Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

BCF narrative plan template

Health and Wellbeing Board(s)

Southampton City

1. Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils) and 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, ICB and Primary Care Networks (clinical leads), Community and Voluntary Sector and officers within the ICB 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 - Southampton
- End of Life Steering Group – Southampton and South West Hampshire
- Children's Multiagency Partnership Board - Southampton
- Learning Disability Partnership Board - Southampton
- Onward Care Group (Complex discharge and Integrated Discharge Bureau) – Southampton and South West Hampshire
- Mental health forum/No wrong door group – two levels, Southampton and ICB
- Local Delivery System Group – Southampton and South West Hampshire
- Carers Partnership Board – Southampton
- Better Care Finance and Performance Group – Southampton
- Discharge and Community Capacity Cell – Hampshire and IoW

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; ICB; 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 2022-2023.

As part of the wider context the Integrated Commissioning Unit works with partners across the care system to develop market position statements which reflect local need and seek to stimulate the market. Further to this social care providers have engagement through a number of forums and processes which guides their work in partnership with the ICB and LA and thus contributing to the overall picture.

Public health colleagues have worked with commissioners, services and service users to identify the impact of the Covid 19 pandemic on our population and services. This has helped to inform the planning for this financial year and will continue to do so going forward. Evidence of this is seen in the work with the social care market in particular and core community services who are responding to a rise in the levels of complexity of both people living with physical illness, mental illness and related frailty. Reference to a change in the provision can also be found in the section related to hospital discharge or 'Provide the right care in the right place at the right time'.

2. Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Priorities for 2022-2023

The Southampton 5 year health and care strategy (2020 – 2025) provides strategic direction for all system partners with the priorities listed below generated by all system partners. These priorities are distributed across the four programme areas of Start Well, Live Well,

Age Well and Die Well. The BCF priorities, as a subset of the overall health and care strategy delivery, are informed by this priority setting process.

Start Well

1. Reducing childhood obesity
2. Improving children and young people's emotional and mental wellbeing
3. Improving outcomes in the Early years - personal, social and emotional development; communication and language; and physical development

Live Well

4. Improving Mental Health & tackling loneliness
5. Improving lives for the most vulnerable, e.g. people with LD, MH problems, people living in most deprived areas
6. Tackling smoking, drugs and alcohol misuse

Age Well

7. Proactive Care approach

Die Well

8. Early identification of people at End of Life
9. Promote accessibility of End of Life care for all
10. Out of Hospital End of Life Care Coordination

Detailed below are the BCF priorities in relation to the 5 year health and care strategy and BCF policy and planning requirements -

- **Priority 1: Delivering on Avoidable Admissions/enable people to stay well, safe and independent at home for longer -** Strong focus on prevention, admission avoidance through our urgent Response Service, proactive care at home (reducing preventable admission to long term care), carers services and Enhanced Health in Care Homes (EHCH) arrangements.
- **Priority 2: Further developing the discharge model to promote right care in the right place at the right time:** including Recovery and Assessment and Home First as a feature of the BCF plan.
    - Hospital Discharge process and out of hospital capacity
    - A flexible and broad offer of recovery and assessment, promoting a home first approach
    - Particular focus on discharge capacity for those with the most complex needs
- **Priority 3: Increase the number of people who see benefit from Rehabilitation and Reablement,** meaning a continued focus on reducing dependency on longer term care provision.
- **Priority 4: Implement new models of care (within Adults and Children's)** which better support the delivery of integrated proactive care and support in our communities.
- **Priority 5: Effective utilisation of the Disability Facilities Grant –** promoting independence and personalised care/strength-based approaches.

Key Changes to our previous BCF plan build upon the excellent foundation of previous years and are based upon the above priorities, in summary these are:

Priority 1

- Expansion and redesign of our Urgent Response Service/Urgent Community Response and Reablement Service through a number of funding sources.
    - Virtual Ward developments in year, supported by existing and service development funding, will become central to this integrated approach to admission avoidance.
- Refresh of our wrap around approach with care homes including our core community services and EHCH service arrangements.
- Embedding the enhanced Primary Care Mental Health Team which is delivered through a dedicated Southampton City Mental Health Partnership Board, with collaboration between ICB, PCNs, SHFT, DHUFT (IAPT) and VSCE delivery of the Community Mental Health Transformation continues.
- Promoting further work to implement the adults and young people's carers strategies which have already benefited from a range of good practice developments in 2021/2022.
- Review and refresh of VCSE prevention and early intervention offer, including advice, information and guidance and community development.
- 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'.

