Better Care Fund Narrative Plan

Southampton

Health & Wellbeing Board – Southampton City

2021/2022

1. ***Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils. How have you gone about involving these stakeholders?***

The Better Care Plan (BCF) for Southampton has its basis in our 5 year Health and Care Strategy (2020 – 2025). This strategy was formed through a partnership of health, care and community and voluntary sector representation and based on the Joint Strategic Needs Assessment (JSNA). The slide below provides an overall summary of the strategy –

This year's BCF plan has been informed by a range of groups within the governance structure. The Better Care Steering Board being the driving force behind the plan, both in its formation and oversight. This board is formed of our leaders in health care, adult and children's social care, public health ,CCG and Primary Care Networks (clinical leads), Community and Voluntary Sector and officers within the CCG and Local Authority (including representation from Housing). In addition, linked with the priorities in the slide above there are a range of other groups which have contributed to form the BCF plan for this year, these include –

- Ageing Well Group
- End of Life Steering Group
- Children's Multiagency Partnership Board
- Learning Disability Partnership Board
- Onward Care Group (Complex discharge and Integrated Discharge Bureau)
- Mental health forum/No wrong door group

- Operational Delivery Group – Southampton and South West Hampshire
- Carers Partnership Board - Southampton

These groups are formed of a wider range of partners from across the system of health, care and wider wellbeing: Local Authority, including Public Health, Adult Social Care, Children and Families, Communities, and Housing; CCG; health care providers including acute care, community care and mental health; Community and Voluntary sector; Primary Care and Primary Care Networks; Carers and people who use our services. Together these groups help to inform the next steps in delivering our 5 year Health and Care Plan and, with it, the next stages for the BCF Plan in 2021-2022.

2. Executive Summary

Priorities for 2021/2022

- **Priority 1: Delivering on Avoidable Admissions -** Strong focus on admission avoidance through our urgent Response Service and Enhanced Health in Care Homes (EHCH) arrangements.
- **Priority 2: Focus on embedding the new approach to discharge,** including Discharge to Assess and home first as a feature within the BCF plan.
    - Including the Community Discharge Hub/Single Point of Access (SPoA)
    - A flexible and broad offer of discharge to assess provision (D2A), promoting a home first approach
- **Priority 3: Focus on reducing long term admissions to residential care,** including elements of the High Impact Change Model (Reducing preventable admissions to hospital and long-term care)
- **Priority 4: Increase the number of people who see benefit from Reablement,** meaning a continued focus on reducing dependency on longer term care provision.
- **Priority 5: Implement new models of care (within Adults and Children's)** which better support the delivery of integrated care and support in our communities and work towards anticipatory care as standard.
- **Priority 6: Effective utilisation of the Disability Facilities Grant –** promoting independence and personalised care/strength based approaches.

Changes to our previous BCF plan are based upon the above priorities and recovery of services post pandemic across all schemes. The details of schemes within our BCF plan can be found in Appendix 1, in summary these are:

Priority 1 and 4

- Expansion and redesign of our Urgent Response Service/Urgent Community Response and Reablement Service through a number of funding sources.
- Expansion of our EHCH service arrangements through commissioned contracts with our GP federation and partnership work with Primary Care Networks.
- Expanding our mental health crisis offer through the 'Lighthouse', a city based community facility that supports individuals in a recovery-focused way to manage their mental health crisis.

- Development of Children's Hospital at Home service, building on the learning from Covid Virtual Wards in adults.

Priority 2

- Embedding the new discharge pathways in particular through making the Single Point of Access a sustainable element of delivery model.
- Working with our provider market to promote a flexible offer of Discharge to Assess (D2A) arrangements to care homes and patients own homes (Home First)

Priority 3 and 5

- Roll out of integrated care teams with a broader scope across the city, building on the test and learn work of the last 2 – 3 years. SCC developing a locality model in Adult social care, Children's social care and Communities aligns with this roll out.
    - Including linking of further services with Early Help and Young People's locality teams.
- Further developments in our prevention and early intervention offer and LD integrated commissioning approach that promote people staying well and independent for longer, 'active lives'.
- Development of the locality model for supporting children and families with SEND as part of the next phase of service redesign (the Children's Destination 22 programme)
- Expansion of Crisis and Therapeutic offer within the integrated health and social care provision for children with complex behavioural & emotional needs.
- Enhanced Primary Care Mental Health Team through a dedicated Southampton City Mental Health Partnership Board, with collaboration between CCG, PCNs, SHFT, DHUFT (IAPT) and VSCE delivery of the Community Mental Health Transformation continues.

Priority 6

- Implementation of recommendations following a comprehensive review of DFG undertaken during 2020/2021.
    - Substantial system change in relation to ensure effective provision of adaptations through the DFG that promotes independence for the residents of Southampton.

