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Democratic Support
Plymouth City Council
Civic Centre
Plymouth PL1 2AA

Please ask for Amelia Boulter
T 01752 304570
E amelia.boulter@plymouth.gov.uk
www.plymouth.gov.uk/democracy
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#plymreview

TO FOLLOW SUPPLEMENT

SCRUTINY - COOPERATIVE SCRUTINY REVIEWS

FAIRER CHARGING, INTEGRATED COMMISSIONING AND INTEGRATED COMMUNITY HEALTH AND SOCIAL CARE DELIVERY

Wednesday 2 July and Thursday 3 July 2014
10 am
Warspite Room, Council House

Members:
Councillor Aspinall, Chair
Councillor James, Vice Chair
Councillors Bridgeman, Dr.Mahony, Mrs Nicholson and Parker.

Members are invited to attend the above meeting to consider the items of business overleaf.

PLEASE FIND ATTACHED REPORT FOR CONSIDERATION UNDER AGENDA ITEM 4b, 4c and 4d.

Tracey Lee
Chief Executive

SCRUTINY - COOPERATIVE SCRUTINY REVIEWS

PLYMOUTH CITY COUNCIL

Subject:	Fairer Charging for Non – Residential Services
Committee:	Cabinet
Date:	15 July 2014
Cabinet Member:	Councillor Tuffin
CMT Member:	Carole Burgoyne (Strategic Director for People)
Author:	Dave Simpkins, (Assistant Director of Co-operative Commissioning and Adult Social Care)
Contact:	Tel: 01752 304407 Email: dave.simpkins@plymouth.gov.uk
Ref:	FC/2014
Key Decision:	Yes
Part:	I

Purpose of the report:

This report sets out Plymouth City Councils proposed revised Fairer Charging Policy for non-residential services.

It sets out the legal framework for charging in relation to non- residential services and the rationale for changing the existing policy.

This proposed policy will bring Plymouth into line with comparator and neighbouring authorities. It aligns Fairer Charging to the City Council's Fees, Charges and Concessions Policy. It also aligns to the guidance and regulations of the new Care Act 2014. Implementation of the policy will raise additional revenue which in turn will protect front line service delivery.

The report also details the consultation process undertaken in developing this policy and how the policy will meet individual circumstances and needs.

The Brilliant Co-operative Council Corporate Plan 2013/14 -2016/17:

The proposed policy aligns to the Plymouth City Council Corporate Plan objective of creating a Fairer Plymouth where everyone does their bit. It also aligns to the Fees, Charges and Concessions Policy agreed by Cabinet in November 2013. This sets down a consistent and fair approach to fees and charges, in order to deliver the Council's overall objectives whilst protecting, wherever possible, the most vulnerable citizens of Plymouth.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:

Additional resources would be required in Client Financial Services to expedite the re-assessment process required for existing service users. It has been estimated that the cost of additional assessment and visiting officers would be in the region of £40,000.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

Due to the population profile of affected service users no specific Child Poverty, Community Safety or Health and Safety Issues have been identified.

To effect the changes of the new proposed policy, a full reassessment of our existing client base, estimated at 2800 service users will be required. If the proposed policy is approved it will be implemented with immediate effect for all new service users. The re-assessment of existing service users will take a minimum of 8 weeks and the policy would be implemented for existing clients immediately upon completion of that process.

Additional resources would be required in Client Financial Services to expedite the re-assessment process and capture additional income during 2014/15. It has been estimated that the cost of additional assessment and visiting officers would be in the region of £40,000.

A review of the Client Financial Services Team will be needed to ensure that there is capacity to conduct annual reviews and ensure that charges reflect any changes in service users' financial situations.

Equality and Diversity:

Has an Equality Impact Assessment been undertaken? Yes (please refer to the background papers)

When considering this proposal it is important to have due regard to the public sector equalities duties imposed upon the Council by section 149 Equalities Act 2010 to

- Eliminate unlawful discrimination, harassment and victimisation and
- Advance equality of opportunity between people who share a protected characteristic from those who do not and to
- Foster good relations between people who share protected characteristics and others

The relevant protected characteristics for this purpose are: (a) age; (b) disability; (c) gender reassignment; (d) pregnancy and maternity; (e) race; (f) religion or belief; (g) sex; (h) sexual orientation . . . ."

Compliance with the duties in this section may involve treating some persons more favourably than others.

Detailed equality impact assessments have been carried out and updated through this process and are supplied for you to consider. You are asked to note the adverse impact on some protected groups and the actions proposed to address them. You are then asked to balance any residual impact against the need to implement the proposed changes for the reasons set out in this report.

Recommendations and Reasons for recommended action:

To agree the proposed fairer charging policy as submitted which takes into account 70% of Disability Living Allowance, Attendance Allowance and Severe Disability Allowance as income, with the remaining 30% being disregarded to cover additional disability related expenditure. The proposal includes the ability for individuals to request an assessment and provide evidence of their disability related expenditure if they consider that their expenditure is greater than the equivalent of the 30% disregard.

Reasons for Recommendations

These disability related allowances are provided by the Government to pay for the costs of an individual's identified care and support needs. Currently in disregarding these allowances, the local authority is in effect paying again for such care related costs. This is therefore not fair or reasonable.

This will result in more service users having to make a contribution towards their package of care, whilst leaving sufficient funds to meet their expenses. This is consistent with other council policies such as the requirement for everyone (of working age) to contribute something towards their Council Tax and all organisations having to pay something towards their business rates.

Veterans will be afforded protection within the Policy.

The current system of charging is not consistent between service users as it does not take account of all income available to all service users and therefore is not equitable.

The policy will ensure that charging will be based on the ability to pay, and meet the legal framework for such policies.

The policy will bring Plymouth into line with the requirements set out in the new Care Act regulations and guidance.

Alternative options considered and rejected:

An option of keeping the present system has been considered however this has been rejected due to: the inequity of the current policy, the financial situation facing the Local Authority and our agreed policy on Fees and Charges. Without a revised Fairer Charging Policy the Local Authority would be required to make significant additional savings which may have the effect of reducing frontline service delivery.

Published work / information:

None

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
DH Guidance	X								
Equality Impact Assessment	X								
Full Consultation Document	X								

Sign off:

Fin	PeopleFAC1415001	Leg	LT18324	Mon Off	DVS20428.	HR	HR-CS25.6.14.	Assets		IT		Strat Proc	
Originating SMT Member: Dave Simpkins													
Has the Cabinet Member(s) agreed the content of the report? Yes / No													

1. Background and Context

1.1 Charging for non-residential services is discretionary. There is no statutorily defined procedure for assessing non-residential charges. The power to charge derives from Section 17 Health and Social Services and Social Security Adjudications Act 1983 (HASSASSAA) which empowers the local authority to recover such charge (if any) for a service as they consider reasonable.

1.2 Charging under Section 17 HASSASSAA is subject to means testing. Where a person is able to satisfy the local authority that their means are insufficient for it to be reasonably practicable for them to pay the full amount for the service, the local authority shall not require them to pay more than it appears to them that it is reasonably practicable for them to pay.

1.3 Like most local authorities, Plymouth City Council is reliant on the income raised from charging for such services to fund a proportion of the costs. Without this income, service levels would be significantly reduced. Central government assumes that councils will partly fund services from client charges when allocating funding each year.

2. Current Situation

2.1 Prior to 2011 Plymouth City Council took into account the income a person received from their Disability Living Allowance, excluding the mobility element, Attendance Allowance and Severe Disability Benefit. Disability related expenditure was also assessed and taken into account when calculating a person's contribution to their care.

2.2 Following the introduction of Personal Budgets a decision was taken to discount these three income sources when assessing how much a person could contribute towards their personal budget. This change of policy was to simplify the very complicated system of assessment and was also based on an optimistic view that that people would use their disability allowances to buy their care and support on the open market. In reality people continued to seek assessment and the provision of support services from the local authority.

2.3 As a consequence of the Council disregarding disability allowances, people are actually better off coming to the Council for their care services. There is as a result less money available to spend on meeting the care needs of the general population of Plymouth.

3. Comparison to other Local Authorities

3.1 The CIPFA Financial Assessments Benchmarking Club 2012, consisting of 28 members, has identified that Plymouth City Council has the highest number of service users paying no contribution towards the cost of care at 87%, the average being 46 %.

3.2 This benchmarking evidenced that Plymouth is in the minority that totally disregards disability allowances. When we contacted the other 27 councils we were informed that they all included Disability Related Allowances as income and made an allowance for additional Disability Related Expenditure (DRE).

3.3 Devon County Council, Cornwall Council and Torbay Council all take 100% of Disability Related Allowances into account as income. Devon applies a flat rate allowance of £30 for DRE although service users have a choice to agree to this or provide evidence of all outgoings and expenses claimed. Cornwall and Torbay undertake a full assessment for DRE with the average DRE for Torbay being £18 per week.

3.4 Plymouth nationally is in the extreme minority who do not take Disability Related Allowances into account as income. We were able to make contact with 124 of the 130 English local authorities. 123 of the 124 take Disability Related Allowances into account as income.

3.5 Disregarding a % of Disability Related Allowances rather than applying a flat rate, is fairer as it will correspond to the level of need. For example those with higher needs will receive a higher level of benefit and the disregard will equally be greater.

3.6 An example of the impact is shown in the table below which reflects the most common types of disability related income. The average for Plymouth equating to £26.97 per week.

Benefit	Rate	30%
AA low rate only	£54.45	£16.34
AA Low rate plus SDP	£115.55	£34.67
AA high rate only	£81.30	£24.39
AA high rate plus SDP	£142.40	£42.72
DLA low rate only	£21.55	£6.47
DLA mid rate only	£54.45	£16.34
DLA mid rate plus SDP	£115.55	£34.67
DLA high rate only	£81.30	£24.39
DLA high rate plus SDP	£142.40	£42.72

4. Proposed Fairer Charging Policy

4.1 The revised proposed policy (Appendix A) would take account of 70% of the core Disability Related Allowances as income (Disability Living Allowance, Attendance Allowance and the Severe Disability Allowance.) If a service user is in receipt of disability allowances, there is acceptance that there will be additional disability related expenditure and that they need to use some of this money towards this. The policy therefore automatically disregards a standard allowance of 30% of disability related allowances to cover these expenses. However an individually assessed allowance may be calculated in respect of those who feel their additional needs exceed the standard 30% disregard.

4.2 This proposed policy change would ensure that Government allowances paid to people to meet their care and support needs, is properly used to contribute to their assessed care and support package and that the local authority does not effectively have to pay for the costs of such services again. This is fair and in keeping with the new Fees, Charges and Concessions policy.

4.3 The policy meets the statutory guidelines as set out in "Fairer Charging Policies for Home Care and other non-residential Social Services: Guidance for Councils with Social Services Responsibilities", Department of Health 2003 and Non-Residential Social Services' and Fairer Contributions Guidance issued in November 2010 under section 7 of the Local Authority Social Services Act 1970.

4.4 The proposed policy will bring Plymouth into line with into line with the requirements set out in the new Care Act regulations and guidance.

4.5 Veterans would be afforded protection within the proposed new policy as the following will be disregarded:

Guaranteed income payment paid under Armed Forces Compensation Scheme (payable to veterans only)
War pensions mobility supplement
Full disregard of any War pension
War Widows Special Payments
An element of Armed Forces Independence Payment

4.6 A detailed list of benefits and allowances that will be disregarded under the new proposed policy is included in the table set out below.