Priority 2

- Refresh of the discharge operational processes, building upon the extensive work undertaken in 2021/2022 to embed the new discharge guidance.
- Clear plan for rehab/reablement and recovery and assessment provision, beds and community, in scope -
    - Priority areas include addressing the demand for those with the most complex needs
    - General and specialist rehabilitation
    - Wrap around services for recovery and assessment provision

Priority 3

- Embedding of the rehab and reablement offer available to the city's residents, building on the development work undertaken in 2021/2022.
- Aligning current rehab and reablement offer with the Virtual Ward (VW) developments to ensure effective onward support for VW patients.

Priority 4

- Continued roll out of integrated care teams/One Team with a broader scope across the city, building on the test and learn work of the last 2 – 3 years. Aligned with this

SCC are developing a locality model in adult social care, Children's social care and Communities.

    - Including linking of further services with Early Help and Young People's locality teams.

- 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)
- Improving care for the most vulnerable children and reducing health inequalities – through a broadening of the therapeutic approach as part of the Integrated Health and Social Care provision for children with complex behavioural & emotional needs.

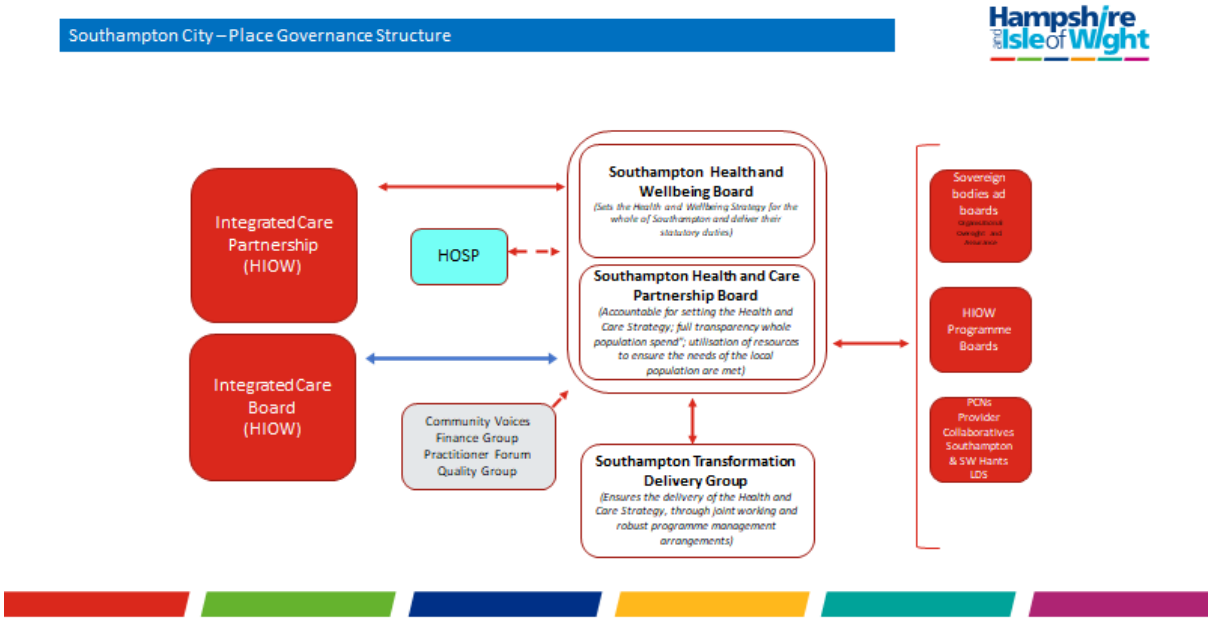
Priority 5

- Further 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**

The Governance Structure for the BCF plan in place at the outset of 2022/2023 has been reviewed to reflect the changes which will be required with the next stage of Integrated Care System Development. These arrangementslink with Southampton and South West local delivery system through our Local System Delivery Group, providing cross system oversight for the acute trust footprint.