3. Governance
Please briefly outline the governance for the BCF plan and its implementation in your area.

The Governance Structure for the BCF plan in place at the outset of 2021/2022 will be reviewed during that year to reflect the changes which will be required with the next stage of Integrated Care System Development. These arrangements, and those in the future, link with Southampton and South West local delivery system through our Operational Delivery Group, providing cross system oversight for the acute trust footprint.

The details below describe the existing arrangements, noting that the new governance arrangements for April 2022/2023 are at the design stage. These new governance

arrangements include a Programme Management approach to all areas of the BCF plan and wider 5 year Health and Care Strategy. Strengthening the oversight and challenge within the Southampton system.

Health and Wellbeing Board

The Health and Wellbeing Board (HWBB) acts as a formal committee of Southampton City Council, charged with promoting greater integration and partnership between the NHS, public health and local government. It has ongoing oversight of the Southampton City Health and Care Strategy and the BCF plan. The HWBB provides oversight and strategic direction for the Joint Commissioning Board and Better Care Southampton Board

Joint Commissioning Board

The Board monitors the performance of the Integrated Commissioning unit and ensure that it delivers the statutory and regulatory obligation of the partners of the Better Care Fund and relevant Section 75 agreements. Acting as the single health and care commissioning body for the city of Southampton and a single point for decision making. The JCB membership includes the main commissioners of health and care services in the city; Southampton local team representatives from Hampshire, Southampton and IoW Clinical Commissioning Group and Southampton City Council. The JCB ensures effective collaboration, assurance, oversight and good governance arrangements to ensure achievement of the city's health and care strategic objectives. The JCB enable continued engagement and momentum of the strategy and assist with resolving any delivery issues which cannot be resolved by the Better Care Southampton Board.

Better Care Southampton Board

The Better Care Southampton Board membership includes senior representatives from key health and care organisations across the city, including the voluntary sector. The purpose of the Board is to set strategic direction and oversee the successful delivery of the strategy. The Board will hold the delivery groups to account for delivering the agreed plans and outcomes, and will help to remove barriers to progress. Progress will be regularly reviewed to ensure that actions not only remain on track and anticipated key outcomes can be fully realised, but that the delivery plan is updated with new actions and measures as appropriate. A range of health and care outcome indicators will be monitored to inform whether the interventions in the strategy are having an impact.

Finance and Performance Monitoring Group

The purpose of the Better Care Finance and Performance Monitoring Group (F&PMG) is to have oversight of the Better Care Fund S75 agreements and to provide assurance to Joint Commissioning Board that the funding and performance are being appropriately and effectively managed. It is formed from CCG and Local Authority officers, including finance leads, with appropriate authority, including those that lead individual schemes. The schemes are :–

1. Supporting Carers
2. Integrated Locality Working
3. Integrated Rehabilitation and Reablement and Hospital Discharge
4. Aids to Independence
5. Prevention and Early Intervention

6. Learning Disability Integration
7. Promoting uptake of Direct Payments
8. Transforming Long Term Care
9. Integrated provision for children with special educational needs and disability (SEND)
10. Integrated health and social care provision for children with complex behavioural & emotional needs

Delivery Groups

There are a number of delivery groups in the city which are responsible for delivery of individual elements of the BCF plan and 5 Year Health and Care Strategy. They broadly represent the main programmes of work and include –

- Ageing Well Group
- End of Life Steering Group
- Workforce Group - multiagency
- Childrens Multiagency Partnership Board
- Rehab and Reablement Partnership Board
- Mental Health Partnership Board
- Carers Partnership Board
- Learning Disability – Co-production Group

All of these groups are formed of the relevant partners, with a strong focus on inclusivity enabling a coproduction approach as standard. In addition the Ageing Well Group and LD Coproduction group include representation from Adult Social Care Partners and housing leads within the Local Authority. Coproduction in some settings is driven by groups which have this as their specific purpose, e.g. Carers and Learning Disability. These groups form part of the overall infrastructure and therefore promote design changes to services in medium and long term.

4. Overall approach to integration
Brief outline of approach to embedding integrated, person centred health, social care and housing services including

The **joint priorities** for 2021-22 are as follows -

Priority 1: Delivering on Avoidable Admissions - Strong focus on admission avoidance through our Urgent Response Service and Enhance Health into Care Homes (EHCH) arrangements.

Priority 2: Focus on embedding the new approach to discharge, including discharge to assess and home first as a feature within the BCF plan.

- Including the Community Discharge Hub/Single Point of Access (SPoA)
- A flexible and broad offer of discharge to assess provision (D2A), promoting a home first approach

Priority 3: Focus on reducing long term admissions to residential care, including elements of the High Impact Change Model (Reducing preventable admissions to hospital and long-term care)

Priority 4: Increase the number of people who see benefit from Reablement, meaning a continued focus on reducing dependency on longer term care provision.