Benefits Counted as Income	Benefits Disregarded as Income
State benefits (e.g. Retirement Pension, Pension Credit, Incapacity Benefit, ESA, Severe Disability Allowance, Income Support and/or Universal Credit, Disability Benefits including Attendance Allowance, Disability Living Allowance Care Component and/or Personal Independence Payment.) Occupational and private pensions or other regular income from investments Tariff income on savings above £14,250 (this assumes £1 for every £250 of capital, or part thereof, between the lower and upper capital limits as stated in CRAG) Any other income from other sources, e.g. rental from property, etc.	Earnings from employment Mobility Component of; Disability Living Allowance, Attendance Allowance Personal Independence Payment, War Pensioner's Mobility Supplement Full disregard of any War Pensions War Widows Special Payments Savings credit element of Pension Credit Night rate of Disability Living Allowance (Care Component) or Attendance Allowance Guaranteed Income Payment paid under Armed Forces Compensation Scheme (payable to veterans only) Child Tax Credit An element of Armed Forces Independence Payment Working Tax Credits Child Benefit

5. Consultation Process

5.1 In developing the revised policy a Consultation process ran from the beginning of January 2014 to the 6 April 2014, which was subsequently extended to 1 May 2014

5.2 The consultation process consisted of a number of elements -

- Letters and survey questionnaires were sent out to all service users receiving community based services and financial representatives. The information was produced in large print for the visually impaired and easy read format and contact telephone number given for queries. Over 1102 surveys have been returned of which 20 were completed on line leaving the bulk of surveys posted or handed to us and collated by staff at Windsor House.
- Information sent out to umbrella voluntary organisations and interest parties (Job Centre Plus, Plymouth CAB, Age UK Plymouth, SEAP, Plymouth Guild, PAGES Advocacy, Plymouth Highbury Trust, Plymouth Independent Living, The DOVE Project, Regard, Shared Lives SW, Colebrook SW/Healthwatch, Spectrum, Scope, Hanover, Pocklington Trust, A4E)
- Consultation documents were published on the Council's consultation portal. These included the Fairer Charging Guide, with hard copies provided to those who requested and a set of "Frequently Asked Questions" was published.

- Letter sent to all service users, financial representatives and interested parties providing details of the four Drop-In consultation events.
- Three two hour Drop-In events were held across the City; Plymstock Library, The Highbury Trust and the Devonport Welcome Hall together with an all-day drop-in event at the Plymouth Guildhall. Around 200 service users and their carers attended these events with the majority finding the event helpful. Comment received on a completed survey "The people at the Guildhall consultation were very helpful and caring, and eased several of my concerns. Thank you."

6. Consultation Findings

6.1 There were a number of themes/issues that are emerging from the consultation-

Consultation Themes	Response
Why are we charging for services?	The level of charging for non-residential services is discretionary. We are proposing to include all disability related benefits in our financial assessments. We aim to bring ourselves in line with other authorities who operate their fairer charging policy in this way. Like most Local Authorities providing care, Plymouth City Council must charge for some services provided in order to meet part of the cost of running the service. If the Council didn't charge for services we wouldn't be able to offer such a wide range of services to meet individual's needs. Our comparators take account of 100% of the disability related benefits and then either apply a standard discount for disability related expenditure or request evidence of expenditure incurred by service users to calculate the exact discount
Is this Legal?	The power to charge derives from Section 17 Health and Social Services and Social Security Adjudications Act 1983 (HASSASSAA) which empowers the local authority to recover such charge (if any) for a service as they consider reasonable.
Affordability of services	A service user will only ever pay up to the maximum assessed charge for means tested services, which will take into account the ability to pay. The Council follows Government guidance to assess the maximum assessed charge which will ensure that service users are left with income support/pension credit guarantee level plus 25% after paying adult social care charges. The financial assessment also takes into account disability related expenses and basic housing costs.
Significant increase in charges for some service users	The level of potential increases for existing users is of concern but service users will only ever be required to pay that which they have been assessed as able to afford. The current system of charging is not consistent between service users as it does not take account of all income available to all service users and is therefore not equitable.
Level of disability	This is mitigated by the proposed policy including the ability for individuals

related expenses greater than the 30% proposed.	to request a full assessment of their disability related expenditure where they can evidence that this is greater than the proposed 30%. Feedback included comments where service users had been encouraged, when devising their support plan under the current operating model, to use their disability benefits to supplement or support their personal budget and have been using their DRB to pay for additional personal assistant or day care related expenses. The impact on taking these benefits into account could reduce the service user's ability to fund these elements of their support plan. Therefore the current personal budget operating model will be reviewed to ensure that we were not asking service users to in effect use their DRB to pay twice for services or compromise the ability to collect the required level of income.
What if I cannot afford my usual care/expenses because of this change?	Service users will have the opportunity to discuss certain costs and expenses they have, that they may use their DRB to pay for. The sustainability of services is acknowledged and Government guidance states that the effect of service users refusing or withdrawing from services because of charge should be monitored.
Unfairness towards savers.	Those service users who have savings over £23,250 are deemed able to pay the full cost of services. The "capital threshold" is consistent with the Government's guidance for the charging of residential and nursing care and it is not appropriate to have a different level for those receiving non-residential services. The value of property is not taken into account when assessing the contribution for non-residential services.
Impact on Carers.	The impact on carers is a theme which is linked to the affordability of services and the potential for service users to withdraw from existing services or carers to withdraw from providing support. This will be mitigated by the fact that service users will only be charged their maximum charge as contained in their financial assessment.
How/when will these changes be implemented?	The revised policy cannot be applied until it has had agreement by Cabinet. If agreed the proposal is that the revised policy will be applied to new service users straight away with no change to existing service users' contributions until all have been reassessed. It is proposed that any change in the contribution will then be applied on the same date following completion of all re-assessments.

7. Impact on Service Users

7.1 The policy will have a less favourable impact on older people and people with a disability, the higher proportion of which will be female but the nature of the users demographic of social care is such that this is to be expected.

7.2 The demographic spread of Adult social care community based services users is broadly consistent across all post codes and areas of the City.

7.3 As requested by the Portfolio Holder we undertook to review a controlled sample of 100 service users across the various service types. This sample is reflective of the demographic spread of service users across the City. We were able to examine the impact of the proposed policy change for 95 services users as follows:

49 of the 95 people currently make no contribution and the impact for them is:

Remaining on a nil contribution	13 out of 49
Increase from nil	36 out of 49 Av. £33.80 per week

46 of the 95 people who do currently make a contribution will have the following impact:

Current contribution same	10 out of 46
Current contribution decreased	2 out of 46
Current contribution increased	34 out of 46 Av. £17.68 per week

It should be noted that it is difficult to be more precise in this report about service user impact as the outcome of assessments will be highly variable dependent on an individual person's circumstances and needs, their income and expenses.

7.4 As a result of the extended period of consultation we also carried out an in depth review of six cases looking at the assessment of need, the support plan and the financial details relating to income and the client contribution under our proposed charging policy. As a consequence:

- We have amended our operational practices and proposed policy to ensure equity of service provision, for example, where a service user lives at home supported by family members compared to a service user living independently supported by paid carers.
- We will ensure that we apply the Department of Health's guidance for Councils on Fairer Charging that states if the council purchases no element of night care, the night care element of the AA, DLA, CAA or ESDA should not be taken into account as income in the assessment.
- We will ensure that we help service users to maximise their entitlement to benefits and allowances that will support their disability.
- Where people are already using their disability allowances to fund a portion of their agreed care and support needs, we will make an adjustment to their charges to reflect this.

7.5 In order to ensure that the proposed new arrangements are being applied in accordance with the policy and in a fair and equitable way for service users, we will undertake to conduct a detailed audit of the process six months after implementation.

8. Equality Considerations

8.1 This policy aims to be fair and implementation should not lead to anyone being unfairly disadvantaged. If a customer feels that this policy does not treat them fairly, they can ask for a review of their assessment. Plymouth City Council aims to ensure equality of treatment and access to services for all.

8.2 No person or groups of persons applying for services from the council will be treated any less favourably than any other person on the grounds of age, gender, sexual orientation, race and nationality, nature of disability, marital status, religion or belief. Information about council services will be accessible and, where necessary, targeted to those who may otherwise have trouble accessing information or services

9. Implementation

9.1 Once the policy is agreed all new service users will be charged under the new policy. This will involve signposting to maximise benefits. Existing service users will all be reassessed over an 8 week period and the policy will then be implemented on completion.

Appendices

- Appendix A – Fairer Charging Policy

Draft Fairer Charging Policy V3.doc

- Appendix B – Consultation Feedback

Consultation feedback

Fairer Charging Policy

PLYMOUTH
CITY COUNCIL

Contents

1 Introduction

Adult Social Care has gone through a period of significant change and the on-going budget pressures on the service are very significant. Currently, Plymouth City Council does not take account of disability related benefits in respect of a client's income. With this in mind, Plymouth City Council has reviewed its Fairer Charging Policy and will now take into account 70% of disability related benefits as income with the remaining 30% being disregarded to cover disability related expenditure. This policy has been written following a period of consultation on proposals which were given final approval by full council on 30th June 2014.

The introduction of the Care Act in May 2014 will have an impact on the fairer charging policy and will need to reflect the cap of costs that people will have to pay for care in their lifetime. The care bill is due to take effect from April 2015 and therefore this policy will need to be reviewed during 2015/16.

1.1 Legislative context

Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 (HASSASSA Act 1983) gives local authorities a discretionary power to charge adult recipients of non-residential and some respite services such amounts as they consider reasonable.

Like most local authorities, Plymouth City Council is reliant on the income raised from charging for such services to fund a proportion of the costs. Without this income, service levels would be significantly reduced. Central government assumes that councils will partly fund services from client charges when allocating funding each year. Plymouth City Council has developed this charging policy on the basis of equity, need and a duty to provide care.

The policy meets the statutory guidelines as set out in "Fairer Charging Policies for Home Care and other non-residential Social Services: Guidance for Councils with Social Services Responsibilities", Department of Health 2003 and Non-Residential Social Services' and Fairer Contributions Guidance issued in November 2010 under section 7 of the Local Authority Social Services Act 1970.

1.2 Equality statement

This policy aims to be fair and implementation should not lead to anyone being unfairly disadvantaged. If a customer feels that this policy does not treat them fairly, they can ask for a review of their assessment. Plymouth City Council aims to ensure equality of treatment and access to services for all.

No person or groups of persons applying for services from the council will be treated any less favourably than any other person on the grounds of age, gender, sexual orientation, race and nationality, nature of disability, marital status, religion or belief. Information about council services will be accessible and, where necessary, targeted to those who may otherwise have trouble accessing information or services

2 Charges for Services

2.1 Services for which a charge may be made

- Home care
- Day care and day opportunities/activities
- Bath in day care settings
- Individual assistance
- Personal Budgets (for those buying their own care)
- Extra care
- Supported living
- Respite

This list is not exhaustive.

2.2 Carers

Carers, providing regular and substantial care as determined by the Carers (Recognition and Services) Act 1995, will not be financially assessed and charged for any services provided directly to them.

However, services delivered to the cared-for person which benefit the carer by allowing them to take a break from caring will be subject to a charge. For example the regular respite scheme. This charge will depend on the financial circumstances of the cared-for person.

3 Financial Assessments

A financial assessment will be offered to everyone receiving non-residential community care service, initial respite stays or multiple services.

3.1 Non-disclosure

If a person receiving a chargeable service does not wish to have a financial assessment or either refuses or chooses not to disclose their financial circumstances, then they will be required to pay the full cost of the service provided to them.