The details below describe the new governance arrangements being implemented in the second quarter of this financial year. 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. The slide below represents the proposed governance structure for implementation following the instigation of the ICB on the 1st of July 2022.



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 Southampton Transformation Delivery Group

Southampton Health and Care Partnership Board

Amongst other functions 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 membership includes the main commissioners of health and care services in the city; Southampton local team representatives from Hampshire and IoW Integrated Care Board and Southampton City Council; and from this year representation from key providers of health and care in the city. The Board ensures effective collaboration, assurance, oversight and good governance arrangements to ensure achievement of the city's health and care strategic objectives. The Southampton Health and Care Partnership Board enables continued engagement and momentum of the strategy and assist with resolving any delivery issues which cannot be resolved by the Southampton Transformation Delivery Group.

Southampton Transformation Delivery Group

The Southampton Transformation Delivery Group, which will be implemented later this year, includes membership from senior representatives of key health and care organisations across the city, including the voluntary sector. The purpose of the Board is to ensure the delivery of the Health and Care Strategy (of which the BCF plan is a subset), through joint working and robust programme management arrangements. The group will hold the programmes 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.

Until the new delivery group is formally in place the pre-existing arrangement with the Better Care Steering Board will be sustained. Details of the function for this board are available in the previous return for 2021/2022.

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 the Southampton Transformation Delivery Group that the funding and performance are being appropriately and effectively managed. It is formed from ICB 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/One Team
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/iBCF
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.

4. Overall BCF plan and approach to integration

The **joint priorities** for 2022/2023 are those stated in the priorities section on page 3 of this document. The narrative below outlines specific areas of work that are embedding integrated, person-centre health, social care and housing services.

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 and IoW NHS Integrated Care Board (ICB). 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
- Sustaining and further developing integrated rehabilitation and reablement services; improvements to mental health crisis care; leadership of the design and implementation of integrated Children's services; gorwing 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 city. For the ICB 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 2022/2023 of £22.892m and a total pooled fund of £143.562m, £91.259m from the ICB and £52.303m from SCC.
  The ICU aligns aspects of the Council and Southampton City Integrated Care Board (ICB) 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.

How BCF funded services are supporting your approach to integration

Intermediate care – In addition to that noted earlier, there are a range of schemes in place which support people to remain independent at home. The first of which being Integrated Rehab and Reablement, a successful 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.

During the last year we have continued to see a rise in the demand and complexity of need for intermediate care, supported in part by the expansion to our Urgent Community Response/Urgent Response Service (URS). URS form part of our integrated rehab and reablement service in the city, and as such the embedding of the 2 hour response expansion from 2021/2022 is a key priority for this year's BCF plan. The Virtual Ward expansion, supported by SDF funding this year, will also form part of the integrated rehab and reablement service and therefore the BCF plan will include oversight of this exciting opportunity for that service. Delivery of metric 8.1 (rate of unplanned hospitalisation) is predicated on the success of embedding these functions into our integrated offer.

Southampton also makes a significant investment in reablement provision which along with clinical elements of the integrated service seeks to promote independence and of course promote the achievement of metrics 8.4 & 8.5. Comprehensive capacity and demand planning work has been undertaken to ascertain what level of recovery and assessment provision (previously known as D2A) is required for the city – further detail can be found in the element of this narrative which responds to national condition 4, 'right care in the right place at the right time'.

Joint Equipment Service - Overall the demand for services which promote independence has continued to increase in this phase of the pandemic. 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 old and older old population. The Joint Equipment Service supports this position with the plan continuing to promote innovation in this key area of integration.

Ageing well - 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 further implementation of the two strategies (adults and young carers) following the conclusion of a scrutiny enquiry in 2021/2022. This carers work is made possible under the BCF pooled fund arrangements and supported as a key programme area for the ICB and SCC.

The Ageing Well plan also includes the development of community integrated teams or 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 here continues driving forward the proactive care approach with our Primary Care Networks, inclusive of our approach to care home support and Enhanced Health into Care Homes (EHCH).

