teams
- Key components of integrated working in place: risk profiling & proactive case management, care coordination & key worker role, single assessment – initially focussing on over 75 population
- Shared Care plans – available on Hampshire Healthcare Record
- Community navigators pilot going live
- Carers assessment and support services commissioned
- Over 75 nurses – piloting 3 models across the city – due for evaluation end of this year

- Workforce development programme – focussing on public sector staff, rolling out to domiciliary care staff
- Integrated Rehabilitation and reablement Service – anticipated to go live this Autumn (pending Cabinet decision and outcome of consultation)
- Additional domiciliary care capacity – new contractual framework gone live April 2015
- Falls liaison service and exercise classes being piloted with Age UK
- Discharge processes under review and new pathways being implemented for Winter 2015

What next

- Single point of access
- Roll out to other client groups, eg. people with learning disabilities, mental health problems, children
- Automated shared care plans
- Continue to embed, evaluate and develop model