Priority 5: Implement new models of care which better support the delivery of integrated care and support in our communities and work towards anticipatory care as standard.

Priority 6: Effective utilisation of the Disability Facilities Grant – promoting independence and personalised care/strength based approaches.

Approaches to joint/collaborative commissioning

Southampton has an Integrated Commissioning Unit (ICU) which commissions health, care, and support services for the people of Southampton on behalf of Southampton City Council and Hampshire, Southampton, and Isle of Wight (HSI) NHS Clinical Commissioning Group. The purpose of the ICU is to enable both organisations to work together to make best use of our resources to commission sustainable, high quality services which meet the needs of local people now, and in the future.

Our key service objective is redesigning and commissioning across the full life course to manage increasing demand for health and social care, improve outcomes, improve quality, increase effective use of resources, avoid costs and release savings. Based on understanding the current and future health and care needs of the local community:

- Health and Care system redesign and transformational change, working together across health and social care to deliver integrated, person centred, joined up care for people in Southampton and to strengthen prevention and early intervention to support people to maintain their independence and wellbeing
- Development of integrated rehabilitation and reablement services; improvements to mental health crisis care; leadership of the design and implementation of integrated Children's services; establishment of Community Solutions; refocus Housing Related Support; leadership of Southampton Five Year Health and Care Strategy
- Improve and sustain quality of services across the health and care market, including effective contract management and monitoring, to ensure that people are provided with a safe, high quality, positive experience of care in all health and care providers ranging from individual social care providers and voluntary sector organisations to large health providers such as University Hospital of Southampton NHS Trust
- Support commissioning activities that facilitate, manage and develop a strong provider market that is able to respond to an increasingly diverse and complex customer group
- The scope of services commissioned includes all children and young people, adult health and social care, public health and housing for vulnerable people in the Council. For the CCG the services include all community health services (children and adults), services for those with mental health problems, disabilities or long-term conditions plus acute care for children and maternity services.
- The ICU also manages (on behalf of the Joint Commissioning Board/ HWBB) one of the largest Better Care pooled funds in the country. Mandated level for 2021/2022 of £32,469,932 and a total pooled fund of £140.358m, £86.080m from the CCG and £54.278m from SCC.
- The ICU aligns aspects of the Council and Southampton City Clinical Commissioning group (CCG) commissioning functions under a single management structure, with

staffing from each organisation committed to the ICU in exercise of powers under section 113 of the 1972 Act, to work towards the delivery of a shared strategy.

The work of the ICU continues, working closely with transformation colleagues within partner organisations and with commissioning colleagues across the ICS. There is active work "leaning in " to support Primary care with their commissioning functions, The planning for future governance as the Integrated Care System evolves will further strengthen collaborative commissioning approaches.

Collaborative work is being undertaken to refresh the Children's strategy for the city and review and refresh the commissioning and provision of services.

Throughout last year and this the ICU has supported the system of health and care to consider the impact of the pandemic on BCF and wider plans. The evidence of this is seen in the refresh of the 5 Year Health and Care strategy which now reflects adjusted timelines for many of the schemes in BCF. Some examples are –

- Extra Care – new site in the city having an adjusted timeline to reflect the impact of the pandemic on social care market and therefore the ability to have robust onsite care provision for this important and complex client group.
- Home First principle - in implementing our hospital discharge and admission avoidance schemes, the ICU has supported the system to work with the social care provider market, acknowledging the significant pandemic impact on capacity and workforce in this setting which has been a limiting factor for the implementation of this principle. This is evidenced through a workforce plan set up with the system, including social care providers, that begins to address these challenges.
- End of life care – this year, in response to the rising levels of frailty in the population and rising demand for end of life support, we have promoted earlier implementation of a 24/7 end of life support service with our charitable partner in the city. This has been a significant success, supported by joint working between said partner, our community health provider and Acute Visiting Service Provider in the city.

Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Overall the demand for services promoting independence has significantly increased over the last 18 months. Evidence within our Rehab and Reablement service would suggest that this is related to the change in hospital discharge process and an increasing level of frailty in our younger and older old population. The Joint Equipment Service supports this with a rise in the mean pieces of equipment per person rather than in the numbers of people requiring equipment, with the costs of this service rising by approximately 33%.

In addition to that noted earlier, there are a range of schemes in place which aim to support people to remain independent at home. The first of which being Integrated Rehab and Reablement, a service that has been in place for several years. The service has an integrated leadership team, and provider section 75, in place that promotes an integrated approach to delivery. Based upon the success of this service additional resource has been

provided to expand it to achieve more hours of care and Reablement delivered, during this year, from the CCG allocation in addition to Ageing Well funding for Urgent Community Response.

