DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		BETTER CARE SOUTHAMPTON UPDATE AND QUARTER 2 PERFORMANCE		
DATE OF DECISION:		27 JANUARY 2016		
REPORT OF:		Stephanie Ramsey, Director of Quality and Integration		
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STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This paper has been prepared for the Health and Wellbeing Board to provide an update on progress against the Southampton Better Care plan which is coming to the end of its first year. It highlights performance to date and recommendations for developing Better Care going forward as we prepare for 2016/17 and beyond.

Policy guidance has recently been published for the Better Care Fund (BCF) in 2016/17. This states that the Better Care Fund will be increased to a mandated minimum of £3.9 billion (for Southampton the minimum requirement has increased from £15.325m (revenue funding) to £15.892m) with additional funding being made available to local authorities from 2017/18 equating to £1.5 billion by 2019/20.

The policy guidance signals a clear direction of travel towards system wide health and social care integration, noting the Government's Spending Review requirement to produce a whole system integration plan for 2017. Better Care is seen as a first step in achieving this.

The policy guidance also highlights the importance that BCF plans are aligned to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of 7 day services.

Final detailed guidance is still awaited in the NHS Technical Planning Guidance but known changes for 16/17 include:

- Removal of the payment for performance element (linked to the reduction in NEL hospital admissions) – although reducing non elective admissions will remain a target.
- Two new national conditions requiring local areas to fund NHS commissioned out of hospital services and to develop a clear focused action plan for managing delayed transfers of care (DTOC).

Better Care plans for 2016/17 are required to be agreed by Health and Wellbeing

Boards and signed off by the relevant local authority and clinical commissioning group (CCG).

A first cut submission is due 8 February 2016 with the final submission due 16 March 2016. This will need to include a short, jointly agreed narrative plan, confirmed funding contributions, a scheme level spending plan and quarterly trajectory for the national metrics.

RECOMMENDATIONS :

(i) To note the progress with implementation of Better Care Southampton which is coming to the end of its first year.

(ii) To consider the future of Better Care Southampton for 2016/17 and beyond, noting the policy context towards whole system integration of health and social care.

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REASONS FOR REPORT RECOMMENDATIONS

1. From 1 April 2015 local authorities and CCGs were required to establish a pooled fund under Section 75 of the NHS Act 2006 for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authority. Policy guidance for 2016/17 builds on this requirement and overall direction of travel towards whole system integration. Local Authorities working with CCGs are required to submit a 2016/17 first draft plan for developing their Better Care plans by 8 February (alongside CCG Operating Plans), with a second submission required by 16 March 2016. Health and Wellbeing Boards are responsible for finalising and signing off the final Better Care Plans by 20 April 2016.

2. Southampton, through the Integration Board, has recently undertaken a review of progress against its Better Care Plan and taken stock of priorities moving forward. This review has led to a draft Blue Print for the future which will inform the plan for 2016/17. Key priorities identified by the Blue Print are outlined for consideration by the HWBB in this report.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. Not applicable

DETAIL (Including consultation carried out)

Background

4. In January 2015, Southampton City Council Cabinet and Southampton City CCG Governing Body approved entering into a S75 of the National Health Service Act 2006 Partnership Agreement pooled fund to bring together approx. £60m of health and social care community resources to deliver 3 schemes in line with the national requirement for CCGs and local authorities to pool budgets and agree an integrated spending plan for how they will use their Better Care Fund allocation. These schemes were:
   - Support to carers (£1.334m)
   - Cluster teams (£30.634m)
   - Rehabilitation/Reablement and supported discharge (£26.015m).

In doing so, Southampton took the decision to go above and beyond the national minimum requirement, reflecting its ambition to integrate at scale and completely transform the delivery of health and social care services, ultimately seeking to pool over £130m of health and social care resource.

Southampton's 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. Better Care has the following overarching aims:

- **To put Individuals at the heart of their own care**
- **To focus on prevention and early intervention**.
- **To build community capacity**
- **To help people to retain and regain their independence**

The key principles are:

- **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

5. **Progress to date**

As part of implementation regular reporting has to be made to NHS England and the national Better Care Support Team. The Quarterly returns form part of the overall accountability framework for the BCF as set out in the national guidance (Guidance for the Operationalisation of the BCF in 2015-16) issued in March 2015.