3.2 The Financial Assessment Process

The financial assessment process is an assessment of financial means. This will be in addition to an assessment of need made under the NHS and Community Care Act 1990. A charge will be made based upon information provided by the customer on a Financial Assessment form and assessed in accordance with Fairer Charging & Fairer Contributions Guidance. Evidence to support the financial assessment will be required and this will be explained at the time the form is completed. Failure to supply information may result in full costs being charged.

The assessment process looks at the service user's ability to pay a charge. Financial information of the service user will be needed and this can include details about shared property/income for example in the case of married or unmarried couples. This may require us to ask the partner to tell us about their financial situation. In the case of married or unmarried couples we ensure that the service user is not required to pay additional

charges as a result of being part of a couple and include additional calculations as part of the assessment. . We call this a 'better off' calculation.

3.3 Key Elements

The financial assessment is broken down into four key elements:

- Income and capital, including some property
- Property, this relates to property that is owned by the service user but is not lived in by them.
- Allowable expenditure and disregards
- Disposable income
- Charge calculation

3.4 Income and Capital

3.4.1 Capital limit

The financial assessment will apply the capital limits determined each year by the Secretary of State and set out in the "Charging for Residential Accommodation Guide" (CRAG) issued by the Department of Health (DH). These are currently set with the lower limit of £14,250 and upper limit of £23,250, £43 as of April 2014. These are subject to annual review each April by the Department of Health.

If the total sum of the customer's capital is equal to or more than £23,250 in savings, investments and property they will be required to pay the full cost of any service they receive.

If a customer has less than £23,250 in savings, investments and property, the Financial Assessment Team has to make sure the service user has enough money to cover all of the following before they will have to pay towards the cost of their services –

An amount that is equal to Income Support or Pension Credit Guarantee (this is a weekly amount of money the Government sets as the lowest level of income that everyone should have to live on) plus 25%

Enough income to pay housing costs. This includes rent (after housing benefit), mortgage payments and Council Tax (after any Council Tax Reduction). This does not include money to pay any arrears of housing costs.

Enough income to cover any costs relating to their disability.

As part of the assessment the Financial Assessment officer may ask about service user's expenditure if the capital levels have dropped below £23,500, in what could be classed as an unreasonable period of time. Income, capital or property must not be transferred or given away intending to avoid paying the costs of care, or to claim additional welfare. If a service user is considered to have transferred money in this way this could be classed as deprivation of capital and the assessment would be made based on the level of capital if reasonable expenditure had been made. This would be discussed with the service user at the time of the assessment.

3.4.2 What counts as capital?

Plymouth City Council will take account of government guidelines regarding what can be considered as capital as set out in CRAG. Capital includes, for example:

- Money in any bank/building society current and deposit account
- Post Office/National Savings and Premium Bonds, Income Bonds
- PEPs, TESSAs and ISAs
- Stocks, Shares and Unit Trusts
- Trust Funds – Some trust funds are disregarded
- Any other cash savings
- Capital held on the person's behalf by another party, Court of Protection, spouse/partner (where capital is held by one partner but the other has a beneficial interest).
- Property - This is any dwelling that is owned by the service user but not lived in by them. This can include houses, static caravans, chalets etc and includes property that may be lived in by another person

Note: the above list is not exhaustive and will be subject to an assessment of individual circumstances. This will be discussed as part of the assessment process.

3.4.3 What counts as income?

Plymouth City Council will take account of government guidelines regarding what can be considered as income as set out in CRAG and "Fairer Charging Policies for Home Care and other non-residential care services". Income includes, for example:

- State benefits (e.g. Retirement Pension, Pension Credit, Incapacity Benefit, ESA, Severed Disability Allowance, Income Support and/or Universal Credit, Disability Benefits including Attendance Allowance, Disability Living Allowance Care Component and/or Personal Independence Payment.
- Occupational and private pensions or other regular income from investments
- Tariff income on savings above £14,250 (this assumes £1 for every £250 of capital, or part thereof, between the lower and upper capital limits as stated in CRAG)
- Any other income from other sources, e.g. rental from property, etc.

3.4.4 The following income will be disregarded, in line with Department of Health Guidance

- Earnings from employment
- Mobility Component of; Disability Living Allowance, Attendance Allowance Personal Independence Payment, War Pensioner's Mobility Supplement
- The first £10 of any War Pensions
- War Widows Special Payments
- Savings credit element of Pension Credit
- Night rate of Disability Living Allowance (Care Component) or Attendance Allowance
- Guaranteed Income Payment paid under Armed Forces Compensation Scheme (payable to veterans only)

- Child Tax Credit
- An element of Armed Forces Independence Payment
- Working Tax Credits
- Child Benefit

3.5 Allowable Expenditure and Disregards

Allowable expenditure is money that is not taken into account when assessing how much income individuals have available that can be used to pay charges. There are two main types of allowable expenditure:

- Protected income (personal allowance + 25%)
- Housing costs - see Point 3.5.3

3.5.1 Protected income (Personal Allowance)

Customers will not be charged against any income that they have up to their basic level of Income Support, or Guarantee Pension Credit, plus 25%.

It is expected that protected income will cover costs such as:

- Food
- Clothing
- Utility bills such as gas, electricity, telephone.
- TV licence
- Repair and replacement of household items
- Repair and maintenance of buildings
- Gardening
- Pets
- Other expenditure, such as personal debts

3.5.2 Disability Related Expenditure

Disability related expenses are those expenses not already covered by a Personal Budget or support plan which occur as a result of disability and which the service user has little or no choice but to incur in order to maintain independence of life.

If a service user is in receipt of disability benefits, there is an expectation that there will be disability related expenditure they need to use some of this money towards. The financial assessment process allows service users to self-assess their disability related expenditure and the Council will automatically disregard a standard allowance of 30% of disability related benefits to cover these expenses. However an individually assessed allowance may be calculated in respect of those who feel their needs exceed the standard allowance. Additional allowances will be discussed by the Financial Assessment Officer. – See Point 3.11

Payments to family members are not normally treated as disability-related expenditure unless identified in the support plan for exceptional circumstances including cultural or religious reasons.

3.5.3 Housing Costs

Allowable housing costs, which will not include any arrears payments, follow;

- Rent payable, under a formal tenancy agreement (less any Housing Benefit received)
- Council Tax (less any Council Tax Reduction)
- Mortgage Payments (both interest only and interest and capital repayments)
- Ground Rent/Service charge (these generally apply to leasehold properties)
- Buildings & Contents insurance
- Water Rates
- Personal Alarm systems

The amount of housing costs that will be treated as allowable expenditure will be the total amount as prescribed above divided by the number of adults in the household.

3.6 Charge Calculation

In order to assess the amount payable towards a person's care and support, the following calculation is undertaken:

INCOME
Minus
PROTECTED INCOME/DISREGARDS/ALLOWANCES
Equals
DISPOSABLE INCOME

Total income (as outlined above) ***less*** protected income, 30% of disability related income and housing costs (all outlined above). The resulting figure is the net disposable income and is the amount that is considered as available for paying towards care and support.

The person will then be asked to pay either their disposable income or the true cost of their care and support, whichever is the **lower** amount.

For example, if a customer's disposable income is £30.00 per week and the service that is received costs £50.00 per week, the customer will pay £30.00 as this is the most that they can pay. However, if the service received costs £20.00 per week, the customer will pay this amount as this is less than their disposable income.

3.7 Benefit maximisation

Local Authorities are required to ensure that those who undergo a financial assessment are offered benefits advice and assistance in order to ensure the income of the assessed person and also their carer is maximised.

All assessed persons will be offered a benefits maximisation check and given assistance with claiming benefits irrespective of whether this has an impact on contributions or not. If claiming additional benefits will result in an increase of charge the assessed person will be

informed of the fact and, wherever possible, be given an indication of the amount of additional contribution.

3.8 Change of Circumstances

Customers are required to notify the council's Financial Assessment Team as soon as possible of any change in circumstance which they might reasonably be expected to know might affect their assessed charge for non-residential care services.

Changes to be notified include changes to personal details such as change of address as well as changes in financial situation, i.e. a change in their income, capital or expenditure.

3.9 Re-assessments

Contributions towards the cost of care and support services will be reviewed periodically to take into account increases in benefits, private pensions and the cost of living. This is known as a financial re-assessment and customers will be informed prior to any increase in contributions.

Service Users can request a re-assessment of their charge if their circumstances change, for example their capital falls below the capital limits as set by the Secretary of State. Request should be made to the Financial Assessment team

3.10 People who refuse to pay

The assessment of care needs is very different to the assessment of finance and contribution. A service may not be withdrawn because the customer refuses to pay the charge. However, failure to pay the assessed contribution is likely to result in the council pursuing the debt through the civil courts.

3.11 Appeals

When a customer indicates that they are dissatisfied with the outcome of the financial assessment and/or charge, they have the right to ask the council to review their assessment.

Section 17 (3) of the Health and Social Services and Social Security Adjudications Act 1983 (HASSASSA) give a person the right to ask the council for a review of the charge which has been assessed, if they consider that they cannot pay.

The statutory guidance states that "information for charge payers should make clear that they may either seek a review of their assessed charge or they may make a formal complaint if they are dissatisfied with any aspect of the assessment".

On receipt of a request for a review, a different financial assessment officer from the one who completed the work will review the original financial assessment and check that the assessment has been carried out fully in line this policy and the treatment is consistent with other customers. A new financial statement may need to be completed to ensure that all relevant details are considered at the initial assessment.

If a review reflects that the 30% Disability Related Expenditure Allowance is not sufficient to meet the essential needs of the service user then an higher rate will be allowed. If the review reflects a lesser allowance is needed the assessment will reflect the lower amount even if it is below the 30% allowance.

If the Financial Assessment Officer is unable to resolve the query to the satisfaction of the service user or representative, the service user will be informed of their right to appeal the decision via the council‘s complaints procedure.

3.12 Sharing information

As we work in partnership with the health service and other agencies to provide a package of services, we sometimes need to share personal information of service users with other organisations involved in their care.

If necessary, a form giving us permission to share personal information with other organisations will need to be completed. For you own protection or for the protection of other people, we may on rare occasions, share information without your permission. Under these circumstances we will explain why this has happened.

3.13 Protection of Public funds

Plymouth City Council prides itself on setting and maintaining high standards and a culture of openness, with core values of fairness trust and value. The Anti-fraud and corruption policy fully supports Plymouth City Council’s desire to maintain an honest authority free from fraud and corruption.

All allegations of financial abuse, financial irregularities or deception to gain access to public funds will be treated seriously, investigate with the appropriately action taken. We aim to protect public funds by ensuring we have a robust assessment process to ensure that those who need financial support will be able to access it.

