Southampton City Better Care Partnership Agreement 2015/16

Quarterly Performance Report

Scheme	**CLUSTERS**
Host	**Southampton City CCG**
Report Author	**Adrian Littlemore, Senior Commissioner ICU**
Reporting Period	**Q1 2015/16**
Report Date	**17 August 2015**

Overall Financial Performance

Annual value	£30.634m CCG = £30.483m SCC = £151k
Year to date budget	£7.659m
Year to date spend	£7.658m
Variance	£0.001m
Reasons for Over/Underspends: N/A	
Actions being taken to address Over/Underspends: Not applicable	
Opportunities for Savings: None identified at present	
Predicted Cost Pressures: None identified at present	

Associated Contracts

Contract	Duration	Annual Value	Any Over/Under spend to date	Summary of Performance to date	Further Comments
Solent NHS Trust Block NHS Contract – community nursing services, including continence, services for people with LTC and podiatry	1 year rolling contract	£9.684m	n/a – block contract	Additional investment in community nursing services and associated additional capacity being closely monitored as service still reporting workload pressures.	

Contract	Duration	Annual Value	Any Over/Under spend to date	Summary of Performance to date	Further Comments
Southern Health Block NHS Contract – OPMH community teams and AMH assessment and community support	1 year rolling contract	£11.750m	As above		
IAPT Service commissioned from Dorset Health Care	1 year rolling contract	£1.993m	As above		
Personalised care for over 75's (GP £5 per head) commissioned from: Solent NHS Trust SMS Central practices	 18 months 18 months 18 months	 £0.403m £0.515m £0.295m	 As above	All teams now in place; embedding of model with GP practices being monitored closely	Evaluation planned for end of calendar year to determine plans for 16/17

Overall Delivery

Original Aims and anticipated Outcomes	• A more integrated approach to service delivery to address system wide problems which cannot be tackled by one agency alone o Through focussing spending on system need rather than agency need. o Through supporting integrated strategic development, mutual responsibility and joint outcome measurement. o Through creating more opportunity for cross skilling of staff. o Through bringing together generic and specialist resources in a more integrated way that supports people's needs holistically but at the same time enables the person and/or the professionals involved in the person's care to access specialist resources for input/advice/support on specific conditions. • Fewer unscheduled admissions to hospital o Through proactive multiagency risk stratification tools which bring together a breadth of information to identify those people most at risk of deterioration and intervene earlier, maintaining and promoting independence o Through better use of case management and shared care planning to better manage people at home o Through a stronger focus on prevention, including falls

	prevention • Fewer admissions to long term care, eg. residential or nursing homes o Through better case management and shared care planning o Through a stronger reablement ethos o Through more proactive discharge planning, ensuring that people are only in hospital for as long as they clinically need to be and that their independence is promoted • Better service user experience o Through supporting people to manage their own health and wellbeing and have a single lead professional who will coordinate their health and social care. o Through providing accessible services in a timely streamlined fashion that will seek to help them to be as independent as possible. o Through providing consistency and reducing duplication through single processes such as single assessment, lead professionals and shared recording and communication systems. • Improved joint working with local communities and voluntary sector o Through development of community navigator role to signpost people to community resources o Through better understanding and knowledge of local area		
Evidence of delivery against original aims and outcomes and how this supports overall BCF targets	• Agreed operational policy developed for integrated working in clusters. Cluster Leadership groups established and meeting on a monthly basis. • High risk patients being identified by multi-disciplinary team. Care plans developed and up-loaded on to the Hampshire Health Record (4486 patient plans). • Cluster performance dashboards developed to measure change and target future interventions. • Work commenced to align other adult or specialist services to deliver through the integrated cluster model. • Options appraisal and seeking commitment to develop a Single Point of Access to services, under development. • Workforce developments progressing with a focus on making "every contact count". • Emerging estates strategy to support integrated working. • Community Navigation being trialled in 2 cluster areas. • Cluster community plans being developed involving health, social care, housing, voluntary and faith groups and local business representatives to bring organisations together to more strongly focus on the needs of the community. • Falls prevention plan developed with system wide implementation. Falls exercise classes and fragility fracture clinics operational. • CQUIN established with Solent NHS Trust as part of contract specifically focussed on working with residential homes to improve management of residents and reduce hospital and nursing home admissions • Over 75 nursing schemes fully operational – due to be evaluated at end of calendar year.		
Performance	<u>Indicator</u>	<u>Plan to date</u>	<u>Actual to date</u>

Indicators	• To significantly reduce permanent admissions to residential and nursing homes	69	83
	• To increase the percentage of older people still at home 91 days post discharge into reablement services	Data still unavailable from SCC	Data still unavailable from SCC
	• To significantly reduce delayed transfers of care	2296	2727
	✓ To reduce avoidable emergency admissions	6953	6944
	• To reduce injuries due to falls	231	258
Summary of Risks and Issues & Mitigating actions	• Reducing the numbers of injuries due to falls remains challenging for a number of reasons: ○ Introducing falls exercise has an evidence based lag effect of at least 6 months as individuals need to build core stability strength and maintain this over time. On a population basis significant numbers of individuals need to have improved and maintained their core stability strength and avoided falls over time to impact on the trajectory. ○ The model for delivery of falls exercise developed previously was based on the assumption that students from Solent University would deliver the sessions as part of their undergraduate degree and individuals being charged for venue and coordination costs. Solent University have now indicated that this is no longer feasible. Work is underway to explore the potential of stimulating existing exercise providers in the City to provide appropriate services. It is highly likely that these potential providers will require financial support to develop and maintain a required service as the full costs cannot be transferred to individuals. ○ Patients who are prescribed bone density medication benefit from taking the medication after many months. On a population basis Fracture Liaison Services (FLS) are known to take 18 months before a population impact is seen. • Admissions to residential and nursing care – the target reduction is a composite target and may not necessarily have a financial benefit if the reduction is mainly focussed on residential admissions. This has been illustrated in the previous year, where although the actual number of permanent admissions reduced, the actual cost increased. An audit of recent residential care admissions is being planned to provide greater understanding of the increasing need of individuals and the interventions that are likely to have the greatest impact on reducing admissions and costs. • Development of IT interoperability - The development the Hampshire Health Record to provide care plan interoperability is challenging. There is a lack of pan Hampshire alignment and shared vision which is impacting on progress. This has been escalated by the CCG and a meeting is scheduled shortly with CSU to discuss. Other delaying		

	factors are the achievement of a data extract from TPP (GP data) and from Paris (social care data). • Community Nursing - The community nursing service is reporting consistently very high levels of demand, which limits the responsiveness of the service. This is despite additional investment in staff resource and in the continence service to undertake routine reviews of patients, releasing community nurses for other duties. The position is being closely monitored through monthly performance review meetings and Solent are undertaking a detailed caseload audit to provide greater transparency.

Summary

Any proposed Changes/ Recommendations for consideration by CPB and HWBB	None at present
Priorities for forthcoming period	• Greater alignment of other adult and specialist services to cluster working. • Review of the Community Nursing specification and demand management strategies, with greater alignment to primary care teams. • Workforce development plans for "every contact counts" rolled out. • Agreed estates strategy and principles • Evaluation of Fragility fracture clinics • Proposals for the provision of falls exercise classes for 2016-17. • Community plans developed with each cluster and proposals for external grant funding supporting community and faith group delivery.

Date received by Commissioning Partnership Board	
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Date received by Health & Wellbeing Board	
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