A key element of the above service is Reablement, which has been part of the integrated service promoting independence for a number of years. Again, building upon the success of the service and the rise in demand related to increasing frailty, there has been investment in this service to make available greater capacity to respond to said demand. The impact on the metric (proportion of older people who were still at home 91 days after discharge from hospital into Reablement/rehabilitation services) is expected to be one of status quo, see 8.5 in the metrics element of the planning template.

In conjunction with the above service the development of community integrated teams continues through our 'One Team' programme. This, as noted in previous plans, includes integration of core community services for adults to promote proactive and reactive health and care for people with complex needs. The work progressed significantly during the pandemic, in particular focusing upon the clinically extremely vulnerable patient group, which provides a strong foundation on which to build this year. This year, and next, will see a formalisation of these arrangements across the city, including elements such as colocation.

All of the above is included as part of our Ageing Well plan, a subset of the 5 year Health and Care Strategy. This plan, and the BCF, includes a carers (unpaid) work stream. Carers have long been a focus of the BCF in Southampton with this year seeing the conclusion of a scrutiny enquiry, writing of two strategies (young carers and adult carers) and initial implementation of the recommendations. Elements of this new carers work is supported by the iBCF grant and seeks to support a strength based approach for our unpaid carers in the city.

Also as part of the 5 year Health and Care strategy we have a Die Well plan which describes the next stages for the development for end of life services and services that support the preparation or planning stage. This year includes the move towards earlier identification of end of life cases, potentially as early as 3 years before death, enabling better preparation and anticipatory care planning. Also, building upon the pandemic response closer working between our end of life services, primary care acute visiting service and community health services is embedding.

The above work is a key element of the personalised care approach being implemented in the city, along with this we are reviewing progress made on the personalised care model in the city this year. Prior to the pandemic we had made significant inroads into implementing the model, however we expect there to have been some impact as a result of the pandemic response. The key areas of focus are: Personalised Care and Support Planning across specialist and core services; Section 117 after care Personal Budget roll out; growing community capacity; social prescribing; and finally service self-assessment of personalised care approaches. These elements together promote a personalised care approach to care that seeks to support individuals to remain independent and in their own home.

Live Well is another subset of the 5 year Health and Care Strategy which includes many of the areas noted within section 7 of this document. This programme of work includes many of the elements encompassed within the BCF plan, e.g.: mental health transformation; prevention and early intervention/healthy lifestyles; and substance use disorder services. In this year there have been developments in our community crisis support ('the Lighthouse') for individuals living with a mental illness, as well as an enhancement to the primary care mental health support.

'The Lighthouse' is a city based community facility that supports individuals in a recovery-focused way to manage their mental health crisis. Local residents using The Lighthouse receive interventions in a therapeutic environment offered by mental health nurses, as well as peer supporters who bring their lived experience to the service. Review of patient outcomes and experience of the virtual model offered during the pandemic has been undertaken to build a more sustainable model which will be expanded to other areas of the city.

Enhanced Primary Care Mental Health Team. Through a dedicated Southampton City Mental Health Partnership Board, with collaboration between CCG, PCNs, Southern Health Foundation Trust, Dorset Healthcare Foundation Trust (Improving Access to Psychological Therapies) and VSCE, delivery of the Community Mental Health Transformation continues. This includes the Enhanced Primary Care Mental Health Team to meet the identified PCN demographic and population health needs. People with unmet significant health needs in Primary Care include; people with serious mental illness (SMI), frequent attenders, people with traits of personality disorder, people stepping down from adult mental health services, physical health checks of patients with SMI. The success of this is through the Additional Roles Reimbursement Scheme (PCNs) and our local transformation plan.

Start Well is another subset of the 5 Year Health and Care Strategy. This programme of work includes many of the same principles found across our Better Care plan, in particular its focus on strengthening early intervention and family centred approaches and integrated locality teams. This year's Better Care plan is supporting work specifically in relation to implementing new models of care (priority 5) which include strengthening the integrated crisis, therapeutic and outreach/consultation offers in our Building Resilience and Strengths Service (a joint funded children's health and social care team for children with the most complex behavioural needs) and redesigning the integrated Jigsaw Service (a jointly funded children's health and social care team for children with learning disabilities) to provide advice and support as part of the early help work in localities. In addition work is in progress to support priority 1 (admission avoidance) including the establishment of a new Children's Hospital at Home Team to support families manage minor child illnesses in the community and the development of a Children's Acute Psychiatric Liaison service to support the Emergency Dept, incorporating youth workers provided by a voluntary sector partner (No Limits) who provide valuable advice, support and signposting for young people.

5. ***Supporting Discharge (national condition four)***
   What is the approach in your area to improving outcomes for people being discharged from hospital?
   How is BCF funded activity supporting safe, timely and effective discharge?