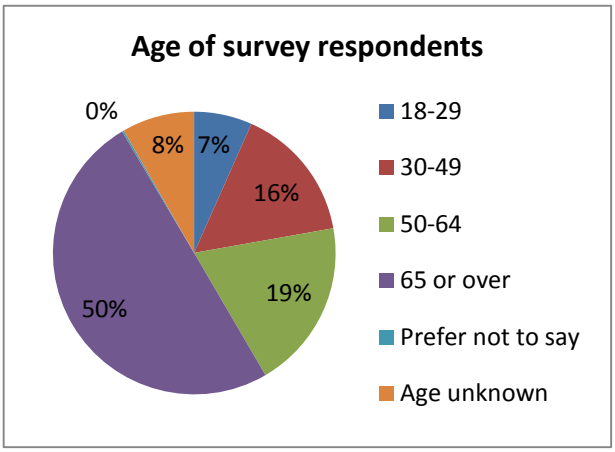
FAIRER CHARGING

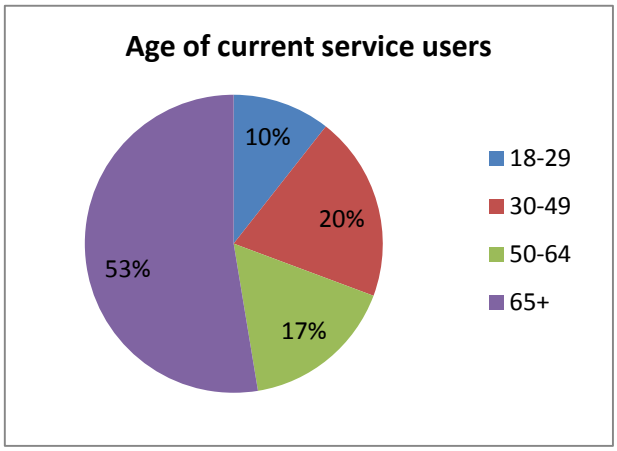
Survey responses

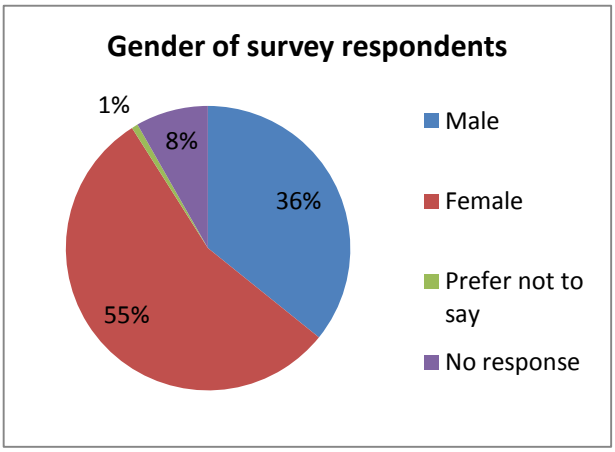
We sent out 3748 surveys and a total of 1103 (29.4%) were completed within the consultation period.

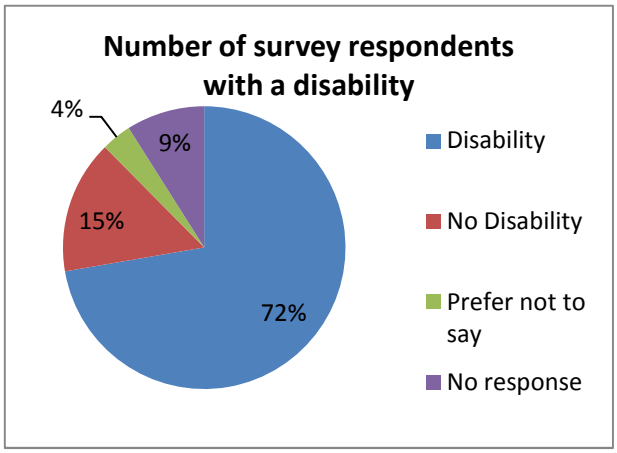
Of these 3748, 46 were completed online and 1056 were returned by post.

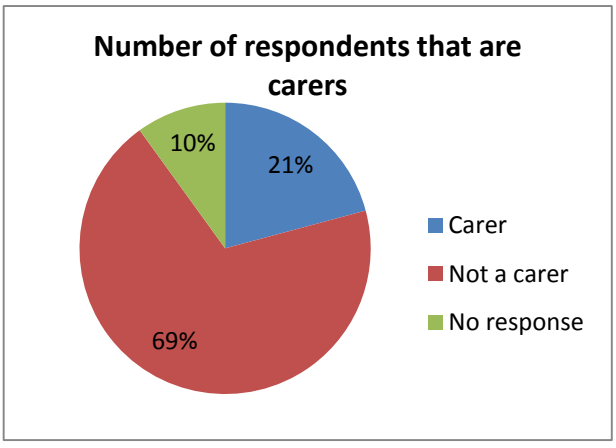
Demographics of clients that have responded;



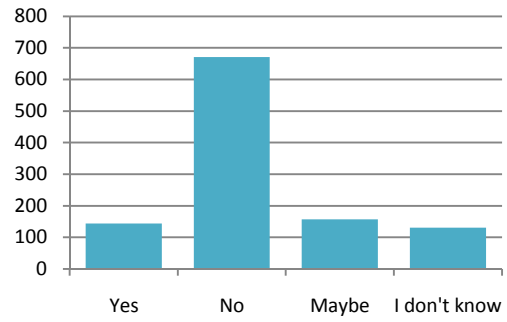




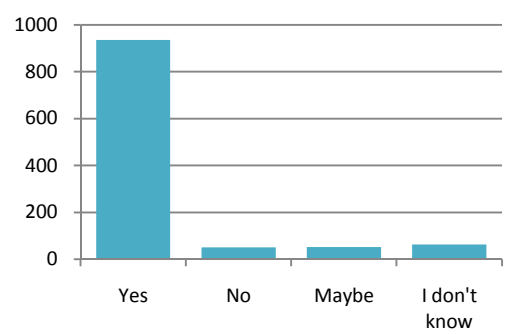




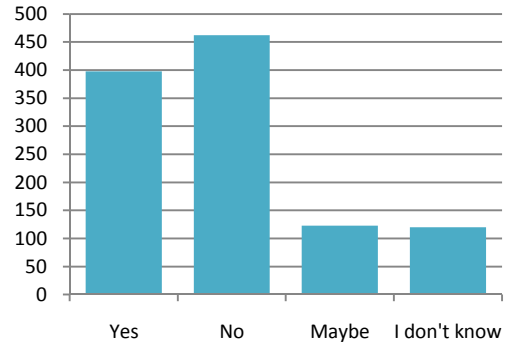
451 of the 1103 responses included written comments. These comments have been read, actioned where appropriate and key themes were summarised in the Frequently Asked Questions documents which was updated throughout the consultation period and made available on the webpage as well as at consultation events.

1. In future if you receive community based care you will have to pay for the full cost of your services if we think you can afford to. Do you agree?	Yes	No	Maybe	I don't know	

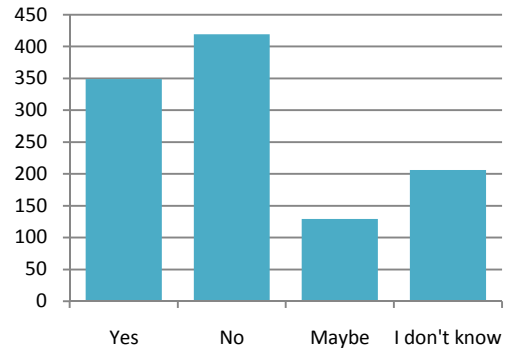
61% of people disagreed with this statement and 27% said yes or maybe.

2. We will financially support you if you are unable to pay the full cost for your community based care. Do you agree?	Yes	No	Maybe	I don't know	

85% of people agreed with this statement.

3. We will take into account all of your available income when assessing how much you can afford to contribute towards your community based care. Do you agree?	Yes	No	Maybe	I don't know	

42% of people disagreed with this statement and 47% of people said yes or maybe.

4. When we are deciding how much you can afford to pay, we will only include 70% of any disability related benefits you receive so that you can use the remainder to pay for any other disability related costs that you have. Do you agree?	Yes	No	Maybe	I don't know	

38% of people agreed with this statement and 44% of people said yes or maybe.

A cross section of the comments received;

What's the point of taking it off to put it back on? I exceed 30% and this would stop my weekly activities which mean I will stay in more and my depression would get worse. Disgusting. If I have to pay for my treatment (social/mental) health care I will cease to be looked after and I will not be able to afford my care and will only end up dead to my disorder or in a mental hospital which isn't cheap for the government. I would love to work but am unable, now you are putting my life in a corner. I have just been bought a cheap violin and through A4e lessons are paid for will this continue or will I have to pay £25-£30 a week. Due to disability need to use taxis which cost money. I think this is disgusting on already poor. Cost of living higher as stay in a lot. I have to have a landline due to my disabilities. This costs money but I could not afford just to have a mobile due to high level of supportive calls.
I am a year 81 year old lady. I am getting good help form the carers. But I can't afford to pay for them. They all are very good to me and very helpful so can you help me in any way I will be grateful for I can't not afford to pay for them
70% is too high because the services that you pay for are only a tiny proportion of the needs/care that is required - this will leave families who have to provide enormous amounts of free care in an even worse situation. Often carers have their earning potential destroyed by the need to care and therefore cannot make up any financial shortfall themselves.
This is going to happen if I agree to it or not.
I receive help in many ways to ensure I am looked after in a way that I can live in my own home. This help includes keeping my home clean my laundry done for me and my shopping done. Trips to doctors/hospital and ensuring my medication and prescriptions are delivered to my surgery. All this is done by my family and I cannot expect them to do this for nothing as petrol and running around cost and plus the facilities they use to look after me.
I don't agree that 70% of my disability benefits should be included! In fact they should not be included at all. My care package is there for me, to prevent a crisis and admission to hospital as a result! Which would cost far more than I am receiving in the package at present. What with other cuts to benefits and the introductions of 'universal credit', this will effect my independence and ability to see family and friends making me socially isolated and having a huge effect on my physical and mental health.
My mother is bedbound due to slow progressing M.S. Also she has lung cancer and early stages dementia. She has to take lots of medication daily. She is classed as severely disabled. We (me and mum) feel, as she did not ask for these illnesses, there are no cures, and therefore should not have to pay for carers, as if she could be rid of these, she would. For her it is compulsory to have help, not choice.
Whilst I agree disabled people have to pay something I strongly disagree with the 70%. I wouldn't mind paying something I think 40-50% would be acceptable. I hope this survey is not going to take too long as it will cause people like myself anxiety and even sleepless nights. I also hope we will not be backdated. It only comes into effect after the person has been assessed.
I agree with the principle that all should pay BUT it has to be fair. I use all my money on my care and transport issues while others use theirs for fags and beer. I do not expect to pay the same as them just because I do my best with such horrible illnesses.
I do not consider that 30% of my disability benefits would be enough to cover all my costs/expenses.
The fact that I am disabled is not a life choice. I have been awarded disability related benefits in recognition of the additional costs I incur being severely disabled, whether or not I need community based care too. There is nothing I would wish for more, than not to need the support of Plymouth City Council's Community Based Care to live and stay alive. For 70% of my disability benefits to be included when financially assessing how much I contribute toward community based care is I believe unfair.

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PLYMOUTH CITY COUNCIL

Subject:	Implementing The Care Act 2014
Committee:	Cabinet
Date:	15 July 2014
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Carole Burgoyne (Strategic Director for People)
Author:	Dave Simpkins (Assistant Director of Adult Social Care and Co-operative Commissioning)
Contact details	Tel: 01752 306820 email: Dave.Simpkins@plymouth.gov.uk
Ref:	IHWB/CA
Key Decision:	Yes
Part:	I

Purpose of the report:

The Care Act 2014 creates a single modern piece of law for adult care and support in England. It will update complex and out-dated legislation that has remained unchanged since 1948.

The reforms introduce significant new duties on Local Authorities and consequently will involve significant change to finances, processes and people.

The purpose of this report is to set out the main changes brought about by the legislation and the approach that Plymouth City Council is adopting to deliver the successful implementation.

The implementation of the Care Act is linked to the wider Integrated Health and Wellbeing Transformation Programme.

The Care Act ensures that people will have clearer information and advice to help them navigate the care system, and a more diverse, high quality range of support to choose from to meet their needs.