Die well - Also as part of the 5 year Health and Care strategy we have a Die Well plan. This describes the next stages for the development for end-of-life services and services that

support the preparation or planning stage. This year includes continued work across the system of care on earlier identification of end-of-life cases (though the One Team work), potentially as early as 3 years before death, enabling better preparation and anticipatory care planning.

Live Well - is another subset of the 5 year Health and Care Strategy which includes areas noted in the inequalities section of this narrative. 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 through the 'no wrong door programme' for individuals living with a mental illness, this includes the embedding of the primary care mental health support which is delivered in partnership with our mental health provider.

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 4) 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 implementation of the redesign recommendations for 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.

Further work is in progress to support priority 1 (admission avoidance) including embedding of the 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. Implementing the BCF Policy Objectives (national condition four)

Enable people to stay well, safe and independent at home for longer

The Southampton approach to supporting people to stay well, safe and independent at home is multifaceted, together the approaches described below contribute to the achievement of our BCF plan and with it this objective and metrics 8.1, 8.4 & 8.5 -

- The integration of our rehab and reablement services enables a seamless approach from crisis/urgent response into recovery, rehab and reablement services. Completion of the capacity and demand template, as a requirement of this return, will continue to inform the planning for future service developments.
- Further development of an integrated community/One team approach, providing multidisciplinary working at a neighbourhood/locality level, which includes a proactive care element for targeted client groups.

- Continued commitment to delivering our community wellbeing service which works through our One Team (health and social care), PCNs and social prescribing to promote independence and supported self-management.
    - The scope of this service being physical illness, mental illness and those living with a learning disability – therefore providing access to support and anticipatory care planning for a broad range of the population. See inequalities section for further details.
- Strong commitment to prevention and early intervention which includes a range of initiatives that promote access, and support to access, assets within our community.
    - One of these services, SO:Linked, provides a community development function that supports community and voluntary sector organisations to form and/or grow along with community navigation which enhances the work undertaken by our PCN employed social prescribers.
    - An SCC promoted community led support service which will accelerate further development of local asset-based delivery this year and the two years following.
- Commissioning a wide range of housing related support provision, including a older persons focused service that has a strong focus on people living in our extra care facilities in the city.
    - The service works in collaboration with the designated home care provision for these facilities thus promoting the ability for residents to remain safe and at home.
    - This service also provides the care line/response line for the city which delivers a specific falls response function in partnership with our NHS falls services in the city.
- Commissioning End of Life services which promote early planning for people entering perhaps the last three years of life, made possible through partnerships with core community services in the city.

This list is not exhaustive, however in all cases made possible under the BCF approach in the city. The asset based working and proactive care made possible through these commissioning arrangements provide a sound basis for Southampton in preparing for further Anticipatory Care approaches going forward. This in work in turn will promote local implementation of the NHS England improvement programme for health inqualities, Core20PLUS5[1].

Provide the right care in the right place at the right time – Our approach to integrating care to deliver better outcomes

Integration is at the heart of Southampton's approach to hospital discharge and ensuring that the right care is provided in the right place at the right time. The city operates as part of a wider Southampton & South West Hampshire Local Delivery System (SSWH LDS) with health and care partners across both Southampton City Council, Hampshire County Council and the Integrated Care System to coordinate discharge arrangements around the geographical footprint covered by Southampton University Hospital Trust. The Southampton system confirms a refresh of the self-

[1] NHS England » Core20PLUS5 – An approach to reducing health inequalities

assessment against the High Impact Change Model for managing transfers of care[2] has been undertaken. Our discharge arrangements are based around 3 over-riding principles:

- People will not remain in hospital when they no longer need to be there – every effort will be made to ensure that discharge happens on the day they no longer meet the criteria to reside which requires early planning
- Every effort should be made to discharge a person back to their own home – "Home First" principle
- All discharges will be safe, person centred and take account of the needs, wishes and best outcomes for the person and their family

These principles in turn are underpinned by the following key metrics that we are using to measure effectiveness:

- Reduction in patients still in hospital who do not meet the criteria to reside (CTR)) and thereby a reduction in bed days lost
- Increase in people able to be discharged to their own homes
- Reduction in permanent residential care admissions (aged 65 and over)

At an operational level, local discharge pathways in Southampton are coordinated via a community based Single Point of Access (SPOA) which brings together local teams under a single SPOA lead to streamline and integrate care for people coming out of hospital on pathways 1 (home with support), 2 (short stay bed) and 3 (permanent 24 hour care bed). The SPOA brings together our integrated Rehab and Reablement service, Adult Social Care Discharge team and Continuing Health Care team to plan and support hospital discharges. Whilst not currently co-located with the hospital, SPOA staff have office space within the hospital and they are increasingly in-reaching into the wards.

We will be reviewing the functioning of our SPOA during 22/23 against the Transfer of Care Hub national guidance with a view to further integrating processes and the various teams, further exploring co-location with the hospital, strengthening case management for people on the D2A pathways and bringing in additional services, in particular housing and VCSE representation. We will also be looking to extend the role of the SPOA to coordinate step up care for people in crisis as well as step down from hospital.

How we are using collaborative commissioning and the BCF pooled fund to support delivery of our aims for hospital discharge

The BCF provides the vehicle for both setting out our jointly agreed strategy as well as implementing our intentions for hospital discharge and providing the right care in the right place at the right time, which for most should be their own home . We are using our BCF pooled fund to jointly commission and fund a range of integrated services. This includes:

[2] Managing transfers of care – A High Impact Change Model: Changes 1-9 | Local Government Association

- Our joint funded integrated rehab and reablement services, identified in the above section, functions within a single team and as such enables a more seamless offer to be delivered, focussed around the needs of the person and facilitating the ability to manage people who also have health/clinical needs at home as part of their reablement episode.
- Short term service capacity which includes home care as well as recovery and assessment beds, jointly funded by the ICB and the Council
- Joint funding of the SPOA functions, mentioned earlier in this section, including assessment and case management

Use of the S75 powers have enabled us to flex health and Local Authority resources within the integrated services to where they best meet need and deliver on our jointly agreed priorities. For example we are investing additional health funding this year through the BCF in:

- Additional home care capacity – short term bridging hours, including enhanced support for people with more complex needs – recognising the impact this also has on improving health outcomes and reducing demand for acute health services by keeping people well and independent for longer
- Enhanced therapy to support more people on pathways 1 and 2 to achieve their optimum potential and return or remain at home
- Case management and additional assessment functions to ensure timely assessment for people being discharged to assess and ensure that every effort is being made to maximise their independence
- VCSE activity providing practical support for people returning home, e.g. the welcome home service
- Trusted assessor to support more timely discharge

The collaborative commissioning arrangements we already have in place through the ICU (as described earlier in this narrative submission) enable a joined up view of the market, joined up planning cycles, and integrated contracting. For example we have joint commissioning frameworks for home care, including short term bridging services which support hospital discharge, and residential placements, operating on behalf of both the ICB and Council; as well as a single brokerage team for both Adult Social Care and Continuing Health Care.

How primary, community and social care services are being delivered to support people to remain at home

As already highlighted, our joint commissioning arrangements enable a more joined up approach to service delivery; we are able to target both health and care resources to work together to support more people at home. The integrated Rehab and Reablement Service has already been shown to be an example of this and is currently keeping 75.2% of people at home 91 days post discharge. We are looking to increase this to 76.8% in 2022/23 and are exploring how we can further streamline pathways so that no patient comes out of hospital on Pathway 1 without being considered for reablement; this will also involve exploring the potential to skill up some of our home care providers in reablement and the extension of our therapy offer, as noted above.

In addition, we will be exploring how community health services could better "lean in" to home care packages to support providers through a mix of training and direct intervention in meeting the needs of people requiring clinical interventions, e.g. enteral feeding, collar care, insulin injections. This forms part of our "Home First" workstream (see below) and work is underway to scope the level of need for clinical interventions, working with providers, and consider the best model to support this need in a home environment moving forward.