Improving outcomes for people discharged from hospital has always been a central element of Southampton's BCF Plan. Over the past 18 months, the CCG and the Council, working in partnership with health and care providers, the voluntary and community sector and Health-watch have transformed the model to meet the national requirements, first published in March 2020, reinforced in August 2021. In August 2021, we took stock of the implementation of this model (including reference to the High Impact Change Model for Managing Transfers of Care[1])

[1] https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshin

and developed a forward plan for the remainder of 2021/22 and beyond, taking account of the need to improve patient outcomes, most importantly strengthening our approach to home first.

The key aims of our discharge model moving forward are to:

- Promote and support people to retain as much independence as possible and maximise their potential for remaining in their own homes – data from April 2019 to Jul 21 is showing that on average 94.8% of patients return to their usual place of residence varying from 93% - 95% each month. Our comparator average is 93.7%. Local analysis suggests that patients over 80 are the least likely to return to their usual place of resident and so our focus will particularly be on supporting the older client group to regain their independence. Noting that local data and BCF data sets are not comparable and the latter is not available with an age profile breakdown, **ambition will be improvement in this metric with the older persons group whilst sustaining performance of 94.8% against the BCF data set**.
- Seek to reduce onward care costs by reducing dependence on bed based and more intensive care wherever possible
- Extend the re-ablement offer to all patients leaving hospital on pathway 1
- Strengthen flexibility in the use of bed based interim care for those who need it to ensure that these resources are utilised more effectively.
- Reduce hospital length of stay, thereby preventing wherever possible people from deconditioning in a hospital bed – data from April 2019 – July 21 shows that 10.4% of patients in Southampton had a 14+ LOS and 5.4% a 21+ LOS (compared to a comparator average of 10.9% and 5.8% respectively). Further analysis shows that this increases with age – highest in over 65yrs and white British ethnicity. Thus the ambition this year will be to see a reduction in the 14+ and 21+ LOS figure of 0.4% respectively.
- Continue to develop the multiagency team approach through further extension of our community based multiagency discharge hub to speed up discharge and manage all step up and step down activity
- Our ambition this year is to sustain the performance of 94.8%, BCF metric, of people being discharged to their usual place of residence and to reduce long lengths of stay by 0.4%. The new model will achieve this through:
- A stronger focus on earlier discharge planning, at the point of admission and within the first 12 hours
- Strengthened Community Discharge Hub with additional Social Work and CHC capacity.
- Development of a flexible core community bed offer. In the new model we are disinvesting in interim D2A beds but need to make sure that those beds that remain are more flexible according to the current needs in the system.
- Strengthened health and care services in the community with the agility to respond quickly and flexibly to greater levels of complexity and acuity in people's own homes at any time of the day 24/7.

In order to deliver this model, we have agreed to prioritise as a system greater investment in the following areas (further detail of which can be found in the embedded document):

- Home care – workforce development as well as additional hours for bridging, night-time care and long term care
- Reablement care
- Community therapy (OT and Physio)
- Community Urgent Response to provide clinical support into care packages and placements as well as our virtual ward model

- Additional Voluntary Sector capacity – including ongoing investment in our existing Welcome Home Scheme
- Additional health and social worker capacity in the Community Discharge Hub to support increased numbers of discharges home and increase in-reach into the hospital
- Additional capacity in community equipment
- Working with L.A. housing services, including Homelessness services, to promote hospital discharge for those that are either Homeless or at risk of Homelessness.

These plans are still subject to confirmation of finances but over the next 12 months, as the home care provision is enhanced, we would envisage decommissioning some of our D2A beds, thereby releasing funding that can be reinvested in the services above.

The BCF is key to supporting this work. Historically we have used the BCF to pool funding, with additional contributions from both the CCG and the Council, to provide us with the flexibility required to deliver our discharge plans. In 2021/22 this part of our BCF pooled fund comes to £17.6M including iBCF investment and covers our integrated Rehab and Reablement Service, Hospital Discharge Team, and additional investment into our Urgent Response Service and D2A schemes – which include both a D2A model for Pathway 1 (supporting people in their own homes) and a D2A model for pathway 2 (for people unable to return straight home). We have also used the BCF to invest additional health funding in home care which has also included training in clinical skills and community equipment and have used some of the iBCF funding for joint work with the Hampshire Care Association to support the market around Covid-19 response and recovery, workforce development, understanding cost pressures and completing a 'cost of care' exercise. The Rehab and Reablement elements noted here are key to meeting the ambition set for metric 8.5 – Proportion of older people who were still at home 91 days after discharge from hospital into Reablement/rehabilitation services.

We note that the BCF funded elements do not form the totality of the hospital discharge arrangements, particularly given the winter surge plans being developed at this point in time. However, in Southampton the scale of the BCF pooled fund arrangement are such that a significant proportion of this work is in scope. Extra care is one such service, with some elements funded from within BCF (e.g. care provision) and others within the wider L.A. scope. This service is one of the key enablers for hospital discharge, supporting timely discharge for often our older population who are resident in those settings.