The Act places more emphasis than ever before on prevention – shifting from a system which manages crises to one which focuses on people's strengths and capabilities and supports them to live independently for as long as possible. Duties also include additional responsibility for assessment. This includes:

- Carers – the Act also included the need to supply services if the carer is eligible,
- All adult regardless of need/support or regardless of financial resources

The Act also places the Safeguarding Adult Boards on a statutory footing.

Funding reforms will introduce a national minimum eligibility threshold, a cap on care costs, the introduction of Independent Personal Budgets, the maintenance of Care Accounts and a universal Deferred Payment Scheme.

The Brilliant Co-operative Council Corporate Plan 2013/14 - 2016/17:

The propositions made in this report align to the Plymouth City Council Corporate Plan by working co-operatively to meet the objectives of creating a Caring and Pioneering Plymouth. It also aligns to the Health and Wellbeing Board's vision of achieving Integration by 2016, as decided in June 2013.

This project will support the Corporate Vision through:

- Being **pioneering** in developing and delivering quality, innovative brilliant services with our citizens and partners that make a real difference to the health and well- being of the residents of Plymouth through challenging economic times.
- **Growing** Plymouth through learning and community development creating opportunities for vulnerable people to develop, making us and them stronger and more confident as a result.
- Putting citizens at the heart of their communities and work with our partners to help us **care for Plymouth**. We will achieve this together by supporting communities, help them develop existing and new enterprises, redesign existing services which will in turn create new jobs, raise aspirations, improve health and educational outcomes and make the city a brilliant place to live, to work and create a future for all that reflects our guiding co-operative values.
- Raising aspirations, improving education, increasing economic growth and regeneration people will have increased **confidence in Plymouth**. With citizens, visitors and investors, identifying us as a "vibrant, confident, pioneering, brilliant place to live and work" with an outstanding quality of life.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

Transformation resources may be required during the project. These should be internal where possible and so will rely on staff being temporarily released from other areas of the organisation.

Requirement for Corporate Support (Legal, HR, Finance, etc.) will need to be managed due to the current high volume of requests for their support.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

The report strengthens our approach to both Child Poverty and Community Safety by focusing on early intervention and prevention and giving every child the best start to life. In line with our Co-operative commissioning principles the approach adopted aims to build both community and individual capacity. Children living in families affected by poverty will feel the benefit of improved family health and wellbeing which directly and indirectly affects economic stability and resilience.

No specific Health and Safety Issues have been identified.

The project will follow the Risk Management Strategy set out for Transformation Programmes and Projects by the Portfolio Office.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? Yes

When considering this proposal it is important to have due regard to the public sector equalities duties imposed upon the Council by section 149 Equalities Act 2010 to

- Eliminate unlawful discrimination, harassment and victimisation and
- Advance equality of opportunity between people who share a protected characteristic from those who do not and to
- Foster good relations between people who share protected characteristics and others

The relevant protected characteristics for this purpose are: (a) age; (b) disability; (c) gender reassignment; (d) pregnancy and maternity; (e) race; (f) religion or belief; (g) sex; (h) sexual orientation.

Compliance with the duties in this section may involve treating some persons more favourably than others.

A programme wide detailed equality impact assessment has been carried out and will continue to be updated through this process.

Recommendations and Reasons for recommended action:

The Care Act represents the most significant change to Adult Social Care legislation since 1948. As such it is recognised that a formal project approach needs to be adopted. Due to the close links to the Corporate Transformation Programme it is recommended that:

1. The implementation of the Care Act should be linked to the wider Integrated Health and Wellbeing Transformation Programme
2. The potential financial impact of the Care Act is recognised and resolve to receive regular update reports as details become clearer

Alternative options considered and rejected:

The Care Act 2014 is a modern piece of law effective from April 2015, and is therefore obligatory. The reforms introduce significant new duties on Local Authorities and consequently will involve significant change to finances, processes and people. The project approach that Plymouth City Council is adopting will ensure the successful implementation of this change.

Published work / information:

Transformation Programme, Report to Cabinet 25th March 2014, including the IHWB Outline Business Case.

http://www.plymouth.gov.uk/mgInternet/documents/s53610/transformation%20cabinet%20march%222014%20final%20MCv1%202.pdf

The Care Act 2014, Elizabeth II: Chapter 23, Royal Assent 14 May 2014.
http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off:

Fin		Leg		Mon Off		HR	HR-CS2 5.6.14.	Assets		IT		Strat Proc	
Originating SMT Member: Dave Simpkins (Assistant Director of Adult Social Care and Co-operative Commissioning)													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

Integrated Health and Wellbeing

Project Brief

Project Name:	**Implementing The Care Act 2014**		
Date:	23-06-2014	**Version:**	1.03
Author:	Craig Williams, Kate Jones		
Owner (SRO):	Carole Burgoyne		

Revision History			
Version	**Date**	**Summary of Changes**	**Changes Marked**
V1	14-05-2014	Initial Draft	KJ
V1.02	22-05-2014	General amendments	CGW /KJ / CMc
V1.03	23-06-2014	Amendments to format	AC/ JD/AM

Approvals				
Name	**Title**	**Signature**	**Date**	**Version**

This document has been distributed to:

Distribution			
Name	**Title**	**Date**	**Version**

Contents

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Introduction to the Plymouth City Council's Transformation Programme and NEW Devon CCG Transforming Community Services Strategy

Context:

2002-12: A Decade of Improvement

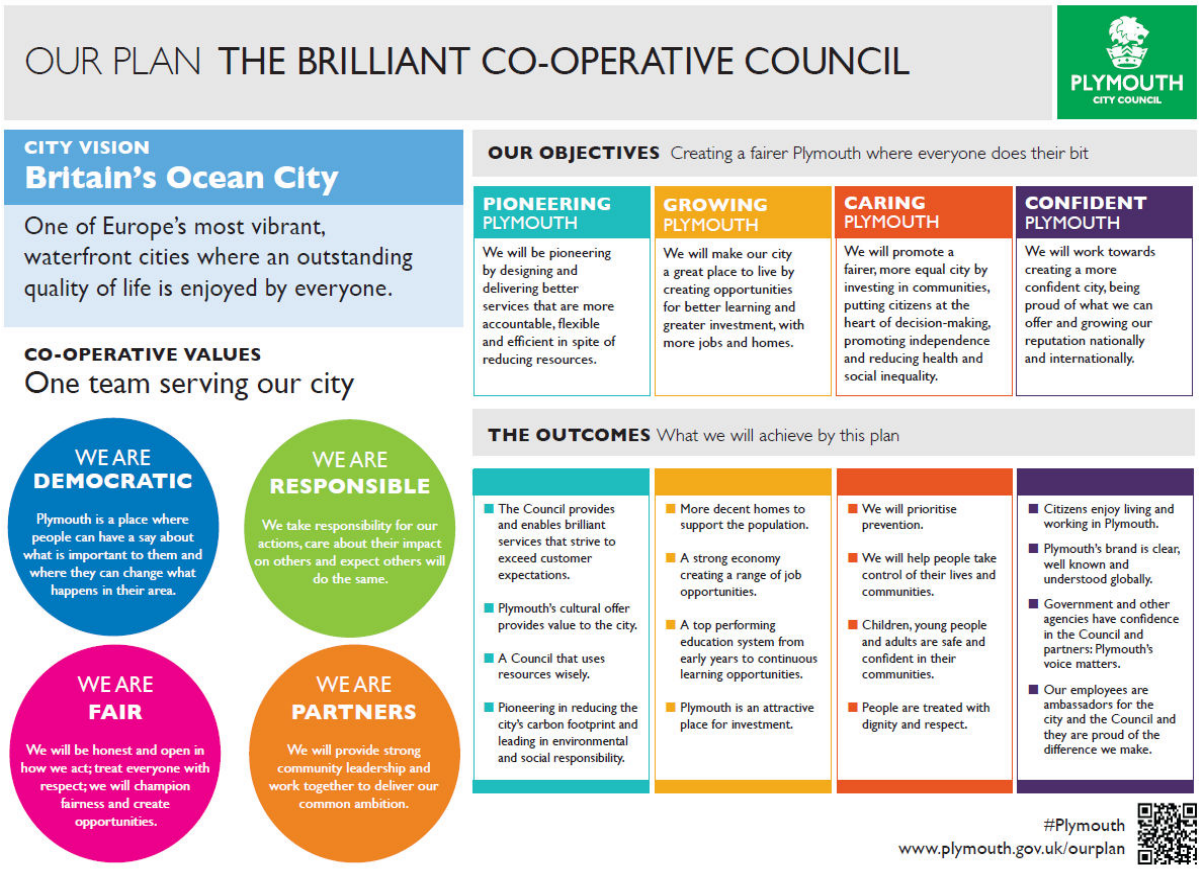
The City of Plymouth has had an extra-ordinary journey over the past ten years. A decade ago, it had a reputation as a city of low aspiration with a lack of vision, weak financial and strategic planning, poor relationships between agencies, and service delivery arrangements that did not meet the needs of all of its citizens. An acknowledgement of the determined and sometimes inspired effort that was then made to improve the city came in 2010 when the Council was voted 'Highest Achieving Council of the Year' by the Municipal Journal. Behind that accolade, foundations had been laid by successive political administrations of a clear, ambitious vision for the city, sound financial management arrangements, the development of strong strategic partnerships and a determined focus on the improvement of service delivery. The Council has acknowledged and embraced its role as a key player in influencing the broader city and regional agenda, driving economic growth and making coherent contributions to broader policy-making.

Drivers for Transformation:

The Brilliant Co-operative Council with less resources

On its adoption of a new Corporate Plan in July 2013, the council set the bar still higher, to become a Brilliant Co-operative Council. This 'Plan on a Page' commits the Council to achieving stretching objectives with measurable outcomes, and also sets out a Co-operative vision for the Council, creating a value-driven framework for the way that it will operate as well as the outcomes that it is committed to achieve.

The Corporate Plan was developed using the principles of a Co-operative Council. It is a short and focused document, but does not compromise on its evidence base, and was co-developed with the Cabinet of the Council, before being presented in person by members of the Corporate Management Team to every member of staff throughout the council at a series of 74 roadshows. The positive results of this commitment to strong communications and engagement were evidenced by 81% of council staff responding to the workplace survey conducted in October 2013 agreeing that they understand and support the values and objectives set out in the Corporate Plan.



The economic, demographic and policy environment affecting public services is accepted as the most challenging in a generation. At the same time as an aging population is placing increased demand on health and social care services, the UK is facing the longest, deepest and most sustained period of cuts to public services spending at least since World War II. The Council's Medium Term Financial plan identified in June 2013 funding cuts of £33million over the next three years which, when added to essential spend on service delivery amount to an estimated funding shortfall of circa £64.5million from 2014/15 to 2016/17, representing 30% of the Council's overall net revenue budget.

The Council has shown remarkable resilience in addressing reduced funding and increased demand in previous years, removing circa £30m of net revenue spend from 2011/12 to 2013/4 through proactive management and careful planning. However the Council has acknowledged that addressing further savings of the magnitude described above while delivering the ambitions of the Corporate Plan will require a radical change of approach.

Review of existing transformation programmes

The council commissioned Ernst and Young in June 2013 to:

- Examine the council's financial projections and provide expert external validation of our assumptions about costs and income in the medium term
- Review the council's existing transformation programmes and provide a view as to whether they will deliver against the Corporate Plan
- Provide advice as to how the council might achieve the maximum possible benefit through a revised approach to transformation

Ernst and Young validated the council's current Medium Term Financial Plan based on projections and assumptions jointly agreed, and judged it to be robust, taking into account the complex financial landscape and changing government policy.