We are also working with the VCSE to make best use of their resource and expertise in providing practical and emotional support to people in their own homes and ensure that this is considered for all people on pathways 0 and 1 and as part of the long term care plans for people on pathway 2. Southampton already has a range of provision delivered by the VCSE, including a Welcome Home scheme for people returning home from hospital, Advice Southampton offering advice, information and support, a Community transport scheme focussed on getting people back home from hospital, Carers in Southampton service, a network of community navigators and the Living Well Service which supports older people in their local communities, facilitating a range of social activities and support. These services are already promoted through the Patient Hub which is located in the hospital for people on pathway 0. We shall be looking at how we better utilise this offer for people leaving hospital on pathways 1 and 2 during 2022/23 through further development of our SPOA and links with the VCSE.

Further development and enhancement of our SPOA to include coordination of step up as well as step down support across primary, community and social care will also support the delivery of joined up health and care to support people in their own homes.

Our "One team" development (also described in this narrative submission), implementation of proactive case management at scale and roll out of Population Health Management tools from this Autumn also supports the delivery of integrated care to enable people to remain at home.

Our plans for further improving discharge and ensuring that people get the right care in the right place

As a SSWH LDS we have developed a 4-point plan with partners from across health and social care for improving hospital discharge. These four workstreams have been influenced by our re-assessment of discharge arrangements against the Hospital Discharge High Impact Change Model and the 10 interventions identified in the 100 Day Challenge. The 4 key workstreams are outlined below:

- **Improving Operational processes** – To ensure that operational processes are purposeful and functional and deliver a discharge pathway that aspires to home first. Key areas of focus are:
    - Embedding the use of Criteria to Reside on all wards
    - Optimising early discharge planning from the point of admission (aiming for EDD to be set within 48 hours, and ideally within 24 hours)

    - Ensuring the SPOAs have sufficient and accurate information, right first time, to support discharge planning, ensuring that patients are attributed to the correct discharge pathway from the start
    - Clear accountability of roles, responsibilities, and decision-making
    - Clear escalation process across all levels
    - Review and update of choice policy
- **Home First** – the BCF data identifies that Southampton is already achieving 94.83%. We are looking to improve on this and achieve 95.24% and reduce the rate of permanent admissions to care homes through this workstream which is focussing on increasing the number of people who can return home by expanding and enhancing the suite of options available including; urgent crisis response, domiciliary support, live in care, reablement and intermediate care as well as access to other community based services including those provided by the voluntary sector. Key areas of focus are:
    - Developing the home care market and support required to enable more people with higher levels of acuity and complexity to return home
    - Enhancing therapy offer to support more people at home
    - Greater us of care technology
    - VCSE
- **Making the best and most appropriate use of short term beds** – To ensure that the right people are admitted to short term beds and proactively supported to maximise their independence potential and return home. Key areas of focus are:
    - Improving assessment and case management processes to ensure that people's long term care needs are assessed in a timely way and there are clear person centred plans and outcomes in place from the earliest opportunity which are closely monitored to
    - Enhancing the therapy offer into short term beds
    - Redefining and recommissioning our short term recovery and assessment beds against a revised specification and key performance indicators with a much stronger reablement ethos
    - Re-commissioning short term beds for people with more complex needs
    - Whole system review of Community Rehab beds to ensure that we are maximising effectiveness and capacity across the whole LDS
- **Improving support to care homes and managing greater levels of acuity and complexity** – To improve flow into care homes and support with managing people when they become more unwell or if they have more complex needs. Key areas of focus are:
    - Development and promotion of the use of Telecare and Telemedicine services to provide advice and support (roll out of Restore 2 across all care homes, vital signs measurement)
    - Training and development of care home staff
    - Anticipatory care planning
    - Improving communication between care homes and health services and the quality of hospital discharge, including roll out of the trusted assessor role

6. Supporting unpaid carers.

The local authority, having completed a scrutiny enquiry focused on informal carers in the last year, have completed the process of drafting strategies for both 'Adults' and 'Children and Young People'. These strategies have informed a range of developments to improve carer identification, carer voice and carer support over the next three years. Some examples of these developments are included below.