The quarterly submissions report progress against delivery of the Better Care national conditions and performance against the national metrics. Below is a summary of performance as at the Q2 return:

- **Non Elective (NEL) hospital admissions** have reduced in 2015/16 compared to 2014/15 and are on target (as at Q2 monitoring) to achieve plan. This reduction is mainly in the 65+ population (2% reduction at M7) which has been the focus of this year's Better Care programme. Conversely hospital admissions have increased (7% increase at M7) in the working age adult population - this will need attention going forward.
- **Delayed transfers of care** are above target (12% over plan at M7) but have reduced significantly compared to the previous year (16% reduction at M7) which is testimony to the significant work being done through the integrated discharge bureau and the complex discharge action plan. The daily number of delayed transfers of care has reduced from around 30-40 in 2014/15 to around 20-30 this year. This will remain a key area of focus going forward.
- **Permanent admissions to residential and nursing homes** are above target (21% over plan at M7) and have fluctuated this year with residential admissions high at the beginning of the year but now reducing; nursing home admissions have remained higher than last year. There has been a general increase in complexity. Action to reduce permanent admissions this

year has included the use of a CQUIN (Commissioning for Quality and Innovation) scheme with Solent NHS Trust to provide targeted support to residential home staff to better enable them to manage people's health needs and prevent escalation - however this has been a small scale pilot in a few homes and will need to be rolled out further to have an impact. Investment in the integrated rehabilitation and reablement service in 2016/17 accompanied by greater use of extra care housing is also expected to reduce reliance on residential care. An audit has been carried out into residential home admissions (final report due shortly) to better understand the reasons for permanent admission and how they might be addressed. This remains a key area of focus.

6. The table below summarises progress in terms of each of the key work streams:

Carers:	An assessment service has been procured from the voluntary sector and went live (June 15). The use of a pooled fund for this service has enabled the CCG and City Council working together to procure a single service against a single specification and budget. The City Council is the lead commissioner for this service. Performance monitoring is showing a significant increase in numbers of carers identified. 748 carers have registered on the database as at 30 Sept 2015. 73 carers assessments have been completed between the start of the service in June 2015 and 30 Sept 2015.
Rehabilitation, Reablement and supported discharge:	The integrated health and social care service will go live from January 2016. There are proposals to implement a revised model of bed based and domiciliary based care from 1 June 2016, subject to approval by Cabinet in February. The integrated service will formally bring together staff teams, systems and processes (e.g. assessment, care planning) and management structures to provide a streamlined redesigned service capable of better responding to crisis and supporting timely discharge, with a greater focus on promoting and maintaining independence in people's own homes to reduce hospital admissions and admissions to residential and nursing homes.
Clusters:	Six clusters have been established across the city for integrated working, based around groups of GP practices. These include frontline staff from community nursing, older people's mental health services, supported housing, social care and primary care along with representation from the community and voluntary sector, led through 6 cluster leadership teams. A workforce development programme is in place funded by Health Education Wessex. Local performance data is available through cluster performance dashboards and risk stratification. The lead professional role and multidisciplinary case management is being trialled. Development of these teams has progressed at differing paces across the city as follows: • Cluster 1 – strong focus upon complex case management

	in the older person, open to becoming a trial area for new telecare approaches and of course expanding the work possible through community navigation. • Cluster 2 – Strong focus upon linking up communication methods between services, including the relaunching of the 'low tech' patient held single record. • Cluster 3 and 4 – These groups have moved past relationship building and begun to provide a step up multidisplinary complex case approach for those cases which the current practice level teams have been unable to fully meet the individuals planning needs. • Cluster 5 – This group is expanding the current practice level MDTs to promote a wider range of persons and knowledge involved in problem solving with complex cases. They have also promoted the new approach of 'low tech' single health record. • Cluster 6 – continues to develop their plan around complex case management, having spent a significant amount of time on relationship building and promoting the single health record concept.
Community Solutions:	All clusters have undertaken a community workshop with voluntary and community sector and statutory health and care providers attending. These workshops have generated a range of themes in each area which will form the basis for individual cluster community solutions work. The overarching community solutions group will aim to pull together any learning and successes from across the clusters. Examples of the common themes are as follows: • Loneliness and isolation – with consideration of embracing the work already done by neighbourhood watch schemes and' timebank' • Access to information – providing a wealth of feedback to inform the information, advice and guidance review underway in qtr 4 1516 and qtr1 1617. • Accessible transport – review underway by Age UK Southampton of community provision informing this challenging area. • Engagement with faith communities and groups – seeking a broad understanding of health and wellbeing approach of the varied cultural groups within the city and informing service provision.

7. **Integration Support bids**

In October 2015, the Better Care Support Team invited local areas to bid for a share of £500k to support implementation of integrated care. The funding was offered in two tranches – 6 November and 11 December. In the first tranche 35 bids were received with a total value of £1.6million, of which £465,000 was awarded. Given the scale of interest, the BCST increased the size of the fund to £1m, with at least another £500,000 available in tranche 2.and a further £580k was awarded.

Southampton was successful in two bids:

- £25k to promote organisational development. The proposal builds upon a bottom up approach to bringing staff together in each cluster to get to know each other's roles, learn together and shape the new ways of working, promoting the organic development required to support new organisational formats.
- £46k to develop a whole system demand and capacity tool to inform future planning.

8. **Future Planning**

The focus of the programme during 2015/16 has initially been older people aged 65+. In planning for Year 2 of Southampton's Better Care programme, the Integration Board has taken the opportunity to reflect on progress to date and consider priorities for the future, aided by the Better Care Support Team self-assessment tool published in November 2015.