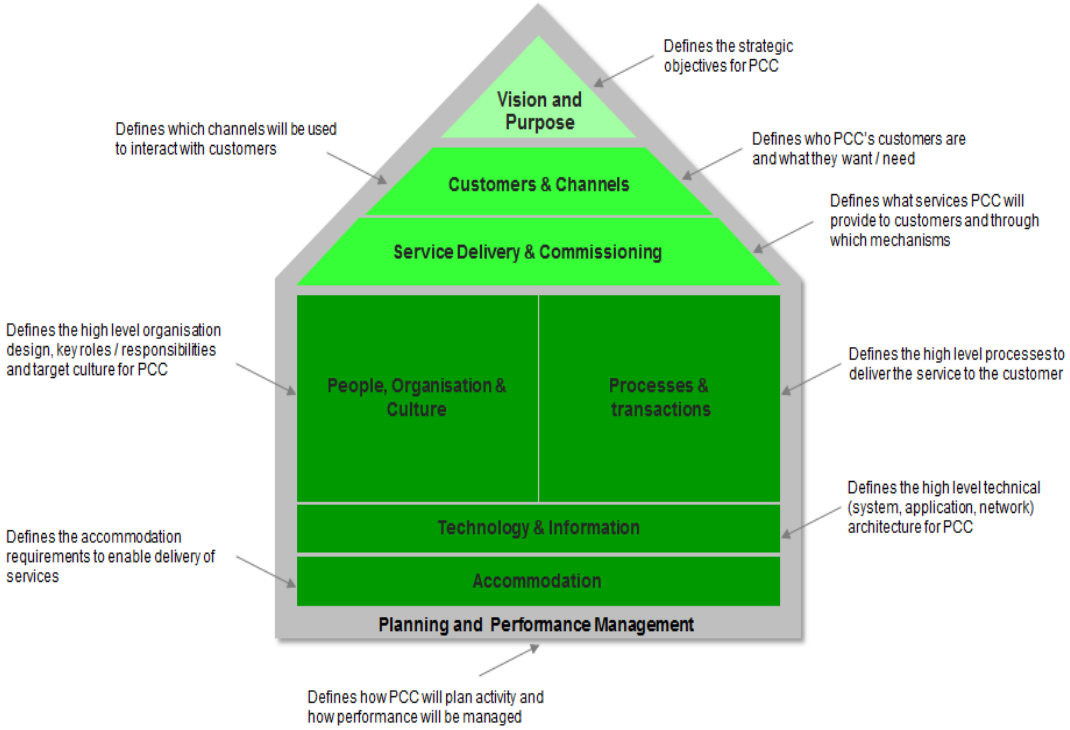
The council has initiated a number of far-reaching and ambitious change programmes over 2012-13 to address the twin aims of addressing financial constraints and improving service delivery. These include:

- Investment in Customer Transformation and Core ICT infrastructure (Cabinet approval September 2012)
- ICT Shared Services: DELT (Cabinet approval October 2013)
- Redevelopment of the Civic Centre and future accommodation requirements (Cabinet approval September 2013)
- Modernising Adult Social Care Provision (Cabinet approval January and August 2013)
- Co-location with Clinical Commissioning Group at Windsor House (Cabinet approval January 2013)

In addition to feedback and advice about individual programmes, the Council received advice that has been carefully considered, and which has informed the overall design of the Transformation Programme and the content of the business cases for the five programmes.

Vision and Direction: The Blueprint

The Council has responded to concerns that, despite strong support for the Corporate Plan from both officers and members, there was a lack of clarity about how the Corporate Plan translates into practical action and a danger that the council might be attempting to 'do the right things, but in the wrong way'. After significant consultation with Members and over 100 staff from all levels and disciplines within the organisation, the Council's vision for the Brilliant Co-operative Council has been translated into a Blueprint which describes the capabilities which the Council will need in the future. These capabilities will be commissioned by the council and will result in services being delivered by the Council and a variety of other organisations operating across the public, community and voluntary and private sectors. The components of the Blueprint are illustrated below:



To inform the development of the main components of the Blueprint, a number of principles have been developed co-operatively with Members, senior officers and staff to ensure that the values set out in the Corporate Plan guide how the Blueprint is developed.

There are 5 programmes to deliver the transformation.

Customer and Service Transformation: This programme will transform the way the council interacts with customers to meet their demands and preferences, and transform the services that the Council decides to retain in-house.

Co-operative Centre of Operations: Creating the business as usual strategic 'centre' for the Council, which uses the co-operative principles and intelligence to co-ordinate organisational decision making and activity.

Integrated Health and Well Being: The Council can engage with partners to deliver services at a lower cost, whilst also improving outcomes and customer satisfaction. The aim of the programme is to achieve "One system, one budget to deliver integrated, personal and sustainable care".

People and Organisational Development: The programme will enable the Council to define and deliver the required workforce and accommodation capability change.

The **Growth, Assets and Municipal Enterprise** programme has been developed to:

- Contribute to the growth of the City and the move towards a brilliant co-operative council.
- Generate and accelerate additional income for Plymouth City Council from economic and housing growth across the Council
- Create a brilliant co-operative street service which will :
    - Make operational changes to enhance service delivery
    - Provide evidence to design and deliver new service delivery models
    - Identify and deliver new opportunities for commercialism, new income streams
- Realise opportunities to bring in additional income from the commercialisation and increased trading of services.

1 BACKGROUND

The Care Act 2014 in England will create a single modern piece of law for adult care and support in England. It will update complex and out-dated legislation that has remained unchanged since 1948.
The Act will bring about many of the improvements to the care system described in the Government's white paper `Caring for Our Future: reforming care and support (July 2012):

- The Assessment Process
- Building Stronger Communities
- Better Information and Advice
- Keeping People Safe

The Act will provide better support for carers and also puts into legislation the changes recommended by the Dilnot Commission regarding the funding of care and support and takes forward elements of the government's initial response to the Francis Inquiry.
The Act is split into 3 parts.

1. Reform of care and support

The Act brings together existing care and support legislation into a new, modern set of laws and builds the system around people's wellbeing, needs and goals.
It sets out new rights for carers, emphasises the importance of preventing and reducing care and support needs, and introduces a national eligibility threshold for care and support.
It introduces a cap on the costs that people will have to pay for care and sets out a universal deferred payment scheme so that people will not have to sell their home in their lifetime to pay for residential care.

11. Response to the Francis Inquiry on failings at Mid-Staffordshire Hospital

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry led by Robert Francis QC, identified failures across the health and care system that must never happen again. The Act helps deliver the Government's commitment to ensure patients are the first and foremost consideration of the system and everyone who works in it.
It sets out Ofsted-style ratings for hospitals and care homes so that patients and the public can compare organisations or services in a fair and balanced way and make informed choices about where to go.
It will enable the new Chief Inspector of Hospitals, appointed by the Care Quality Commission, to trigger a process to deal with unresolved problems with the quality of care, more effectively.
It will also make it a criminal offence for health and care providers to supply or publish false or misleading information.

111. Health Education England and the Health Research Authority

The Act establishes Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental public bodies, giving them the impartiality and stability they need to carry out their roles in improving education and training for healthcare professionals, and protecting the interests of people in health and social care research.

2 CARE ACT KEY MILESTONES AND MAIN PROVISIONS

The significance of this Act should not be underestimated as it replaces much of the legislation that has governed Adult Social Care since 1948. In total it replaces 13 pieces of Primary legislation, 13 pieces of secondary legislation and 3 pieces of statutory guidance. A full breakdown of legislation it replaces is shown in Appendix One.
The main provisions and the timelines for implementation of the Act are set out below:

May 1 2013 – April 1 2014	**April 1st 2014**	**June 2014**	**October 2014**	**April 1st 2015**	**April 1st 2016**
Care Act in Parliament until Royal Assent	Royal Assent of the Care Act	Consultation on draft regulations and guidance for implementation of Part 1 of the Act in 2015/16 (coming into effect April 2015) plus impact assessments	▪ Regulations laid before Parliament for provisions coming into force April 2015 ▪ Publication of regulations and guidance	Care Act part 1 provisions (excluding funding reform) come into force	Care Act part 2 funding reform provisions come into force

Deferred Payments	
Implementation	April 2015
Key Principles	▪ People who face the risk of having to sell their home in their lifetime to pay for care home fees will have the option of a deferred payment
Important Changes	▪ Everyone in a care home who meets the eligibility criteria will be able to ask for a deferred payment regardless of whether or not the local authority pays for their care ▪ Councils will be able to charge interest on loans to ensure they run on a cost neutral basis
Key impact/support requirements for Implementation	▪ Sound financial processes to support increased number of DPAs ▪ Sufficient staff / IT capacity ▪ Creation of a "funding pool" for loans

Additional Assessments and Changes to Eligibility	
Implementation	April 2015
Key Principles	▪ Early intervention and prevention: supporting people as early as possible to help maintain their wellbeing and independence ▪ Eligibility to be set nationally based on risk to the individual's wellbeing (as opposed to the risk to the individual's independence) ▪ Focus on outcomes and wellbeing ▪ Assessment to take into account the needs of the whole family as well as of any carers ▪ New arrangements for transition to adult care and support
Important Changes	▪ Councils will have a new duty to carry out a needs assessment for all carers (no longer dependent on the cared-for person meeting the FACS eligibility criteria) ▪ New duty to provide advice and information to service users and carers who do not meet the eligibility threshold ▪ Duty to assess young people, and carers of children, who are likely to have needs as an adult where it will be of significant benefit, to help them plan for the adult care and support they may need, before they (or the child they care for) reach 18 years ▪ Legal responsibility for local authorities to cooperate to ensure a smooth transition for people with care needs to adulthood ▪ New national eligibility threshold (likely to be set at Substantial and Critical)
Key impact/support requirements for Implementation	▪ Expanded assessment capability to cope with increased demand ▪ Assessment process that is focused on outcomes and wellbeing ▪ Strong and effective partnership working across adults' and children's services during transition

Advice and information	
Implementation	April 2015
Key Principles	▪ Information should be available to all, regardless of how their care is paid for ▪ Good quality, comprehensive and easily accessible information will help people to make good decisions about the care and support they need ▪ Councils have a key role in ensuring good quality advice is available

	locally and for sign posting people to independent financial advice
Important Changes	▪ Councils will be required to provide comprehensive information and advice about care and support services in their area and what process people need to use to get the care and support that is available ▪ They will also need to tell people where they can get independent financial advice about how to fund their care and support ▪ Councils will be required to provide independent advocates to support people to be involved in key processes such as assessment and care planning, where the person would be unable to be involved otherwise
Key impact/support requirements for Implementation	▪ Establish strong joint working arrangements across Health, Children & Adult services to support the transition pathway ▪ Establish processes for sharing information and completing assessments when eligible clients move between areas ▪ Continuous development of Plymouth Online Directory (POD) to ensure up to date and relevant information and advice available

Commissioning	
Implementation	April 2015
Key Principles	▪ A wide range of good quality care and support services will give people more control and choice and ensure better outcomes ▪ Councils have an important role in developing the quality and range of services that local people want and need ▪ Integrated commissioning with key partners, including health and housing, is essential to ensure quality as well as value for money and improve user satisfaction
Important Changes	▪ Duty on councils to join up care and support with health and housing where this delivers better care and promotes wellbeing ▪ Duty on councils to ensure there is a wide range of care and support services available that enable local people to choose the care and support services they want (market shaping) ▪ New right to a personal budget and direct payment
Key impact/support requirements for Implementation	▪ Develop market position statement(s) which clearly identify strengths / weaknesses in local provision ▪ Review interface with Housing functions ▪ Use Better Care Fund (formerly Integration Transformation Fund) to promote coordinated and integrated health and social care

Safeguarding	
Implementation	April 2015
Key Principles	▪ The Act sets out a clear legal framework for how local authorities should protect adults at risk of abuse or neglect
Important Changes	▪ The Act creates a legal framework requiring key organisations with responsibility for adult safeguarding to agree how they must work together to keep vulnerable adults safe. ▪ The Act legislates for Safeguarding Adults Boards (SAB) to be established by the Local Authority.
Key impact/support requirements for Implementation	▪ Establish systems to ensure the SAB arranges Independent Management Reviews and Serious Case Reviews as necessary ▪ Establish joint working protocol with key partners which clarifies roles, responsibilities and allows for the sharing of information.