New investment in a local charity to support the provision of short carers breaks, Communicare, funded through a development grant (under the BCF pooled fund arrangement). The delivery is through a 'good neighbours' network which aims to support carers to have a break for a short time, the functions include -

- Good neighbours support carers whose cared for have lower levels needs, not including personal care
- Carry out a survey of carers of people living with dementia to identify what the carers needs are and how best to support them
- Piloting and testing new approaches for the provision of carers breaks
- Develop a route to allow good neighbours to become more skilled and able to offer personal care for an individual they may have built up a rapport with whose needs have progressed. This route will be via the Shared Lives scheme and is being explored in year.

The council is also reviewing the residential carers breaks/respite provision to ensure that it continues to meet the requirements of the local population. This is a key part of the implementation of the carers strategies for 'Adults' and 'Children and Young People' and the far reaching development plan to improve carer identification, carer voice and carer support.

The carers support services, which have been in place for a number of years, are being reviewed in year with new services to be commissioned for a start date of April 2023. The breadth and depth of the new service will represent the direction stated by the strategies. Aligned with this work, we are exploring using libraries to develop easy to access carers information sites, three libraries have been identified to do this initially. The service is likely to comprise trained library staff, carers volunteers, carer services staff working together. Carers will be able to access information pods which enable video links and document sharing with a range of services which include Advice Southampton, Adult Social Care Connect, Housing etc.

7. Disabled Facilities Grant (DFG) and wider services

DFG

In 2020 Southampton City Council commissioned a comprehensive review into the delivery of its Disabled Facilities Grant Programme and the effectiveness of its Housing Assistance Policy to help deliver meaningful improvements for older and disabled residents of Southampton. Building on this, following the relaxation of covid restrictions, SCC committed to a wholescale internal review of these services to help ensure:

- Significant efficiencies made for Adult Social Care and Children's Social Care provision.
- Help meet BCF aims and objectives to assist older and disabled people to remain in their homes for longer, avoid hospital admissions, establish a new approach to discharge, reduce admissions into residential care, promote independence through personalised care, deliver a strength-based initiative to provide speedier better-quality adaptations, and better value for money across all disability services.

- Clarity between adaptation delivery and the ambitions of SCC's BCF key priorities to develop an integrated approach to housing and adaptations, as well as helping to achieve significant reductions in the waiting times for adaptations for older and disabled residents.

This review is now in its delivery stage, and will positively impact on SCC's overall adaptation delivery for older and disabled residents as well as the over-arching aims and objectives of the BCF:

In 2022-23, as part of SCC's action plan to develop a new strength based integrated housing adaptations service, we will:

- Introduce an in-house home improvement agency, the Home Adaptation Service (HAS) to improve strategic and practical delivery of adaptations in Southampton in the private housing sector, and create a new integrated service of Housing Occupational Therapists (ASC) and Housing Technical Surveyors
- Appoint a Disabled Facilities Grant/ HAS Manager to take responsibility for strategic direction, reporting and performance across all private and council adaptation services reporting directly to the BCB and senior management at SCC
- Make immediate changes to the current Housing Assistance Policy and introduce a Fast-Track Grant up to £10k and a further grant assistance of £1k to the Joint Equipment Store (JES) on top of the £1k currently available for older and disabled applicants for disability equipment. This will assist in reducing demand from a Mandatory DFG, speed up the delivery of straight forward adaptations and help reduce waiting times
- Introduce a new Discretionary Housing Assistance Policy to broaden the assistance available for older and disabled applicants and help reduce reduce waiting times for DFG's
- Recruit additional caseworker support to assist older and disabled residents through their adaptation pathway and help reduce DFG / Assistance waiting times

- Introduce a new IT Platform to improve joint reporting and business analysis
- Introduce new business processes in grant pathways to speed up overall delivery of adaptations for older and disabled residents, reduce paperwork, hand-offs and reduce the underspend of the DFG budget
- Broaden the joint working and support for initiatives such as the Hoarder Scheme, the Wheelchair Service and improved technology options for older and disabled residents, amongst others

The improvements planned this year will create a more effective and accessible provision of the DFG, doing so through internal and external partnership approaches.