We will be looking to build on this approach going forward, subject to 22/23 finances, to deliver the plans above.

University Hospitals Southampton Foundation Trust (UHS) is one of the organisations in the SE that is described as a 'trust of concern'. The data made available as part of the BCF planning process highlights the following –

- Southampton city sum of Emergency Admissions to UHS – 43.59%, noting that being the area in which the trust is based it is the acute trust which serves the majority of our residents/patients.
- Southampton city sum of Emergency Admission to UHS that have a 21+ LOS – 36.05% and a similar position with 14+ LOS.

Whilst this detail suggests that longer stays are an even greater concern for people living outside of Southampton, the city's commissioners and providers of health and care are working hard with UHS towards improving this position. In addition to the discharge developments noted above (in section 5 of the narrative) Southampton and South West

System has a comprehensive 'winter surge plan' which is regularly reviewed in response to the changing circumstances.

6. ***Disabled Facilities Grant (DFG) and wider services***
   What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

DFG

A substantial cross agency review was led by Foundations, national experts on the use of the DFG, between August 2019 and January 2020, focussing on: local processes and practices associated with the assessment and delivery of home adaptations; national good practice; and opportunities afforded through the flexible use of the DFG to improve support and access for disabled and older people. The implementation of the review was held up during the pandemic response until April 2021 when 2 work streams were developed to meet the reviews recommendations.

The work streams focus on

- Refining the DFG assessment and adaptation process to promote a more efficient service which will have an impact on more people as a result. A cross agency project group has been established to undertake this work stream involving social care, health and housing, this group is still in the early stages of its development. The first outcomes of this work will be seen before the end of this financial year.
- Promoting the utilisation of the DFG through short and medium term projects which can be implemented with immediate effect and seek to work with a range of services and sectors across health, care and housing to do so. This has been made possible through utilisation of an underspend existing from previous years DFG. These include –
    - Setting aside a proportion of the grant to allow for the Joint Equipment Store to undertake low cost adaptation activity (e.g. ceiling hoists).
    - Extending the warm homes scheme to incorporate a "safe homes" element.
    - Supporting the Sensory Service Team, part of our integrated rehab and Reablement services, to train other professional to recognise sensory loss early which then allows them to intervene early to work with individuals to maintain their independence including the use of equipment and self-management techniques.
    - Increase in OT support in both children's and adult services to manage DFG assessments.
    - Extension of a Handy person's scheme that undertakes small work at a very low cost (e.g. hand rails, banisters etc).

By working with a broader scope of partners to implement the short and medium term schemes, a positive impact is expected during the second half of 2021/2022. Further expectation being, for these schemes, that some of these initiatives will be established as permanent elements of our offer as part of the revised ongoing DFG process.

Housing Related Support

Housing Related Support (HRS), a scheme fully under the BCF plan, is a key part of the wider prevention and early intervention work which is undertaken in the city. During this year significant effort is being made in reviewing all of our Housing Related Support services, including those for young people, adults and older persons. This review work is undertaken, not only to ensure that contracting requirements are met, but also to enable provision which strives to build the foundation for people to live independent and fulfilling lives. The primary aim of these services being to reduce inequalities, confront deprivation and work with people to build resilience communities in which they live independently.

The review of the service offer for young people and adults is informed by a broad range of stakeholders and service users, including: local authority housing and homeless services; alcohol and substance use disorder services; homeless healthcare; adult and children's social care. A range of improvements will be included in the services, procurement to be completed during the last half or 2021/2022, which enable the following –

- Development of independent living skills and with it support to move on to settled accommodation.
- Improvements in reported physical wellbeing, emotional wellbeing and mental health.
- Improvement in individuals and families link with their communities to promote an outcome of settled accommodation.

These improvements will be made possible through a strong relationship between the commissioned services and their partners in health care, including substance use disorder services and mental health. These relationships are not part of an integrated offer rather a formal approach to partnership which meets the needs of the population.

The older persons HRS (55yrs+) will also be reviewed this year, in scope will be floating support provision and that which is provided within a specific setting e.g. our extra care schemes. The primary aim for these services remains to live independent and fulfilling lives, where possible enabling them to remain in their home with support rather than moving to a 24 hour care setting. This year saw the addition of a new extra care facility for the city, taking the total to 6, an expansion which places greater importance on this review and the support service itself.

The HRS service is critical to the success of these facilities acting as a bridge with other key support services for the residents, e.g. home care, adult social care, housing services, community and voluntary sector and health care. Again, whilst not formal integration, the strong partnerships between these services enable successful support for this client group. As such the review will include engagement with all of these partners and make recommendations for continue improvements in partnership approaches that promote the independence of residents and their ability to remain within that setting.