A new "Blueprint for integrated care in Southampton" is currently being developed which will substantially increase the scale and pace of integration across the city and will set the direction for the Better Care programme for the next 5 years. In particular, this recognises the need to embrace opportunities across the system for better integrating health and social care, in particular, taking account of the new models of care outlined in the NHS 5 Year Forward View and the following local developments:

- the Multispecialty Community Provider (MCP) fast follower programme, led by Solent NHS Trust in partnership with SCC, primary care and the voluntary sector, which is exploring alternative organisational forms to deliver the Southampton Better Care vision.
- Southampton City's primary care strategy which is seeking to develop more sustainable models of primary care and improved access. As from 2016/17, it is expected that new legislation will be passed to enable primary care funding to be included within Better Care pooled funds. This, alongside delegated responsibility to the CCG for primary care budgets in 2016/17, creates new opportunities for integrating resources and provision further.
- The Devolution agenda and development of the Southampton Health and Wellbeing Board.

9. In particular, the Blueprint sets out the need for:

- **More rapid expansion of the integration agenda across the full life-course** – in particular to address pressures within the working age adult client group (where NEL hospital admissions continue to increase, particularly for those with long term conditions and social complex circumstances) and within children's services where the numbers entering the care system have been rising exponentially at a rate which is now 75% higher than the England average.
- **A much stronger focus on prevention and early intervention** – this is central to transforming the health and social care system and achieving financial balance. However, with the pressures on budgets and particularly reductions in the Public Health grant, this will need a more long term whole systems view to planning which sees investment in prevention and early intervention as a priority for all partners across the system, regardless of where the benefits of a particular investment falls. Work has commenced in developing a commissioning programme for prevention and early intervention to support this ambition.
- **A more radical shift in the balance of care out of hospital and into the community** – much has been made of this over the past 20 years, with some progress, but more of a shift in practice is needed. Future development of cluster working and integrated rehabilitation and reablement and hospital discharge are key to the success of this ambition.
- **Significant growth in the community and voluntary sector -** to achieve the focus on prevention and early intervention required and divert people away from public funded services by building resilience, promoting independence and access to community resources. Some progress has been made through the community solutions group. However, Southampton remains far behind some of the leading cities in this area e.g. Leeds, Lambeth and Southwark, Derby. A strenghtened community and voluntary sector is required but this will need investment and support in its infrastructure to allow it to develop and thrive. Work is currently underway as part of the Prevention and Early Intervention (PEI) commissioning programme to determine the best way of doing this.
- **Development of new organisational models which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies -** Southampton's MCP fast follower status provides an opportunity to progress this at pace.
- **New contractual and commissioning models which enable and incentivise the new ways of working described above -** this includes lead provider arrangements to support MCP or other integrated provider models, alliance contracts based around single service specifications and outcomes frameworks, longer term contracts to provide stability to enable providers to work differently and introduction of different currencies based around needs or pathways as opposed to units of care delivered by a single organisation -e.g. capitated budget; total place budgeting.

10. Plans for the Better Care fund in 2016/17 will take account of these priority areas and it is recommended that the pooled fund is increased to include:
    - a new scheme focussed on the development of prevention and early intervention underpinning the PEI commissioning programme referred to above.
    - a new scheme focussed on the development of telehealthcare
    - a new scheme focussed on bringing together health and social care resources for adults with learning disabilities

    Consideration should also be given to the benefits of potentially extending the pooled fund to other client groups, e.g. children and families.

RESOURCE IMPLICATIONS

Capital/Revenue

11. The minimum requirement for the Better Care Fund has increased in 2016/17 from £15.325M Revenue to £15.892 Revenue. The capital requirement for 2015/16 was £1.526M and is expected to remain broadly unchanged for 2016/17. The majority is existing funding sources included within either the Council or CCG budget. This funding is not new to the Health and Social Care system. However, under the conditions of the Better Care Fund, additional funding of £600,000 from within the pool should be provided to help meet the responsibilities of the Council required by the Care Act 2014.

12. The current value of Southampton's Better Care pooled fund is approx. £60m with plans to increase this further in 2016/17 with the potential addition of the 3 schemes identified above. Further detail on these potential additional 3 schemes is currently being worked up and will be presented to the Commissioning Partnership Board for consideration.

Property/Other

13. Not applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. Section 75 of the National Health Service Act 2006.

    The pooled fund agreement will cover governance and technical aspects including accountability, financial reporting and the handling of overspends, underspends and savings requirements.

Other Legal Implications:

15. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to encourage and support integrated working. This is being delivered through guidance for the Operationalisation of the BCF in 2015-16.

POLICY FRAMEWORK IMPLICATIONS

16. The decision sought is wholly consistent with the Council's Health and Wellbeing Strategy and other policy framework strategies and plans.

KEY DECISION?	No
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 and Safety Impact Assessment (ESIA) to be carried out.	No
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	Yes/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	