Health, social care and Housing services

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 last year these services were recommissioned to reflect the changing needs identified by a comprehensive review which was undertaken in the previous year. A range of improvements will be included in the services 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. Early implementation against these improvements underway with the HRS service critical to their success through acting as a bridge with other key support services for the residents.

The older persons HRS (55yrs+) has also been reviewed in light of the strong focus on developing extra care facilities in the city. Indeed, last year saw the opening of an additional state of the art extra care facility for the city, which in turn benefits from the support of this service in partnership with adult social care and private sector dedicated home care provision. This year work will continue, through this service, SCC Housing, Commissioning and Adult Social care to further develop the extra care model for the city. Commissioning will add to this by procuring a framework for housing with care to promote a similar type of support, which together with housing providers, will enable people to stay in the community/their own home for longer.

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 these areas, with a focus on the 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 aspects 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 ICB, e.g. housing services for Council Tenants, Employment Support Teams and Healthy Homes/fuel poverty.

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. Each of these will be considered in turn.

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%. Learning Disability commissioning and integration has long been a part of Southampton's BCF, Active Lives is one of the 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'. This is a long term piece of work which got underway in 2021/2022 and will continue through 2022/2023.

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.

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. As noted in discharge section this group has been a strong focus in much of the hospital discharge work. 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.

The hospital discharge narrative 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 through our work with the community and voluntary sector. The commissioning and development of Social Prescribing functions (above that stated as a requirement within the Primary Care Network Additional Roles scheme) through our SO:Linked service and wider Housing Related Support service are enabling targeted prevention and early intervention work with our older population. In 2022/2023 this will continue to develop to include digital skills and engagement, use of green spaces and general access to community assets. In addition the commissioning team will undertake a full review of this provision to inform the future planning for prevention and early intervention more generally for the city. By supporting people to remain independent for longer this, along with our rehab and reablement service are 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.

Linked with this our key aging well priority for 2022/2023 is a proactive care approach delivered through ongoing development of integrated care/One Team approach, working in partnership with the community and voluntary sector, all with the foundation of implementing a Population Health Management approach. This priority seeks to work with our most vulnerable population, in particular older people, to ensure that proactive or anticipatory care planning is part of a standard offer in the city.

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 two years.

People living with a disability and/or multiple long-term conditions will also benefit from the community work noted in the older persons paragraph above. There is also a strong focus on supporting life planning and anticipatory care planning in our Community Wellbeing Team and 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, to stay well and independent for as long as possible.

People living with mental illness – there is clear evidence to suggest that the pandemic has had an exacerbating effect on existing conditions such anxiety and depression and create “new” mental health needs.

As such people living with mental illness are benefiting from a mental health investment across the ICB in this year, including the ‘no wrong door’ programme. 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. Significant improvements are being seen in the levels of vaccination and health checks for these populations.

The city has significant investment in recovery approaches and rehabilitation for this client group. This year a full review of the rehabilitation offer is underway at an ICS level as well as locally. The latter will include consideration of the housing provision which can more fully enable recovery for this client group. This approach is clear evidence of how working in a within an integrated commissioning setting better meets the needs our most vulnerable clients groups.

People with health and care needs from population groups other than white British – specific engagement with and approaches targeted at non-white British population are in place for a wide range of services. It is particularly evident in many of our prevention and early intervention services, for example our community solutions service (community development and navigation) which works with representative groups, including faith groups, to increase accessibility and promote appropriate service provision. Our Community Wellbeing Team, the service which promotes proactive care in the city, have a similar approach. This service works with referrers to actively seek patients who are non-white British and require a proactive care approach. This service also promotes proactive work with three of the five

focus areas included as part of the core20plus5[3] improvement approach: Severe mental Illness (promoting access to annual health checks and vaccination); Chronic Respiratory Disease (driving the update of all vaccinations in the frailest and most vulnerable members of our population); and Hypertension case finding (through health screening for all patients referred to the service for a proactive approach). As we proceed into the second half of this year the ICS will identify the population group experiencing poorer health outcomes, in keeping with the 'PLUS' element of the improvement approach, the Community Wellbeing Team, along with other services, will be engaged to wrapping care planning and proactive provision around the patients identified.

[3] NHS England » Core20PLUS5 – An approach to reducing health inequalities