7. Equality and health inequalities.

Southampton is an ethnically diverse city:

- **22.3%** of Southampton's residents are from an ethnic group other than White British, compared to 20.2%nationally (2011 Census).
- Southampton has residents from over 55 different countries who between them speak 153 different languages (2011 Census).
- Disability-free life expectancy at birth for males in Southampton is **59.6years**, compared to 62.9 nationally (2016-18). Disability-free life expectancy at birth for females in Southampton is **58.2 years**, compared to 61.9 nationally (2016-18).

- Around **123,000** people in Southampton have a long-term health condition (such as diabetes, heart disease, epilepsy, breathing problems etc.). Over half of these people have two or more conditions for which they need ongoing support.
- 610 adults with a learning disability in Southampton receive long-term support from the local authority (2018/19)
- 3.9% of supported working age adults with a learning disability in paid employment, compared to 5.9% nationally (2018/19).
- **13.5%** of people aged 16 years and over in Southampton have a long-term mental health problem, compared to 9.9%nationally (2018/19).

A more general indicator which shows inequality across the population is **life expectancy**. In Southampton, people living in the most deprived areas of the city die earlier than those living in the least deprived areas. Males living in the most deprived areas of the city are likely to die 6.7 years earlier than males living in the less deprived areas of the city. Females living in the most deprived areas of the city are likely to die 3.1 years earlier than females in the less deprived areas of the city. The actions we have identified focus on impacting on these areas, with a focus on the four priority areas identified below. The greatest challenge, including consideration of the cultural diversity of Southampton, is this gap between those living in the most and least deprived areas of the city. The Health and Wellbeing Strategy, whilst inclusive of the BCF plan, has multiple other schemes and strategies to promote improvements in this overall picture, including: Be Well Strategy; Suicide Prevention Plan; Tobacco Control Plan; Drugs Strategy; and Children and Young people Strategy.

Multiple areas within BCF plan include aspect which support vulnerable people, from ethnic groups other than white British, to access services. Including prevention and early intervention services, e.g. Community Wellbeing Team, Smoking cessation and Housing Related Support, having a targeted approach for those groups and areas of the city. This is further enhanced by BCF schemes working in collaboration with other service areas delivered or commissioned by the Local Authority or CCG, e.g. housing services for Council Tenants, Employment Support Teams and Healthy Homes/fuel poverty.

In addition the city's homeless or at risk of homelessness population includes people from a range of vulnerable groups/protected characteristics. The services provided for our homeless population largely sit outside of the BCF plan, however there is clear evidence that this group are greatly disadvantaged should they experience a health crisis and hospital admission. A review of this area has been undertaken in year and proposals developed from that which will be implemented either in Q4 of this year or early in the BCF plan for next year.

In this context and that of the vision of the Southampton Health and Wellbeing Strategy of 'a culture and environment that promotes and supports health and wellbeing for all', a number of priority areas within the BCF plan have been identified. These are –

1. People living with a learning disability – We have also been able to forecast increases in people with a learning disability. Between 2018 and 2023, the number of people with a learning disability is estimated to increase by 4.2%.
2. Older people – Southampton will see a rise in population overall of 5% by 2023 (based on 2018 population data) the age group with the biggest percentage increase will be the older old i.e. 80+ yrs (14.5%), adding more pressure onto the city's health and care services.
    a. Of note, though not exclusively older persons, prior to the impact of COVID we expected to see 9.7% increase in Frailty, 11.6% increase in Dementia and 10.3% increase in people living with 5 or more long term conditions all by 2023.

3. People living with a disability – whilst a proxy measure, we expect the number of people needing home care support with five or more activities of daily living (such as bathing, using the stairs, getting dressed) to increase by 11.8% between 2018 and 2023. Evidence to date supports this with a rise of the mean home care hours per person from 10 hours per week to 14 hours per week in the last year.
4. People living with mental illness - Social distancing and the impacts of lockdown will (for many) exacerbate existing conditions such anxiety and depression, and create "new" mental health needs. There is a high risk that social distancing may turn into 'social isolation' for those without a strong network of family and friends and a way to connect to others outside the home (known higher risk groups are men, older people and those that live alone).

Changes from previous BCF plan, including inequality of outcomes related to the national metrics.

Changes to the BCF plan which relate to hospital discharge will not be repeated here, see section 5 for detail. Similarly those changes which relate to DFG and Housing can be found in section 6.

Learning Disability commissioning and integration has long been a part of Southampton's BCF, Active Lives is one of the draft key priorities within the Southampton Learning Disabilities Transformation Strategy. The vision states that 'People with learning disabilities will be able to reach their goals and ambitions, through the delivery of good local joint planning, where the voice of the person and their carers are heard, and current inequalities are addressed, by the creation of opportunities, in every part of their lives'.