Funding reform (cap on costs)	
Implementation	April 2016
Key Principles	▪ Financial protection: everyone will know what they have to pay towards the cost of meeting their eligible needs for care and support ▪ People will be protected from having to sell their home in their lifetime to pay for any care home costs ▪ People will be helped to take responsibility for planning and preparing for their care needs in later life
Important Changes	▪ Introduction of a cap on costs of meeting eligible needs for care and support (to be set at £72,000, when it is introduced, for those of state pension age and above when it is introduced) including independent personal budgets and care accounts. The cap will be adjusted annually, as will the amount people have accrued towards the cap ▪ No contribution expected for young people entering adulthood with an eligible care need ▪ Lower cap for adults of working age (level to be determined) ▪ Increase in capital thresholds / extension to the means test providing more support to people with modest wealth. The changes will mean that people with around £118k worth of assets (savings or property) or less will start to receive financial support if they need to go to a care home

	▪ New legal basis for charging covering both residential and non-residential care ▪ Consistent approach towards calculating a contribution towards general living costs for people in residential care (general living costs reflects the cost that people would have to meet if they were living in their own home such as food, energy Acts commonly referred to as `Hotel' costs) ▪ New framework for eligibility with threshold to be set nationally (to be implemented in April 2015)
Key Impact/support requirements for Implementation	▪ Financial and IT systems to establish and monitor care accounts ▪ Additional assessment capacity for all self-funders who ask for a care account

3 FINANCIAL IMPACT OF THE CARE ACT

The Care Act is effective from April 2015 with funding reforms coming into effect 2016. Initial guidance has indicated that the cost of Part 1of these reforms will be in the region of £959,000 and will be met from the Better Care Fund.

Care Act implementation funding in the Better Care Fund (£135m nationally)		**PCC allocation, £000s**
Personalisation	*Create greater incentives for employment for disabled adults in residential care*	*15*
Carers	*Put carers on a par with users for assessment.*	*85*
	Introduce a new duty to provide support for carers	*169*
Information advice and support	*Link LA information portals to national portal*	*0*
	Advice and support to access and plan care, including rights to advocacy	*127*
Quality	*Provider quality profiles*	*26*
Safe-guarding	*Implement statutory Safeguarding Adults Boards*	*41*
Assessment & eligibility	*Set a national minimum eligibility threshold at substantial*	*205*
	Ensure councils provide continuity of care for people moving into their areas until reassessment	*22*
	Clarify responsibility for assessment and provision of social care in prisons	*34*
Veterans	*Disregard of armed forces Guaranteed Income Payments(GIPs) from financial assessment*	*13*
Law reform	*Training social care staff in the new legal framework*	*23*
	Savings from staff time and reduced complaints and litigation	*-69*
Total		***692***
IT	***Capital investment funding including IT systems (£50m nationally)***	*268*
Grand Total		***959***

In order to assess the financial impact of the Funding Reforms that come into effect from 2016, Local Authorities are presently completing a cost modelling tool- known as the Surrey Model. This tool looks at a variety of measures that will impact on the cost of the reforms, including numbers of self funders, wealth, and different characteristics of men and women. Accountants in the Local Authority are in the process of modelling this work with results expected July 2014.

4 LOCAL IMPLEMENTATION

Implementation of the Care Act is linked to the wider Integrated Health and Wellbeing Transformation Programme. In line with this methodology a Sub Project Board has been established, with the Assistant Director for Cooperative Commissioning & Adult Social Care acting as Project Sponsor.
There are a total of four workstream groups to steer through the implementation of the different components:

1. Financial processes & implications
2. Customer journey
3. Preparing the care & support market
4. Safeguarding

Members of this sub-group include work stream leads and corporate stakeholders, including business architecture and ICT:

- The sub-group meets on a monthly basis
- Terms of reference are in place

Also in place are regular project meetings with work stream leads

Work to date:

- April 2014 – implementation plan drawn up
- April 14 – Project Brief drafted
- May 2014 – first ADASS stocktake survey completed and submitted
- May/ June 2014 – baseline assessments for each workstream undertaken
- May/June 2014 – ICT system requirements analysis and planning
- May/June 2014 – Surrey Model utilised to model and understand potential cost of Care Act Implementation
- June 2014 – Briefing for CMT/ CCG and cabinet planning
- June 2014 presentation to CMT
- June 2014 – Communication plan drafted
- June/July 2014 – completion and submission of Care Act Consultation
- On-going – regular attendance at regional events by relevant officers from, Adult Social Care, Finance and Performance.

Next Steps:

- Completion of the "Surrey Model" to set a baseline on the cost of the changes
- Project Brief to be refreshed in line with the consultation document and ADASS stocktake survey
- Overarching Project Plan to be drawn up with sub project plans for each workstream.

APPENDIX ONE

Legislation and guidance to be replaced

The following lists summarise some of the key legal provisions and existing statutory guidance which are to be replaced by the Care Act 2014 and the associated regulations and guidance. Where existing provisions relate to jurisdictions other than England, the provisions will be disapplied so that they no longer relate to English local authorities. Where provisions relate to children as well as adults, they will be disapplied in relation to adults, but will remain in force in relation to children.

Primary legislation to be repealed or disapplied

Title of legislation to be repealed, in whole or in part

- National Assistance Act 1948
- Health Services and Public Health Act 1968
- Local Authority Social Services Act 1970
- Chronically Sick and Disabled Persons Act 1970
- Health and Social Services and Social Security Adjudications Act 1983
- Disabled Persons (Services, Consultation and Representation) Act 1986
- National Health Service and Community Care Act 1990
- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000
- Health and Social Care Act 2001
- Community Care (Delayed Discharges etc.) Act 2003
- Carers (Equal Opportunities) Act 2004
- National Health Service Act 2006

Secondary legislation to be revoked

Title of instruments to be revoked, in whole or in part

- Approvals and directions under S.21(1) NAA 1948 (LAC (93)10)
- National Assistance (Assessment of Resources) Regulations 1992
- National Assistance Act 1948 (Choice of Accommodation) Directions 1992
- National Assistance (Residential Accommodation) (Relevant Contributions) Regulations 2001
- National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) Regulations 2001
- Delayed Discharges (Mental Health Care) (England) Order 2003
- Delayed Discharges (England) Regulations 2003
- National Assistance (Sums for Personal Requirements) Regulations 2003

• Community Care (Delayed Discharges etc.) Act (Qualifying Services) Regulations 2003

• Community Care Assessment Directions 2004

• Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009

• NHS Continuing Healthcare (Responsibilities) Directions 2009

• Ordinary Residence Disputes (National Assistance Act 1948) Directions 2010

Statutory guidance to be cancelled

Title of guidance to be cancelled

• Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care (2010)

• Fairer Charging Policies for Home Care and other non-residential Social Services (2013) and LAC (2001)32

• Charging for residential accommodation guidance (CRAG) (2014)

PLYMOUTH CITY COUNCIL

Subject:	Integrated Commissioning Business Case
Committee:	Cabinet
Date:	15 July 2014
Cabinet Member:	Councillor Ian Tuffin / Councillor Sue McDonald
CMT Member:	Carole Burgoyne (Strategic Director for People)
Authors:	Craig McArdle (Head of Co-operative Commissioning, PCC) Nicola Jones (Head of Western Locality Programmes, NEW Devon CCG)
Contact details	Tel: 01752 307530 email: Craig.McArdle@plymouth.gov.uk
Ref:	IHWB/IC
Key Decision:	Yes
Part:	I

Purpose of the report:

The purpose of this report is to seek Cabinet's approval of a Business Case that sets out how Plymouth City Council and Northern, Eastern and Western Devon CCG are to take forward Integrated Commissioning, in line with the Health and Wellbeing Board's vision of achieving Integration by 2016.

Public sector organisations across the country are facing a combination of severe budget pressures and increasing demand for services and are only able to meet these combined challenges through system wide change.

In response Plymouth Health and Wellbeing Board has adopted a system's leadership approach that has set down a vision of system integration based around Integrated Commissioning, Integrated Health and Care Services and an integrated system of health and wellbeing.

Plymouth City Council (PCC) and Northern, Eastern and Western Devon CCG ('NEW Devon CCG') have already developed strong relationships which can act as a solid foundation to support system wide integration. Co-location has brought commissioning teams into the same building at Windsor House, and this has enabled the development of lead commissioning arrangements, some pooling of budgets, and joint commissioning strategies.

However both organisations recognise that if they are to make the step change in improving services and outcomes for individuals and communities, then achieving the largest scale of commissioning change possible is required. Therefore by building on co-location and existing joint commissioning arrangements, the focus will be to establish a single commissioning function, the development of integrated commissioning strategies and pooling of budgets, through a section 75 agreement.

A Section 75 agreement allows budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated and functions can be reallocated between partners. Legal mechanisms allowing budgets to be pooled are designed to enable greater integration between health and social care and more locally tailored services. This legal flexibility allows a strategic and more efficient approach to commissioning local services across organisations and a basis to form new organisational structures that integrate health and social care.

Fundamental to the new commissioning function will be an enhanced role for an integrated intelligence function that will drive prioritisation of resources, evidence based interventions and innovative models of care and support. And underpinning the approach will be co-operative commissioning principles and values of being democratic, responsible, fair and partners.

Integrated commissioning is not an end in itself and the primary driver is to improve service delivery and provision with the aim of improving outcomes and value for money. Integrated commissioning must deliver integrated wellbeing.

The single commissioning function will therefore focus on developing joined up population based, public health, preventative and early intervention strategies and adopt an asset based approach to providing an integrated system of health and wellbeing, focusing on increasing the capacity and assets of people and place.

Integrated commissioning will provide the opportunity to commission an integrated provider function stretching across health and social care providing the right care at the right time in the right place. Although driven by Integrated Commissioning this is subject to a separate but connected business case.

Integrated commissioning will also have a key role in ensuring that every Child in the City achieves the Best Start to Life. In doing so it is recognised that similar whole system approach to Children's and Young Persons Services needs to be adopted. Co-operative commissioning principles and values will be central to the Children's Services redesign however the detailed implementation is subject to a separate business case.

To deliver such an ambitious programme it is recognised that due diligence will need to be undertaken, with measurable steps along the way. As an initial step towards establishing a more integrated approach to commissioning Plymouth City Council will complete a review of its own commissioning approach first. The aim of the review will be to reduce duplication, clarify roles and bring commissioning for People into one co-operative commissioning unit.