Whilst focussed on adults with learning disabilities, the Active Lives model also provides an enabling function for the wider system to those with autism and/or mental health illness, as it seeks to lay the foundations for a broader range of community supports, through breaking new ground in the city on key issues such as employment and inclusivity. Active Lives will deliver an outcome-focused model which enables individuals to increase their independence skills based on a robust, person-centred assessment and review process and more meaningful, community-based activities, including employment.

As well as offering a wider more inclusive community offer, Active Lives will transform the current model of day support by providing a much more strengths based, person centred and flexible offer which is based around individual outcomes and integrated within local communities. It will include a person centred, strengths-based assessment function, tied closely to outcomes which are regularly monitored, and integrated with a life skills approach and a bespoke employment function.

Further work through partnership between primary care and one of our prevention and early intervention services (Community Wellbeing Team) aims to improve the levels of physical health checks in this client group and at the same time promote Covid and Flu vaccination up take. Whilst this area is not identified through the national metrics it is a key priority for the city and will contribute to admission avoidance to acute care and residential settings.

Older people, as noted in section 5 of this document this group has been a strong focus in much of the hospital discharge work, as we build upon the lessons learnt in 2020/2021. Local intelligence suggests that the oldest old, i.e. 80+yr olds, have the lowest rate of being discharged to their usual place of residence. Whilst this level of detail is not available in the BCF data packs, it is clearly a priority area for the city.

Section five clearly describes some of the work aimed at achieving the above ambition. There is other work underway focusing on prevention and early intervention for this population group, in particular though our work with the community and voluntary sector. Building on the lessons learnt in 2020/2021 our commissioned community development and community navigation service (social prescribing resource in addition to PCN roles) is focusing on how we support older people, and other vulnerable groups, to resume or return to services where safe and appropriate to do so. Where it is not safe to do so they are working with local communities to promote digital engagement and with it access to wellbeing support. These approaches are aimed at supporting wellbeing and by so doing supporting people to remain independent for longer. This, along with the investment (in year) into Reablement noted in section 5, is key to supporting the delivery of metric 8.4 – Long-term support needs of older people met by admission to residential and nursing care homes.

Our Ageing Well group has also considered the High Impact Change Model – Reducing preventable admissions to hospital and long-term care[2]. In Q2 and Q3 will be undertaking a self-assessment against this model to identify other areas for consideration, building on the prevention and early intervention work and by so doing promote admissions avoidance to hospital and long term care.

Linked to this is the Ageing Well allocation (in year and included within the rehab and Reablement scheme) for 2 hour Urgent Community Response will be largely targeting this population, aiming to promote admission avoidance that meets the standards set out in the Ageing Well requirements. Clearly linked with admissions avoidance and supporting people to remain in their own homes for as long as possible. This is a key are for Southampton noting that of the NHS metrics this is the only one where performance is worse than our comparator local authorities and the England average (unplanned Hospitalisations for Chronic Ambulatory Care Sensitive Conditions).

People living with a disability and/or multiple long term conditions will benefit from the community work noted above. In addition there is a strong focus on supporting life planning and anticipatory care planning in our Community Wellbeing Team and also our End of Life Services. The latter promoting life and anticipatory care planning as early as possible, potentially up to 3 years before the end of life. These two services are working to ensure that people seek out the support or make the changes, they may need or wish to, in order to stay well and independent for as long as possible.

In addition work is ongoing in the city to support people who are living with multiple long term conditions, including those conditions which are most prevalent e.g. Diabetes, Heart Failure and Chronic Obstructive Pulmonary Disease. There is a broad support offer, including person centre approaches, supporting self-management and specialist care and advice where this is required. This work contributes to our admission avoidance work overall and supports metric 8.1, Unplanned hospitalisation for Chronic Ambulatory Care Conditions.

People living with mental illness are benefiting from a mental health investment across the ICS in this year, not formally part of the BCF plan. Elements which are included within the BCF plan include an expansion of the support for primary care to provide health checks for people who are living with a SMI through our Community Wellbeing Team. This offer will, as with LD, promote access to flu and Covid vaccination, along with the offer of health and wellbeing planning support.

[2] Reducing preventable admissions to hospital and long-term care – A High Impact Change Model | Local Government Association

Our Improving Access to Psychological Service has undergone a recommissioning process this year, building upon national requirements, best practice and local developments in support of post Covid demand. Impact from this will be seen next year with the new contracts starting on the 1st of April.

The city have also commissioned a mental health network, formed of interested organisations from across the community and voluntary sector. This will enable the sharing of good practice locally, enable partnership opportunities and bidding collaboratives. All of which aims to benefit the local population who are living with a mental illness. In addition the city has commissioned an extension of the JSNA that focuses upon mental health needs, which will be utilised to inform further mental health developments in the coming year.