Plymouth City Council and New Devon CCG will then work towards commissioners coming together with shared line management and pooled commissioning budgets (for services in scope of integration) by March 2015. It is recognised that this will act as a transitional option with a subsequent stage being commissioners and pooled budgets coming together to create a new commissioning entity with potential to grow in terms of geography, scope and partners

Governance and risk sharing arrangements are essential to the success of the project and these will be developed during the delivery phase during the period September – October 2014, with the commissioning strategies and section 75 agreements coming back to governing bodies for final approval after this period.

What does this project mean for Plymouth?

The project aims to bring about the following step change in the way services are commissioned and delivered and at the end of the project the following distinct elements will be in place:

- Single commissioning: Commissioners from both organisations will work together to produce single service specifications for the delivery of services funded from a single integrated budget.

- Single decision-making: Senior managers and clinicians from the local authority and CCG, guided by the Health and Wellbeing Board, will make evidence based and informed decisions together rather than as separate organisations.
- Commissioning will be co- designed and co-produced with people, communities, and providers including voluntary sector organisations and GP Practices: We need to work together to develop our providers and engage with GPs in Plymouth's communities.
- IT systems will work and speak to each other across organisational boundaries.
- "Whole system' measures of success will drive the integrated commissioning of services.

What will people in Plymouth see as a result?

- Easier and earlier access to services that promote wellbeing or that provide help in a crisis
- People empowered to take control of their own health and wellbeing
- Local communities in Plymouth are increasingly supported by strong links between GPs, schools, social workers and community organisations, which helps people like them to stay independent for longer.
- Older people who have come out of hospital are helped to stay at home.
- Families and carers will not have to chase professionals or ask them to talk to each other.
- Children with a learning disability and their families and carers are supported in managing their needs and can trust that when they turn 25 they will continue to receive the support they need.
- Developing social capital that enhances the lives of people in Plymouth through providing local resources that support a greater emphasis on prevention and early intervention.
- Greater economic opportunities as more people get the support they need to work.

The Brilliant Co-operative Council Corporate Plan 2013/14 - 2016/17:

The propositions made in this business case align to the Plymouth City Council Corporate Plan by working co-operatively to meet the objectives of creating a Caring and Pioneering Plymouth. It also aligns to the Health and Wellbeing Board's vision of achieving Integration by 2016, as decided in June 2013.

This project will support the Corporate Vision through:

- Being **pioneering** in developing and delivering quality, innovative brilliant services with our citizens and partners that make a real difference to the health and well- being of the residents of Plymouth through challenging economic times.
- **Growing** Plymouth through learning and community development creating opportunities for vulnerable people to develop, making us and them stronger and more confident as a result.
- Putting citizens at the heart of their communities and work with our partners to help us **care for Plymouth**. We will achieve this together by supporting communities, help them develop existing and new enterprises, redesign existing services which will in turn create new jobs, raise aspirations, improve health and educational outcomes and make the city a brilliant place to live, to work and create a future for all that reflects our guiding co-operative values.
- Raising aspirations, improving education, increasing economic growth and regeneration, people will have increased **confidence in Plymouth**. With citizens, visitors and investors identifying us as a "vibrant, confident, pioneering, brilliant place to live and work" with an outstanding quality of life.

The Integrated Commissioning Project will address the following of the Council's 50 Pledges:

Caring Plymouth - For all of Plymouth's residents whatever their age
1. Continue our pioneering work to make Plymouth a dementia friendly city.

Working Plymouth - The Economy and Jobs
4. Set up a forum to help women return to work on family friendly policies after maternity or childcare leave.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

Transformation resources will be required for the duration of the project. These should be internal where possible and so will rely on staff being temporarily released from other areas of the organisation.

Requirement for Corporate Support (Legal, HR, Finance, etc.) will need to be managed due to the current high volume of requests for their support.

Project costs should be equally split between CCG and PCC.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

The report strengthens our approach to both Child Poverty and Community Safety by focusing on early intervention and prevention and giving every child the best start to life. In line with our Co-operative commissioning principles the approach adopted aims to build both community and individual capacity. Children living in families affected by poverty will feel the benefit of improved family health and wellbeing which directly and indirectly affects economic stability and resilience.

No specific Health and Safety Issues have been identified.

This report will contribute to the response to the Fairness Commission recommendations scheduled for August 2014.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? Yes

When considering this proposal it is important to have due regard to the public sector equalities duties imposed upon the Council by section 149 Equalities Act 2010 to

- Eliminate unlawful discrimination, harassment and victimisation and
- Advance equality of opportunity between people who share a protected characteristic from those who do not and to
- Foster good relations between people who share protected characteristics and others

The relevant protected characteristics for this purpose are: (a) age; (b) disability; (c) gender reassignment; (d) pregnancy and maternity; (e) race; (f) religion or belief; (g) sex; (h) sexual orientation.

Compliance with the duties in this section may involve treating some persons more favourably than others.

A Programme wide detailed equality impact assessment has been completed and will continue to be updated through this process to ensure we take action and mitigate any negative effects on any particular groups or individuals.

Recommendations and Reasons for recommended action:

In order to meet the challenges facing the health and care system it is recommended that NEW Devon Clinical Commissioning Group and Plymouth City Council follow a road map towards integrated commissioning by formally approving the following steps-

1. Plymouth City Council to review all commissioning activity across The People Directorate and ODPH and establish a single co-operative commissioning unit ahead of integration.

2. Plymouth City Council works collaboratively with NEW Devon CCG to achieve the first stage of an Integrated Commissioning Function by March 2015

3. Plymouth City Council works with NEW Devon CCG to develop a section 75 agreement(s) by the end of March 2015 to pool budgets based around:
    a. Wellness
    b. Community Based Care
    c. Complex / Bed Based Care (excluding acute)

4. Plymouth City Council works with NEW Devon CCG to develop single commissioning strategies based around the above.

5. Recommendations III and IV are subject to further Plymouth City Council and NEW Devon CCG Governance Approvals prior to implementation in November 2014.

Alternative options considered and rejected:

A 'do nothing' option has been considered however this has been rejected due to the significant and time-critical budget pressures facing Plymouth City Council and NEW Devon CCG meaning that this option is not feasible. It would also not deliver the strategic ambition of Integration as set down by Plymouth Health and Wellbeing Board.

During the Options Appraisal the option *'Commissioners come together with shared line management but commissioning budgets remain separate'* was also considered but this too was rejected due to the level of integration not being sufficient enough to deliver the desired outcomes. Partners are committed to improving services and outcomes for individuals and communities and recognise that to achieve this, a commitment to achieving the largest scale of commissioning change possible is required.

Published work / information:

Corporate Plan 2013/2014 – 2016/2017, Report to City Council, 22nd July 2013.

http://www.plymouth.gov.uk/mgInternet/documents/s48110/Corporate%20Plan%20Full20Council%2022.07.13.pdf

The Brilliant Cooperative Council Three Year Plan, Report to City Council, 16th September 2013.
http://www.plymouth.gov.uk/mgInternet/documents/s48110/Corporate%20Plan%20Full%20Council%2022.07.13.pdf

The Brilliant Cooperative Council Three Year Plan, Report to Cooperative Scrutiny Board, 16th October 2013.
http://www.plymouth.gov.uk/modgov?modgovlink=http%3A%2F%2Fwww.plymouth.gov.uk%2FmgInternet%2FieListDocuments.aspx%3FCId%3D1071%26amp%3BMId%3D5544%26amp%3BVer%3D4

Transformation Programme, Report to Cabinet 25th March 2014, including the IHWB Outline Business Case.
http://www.plymouth.gov.uk/mgInternet/documents/s53610/transformation%20cabinet%20march%222014%20final%20MCv1%202.pdf

Health and Wellbeing Strategy, Published by Plymouth City Council, February 2014
http://www.plymouth.gov.uk/healthwellbeingstrategy.pdf

Co-operative Commissioning Framework, Published by Plymouth City Council
http://www.plymouth.gov.uk/cooperative_commissioning.pdf

NHS NEW Devon CCG Five-year Strategic Plan (draft), 4 April 2014
http://www.newdevonccg.nhs.uk/who-we-are/what-is-clinical-commissioning/commissioning-framework/100925

Your health, your future, your say: Western Locality's engagement report on Transforming Community Services, March 2014
http://www.newdevonccg.nhs.uk/permanent-link/?rid=101537

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off:

Fin	mc14 15.21	Leg		Mon Off		HR	HR-CS2 5.6.14.	Assets		IT		Strat Proc	
Originating SMT Member: Dave Simpkins (Assistant Director of Adult Social Care and Co-operative Commissioning)													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

Integrated Health and Wellbeing

Business Case

Project Name:	Integrated Commissioning		
Date:	03.06.14	**Version:**	0.4
Author(s):	Craig McArdle, Nicola Jones, Craig Williams, Lynne Kilner, Anna Coles, Paul Walshe, Alex Mehaffey, Mark Appleby		
Owner(s):	Carole Burgoyne & Jerry Clough		

Recent History			
Version:	**Date:**	**Summary of Changes:**	**Changes Marked:**
0.1	14.05.14	Initial Draft	AM
0.2	28.05.14	Update	AM / AC
0.3	03.06.14	Feedback incorporated	CM
0.4	18.06.14	Feedback incorporated	AM / CM

Approvals				
Name:	**Title:**	**Signature:**	**Date:**	**Version:**
	Finance			
	Business Architecture			
	Portfolio Office			
	Legal			
	Human Resources			
	Project Executives			

Distribution			
Name:	**Title:**	**Date:**	**Version:**

Contents

An introduction to the Plymouth City Council's Transformation Programme and NEW Devon CCG Transforming Community Services Strategy

Context:

2002-12: A Decade of Improvement

The City of Plymouth has had an extra-ordinary journey over the past ten years. A decade ago, it had a reputation as a city of low aspiration with a lack of vision, weak financial and strategic planning, poor relationships between agencies, and service delivery arrangements that did not meet the needs of all of its citizens. An acknowledgement of the determined and sometimes inspired effort that was then made to improve the city came in 2010 when the Council was voted 'Highest Achieving Council of the Year' by the Municipal Journal. Behind that accolade, foundations had been laid by successive political administrations of a clear, ambitious vision for the city, sound financial management arrangements, the development of strong strategic partnerships and a determined focus on the improvement of service delivery. The Council has acknowledged and embraced its role as a key player in influencing the broader city and regional agenda, driving economic growth and making coherent contributions to broader policy-making.

Drivers for Transformation:

The Brilliant Co-operative Council with less resources

On its adoption of a new Corporate Plan in July 2013, the council set the bar still higher, to become a Brilliant Co-operative Council. This 'Plan on a Page' commits the Council to achieving stretching objectives with measurable outcomes, and also sets out a Co-operative vision for the Council, creating a value-driven framework for the way that it will operate as well as the outcomes that it is committed to achieve.

The Corporate Plan was developed using the principles of a Co-operative Council. It is a short and focused document, but does not compromise on its evidence base, and was co-developed with the Cabinet of the Council, before being presented in person by members of the Corporate Management Team to every member of staff throughout the council at a series of 74 roadshows. The positive results of this commitment to strong communications and engagement were evidenced by 81% of council staff responding to the workplace survey conducted in October 2013 agreeing that they understand and support the values and objectives set out in the Corporate Plan.

The economic, demographic and policy environment affecting public services is accepted as the most challenging in a generation. At the same time as an aging population is placing increased demand on health and social care services, the UK is facing the longest, deepest and most sustained period of cuts to public services spending at least since World War II. The Council's Medium Term Financial plan identified in June 2013 funding cuts of £33million over the next three years which, when added to essential spend on service delivery amount to an estimated funding shortfall of circa £64.5million from 2014/15 to 2016/17, representing 30% of the Council's overall net revenue budget.

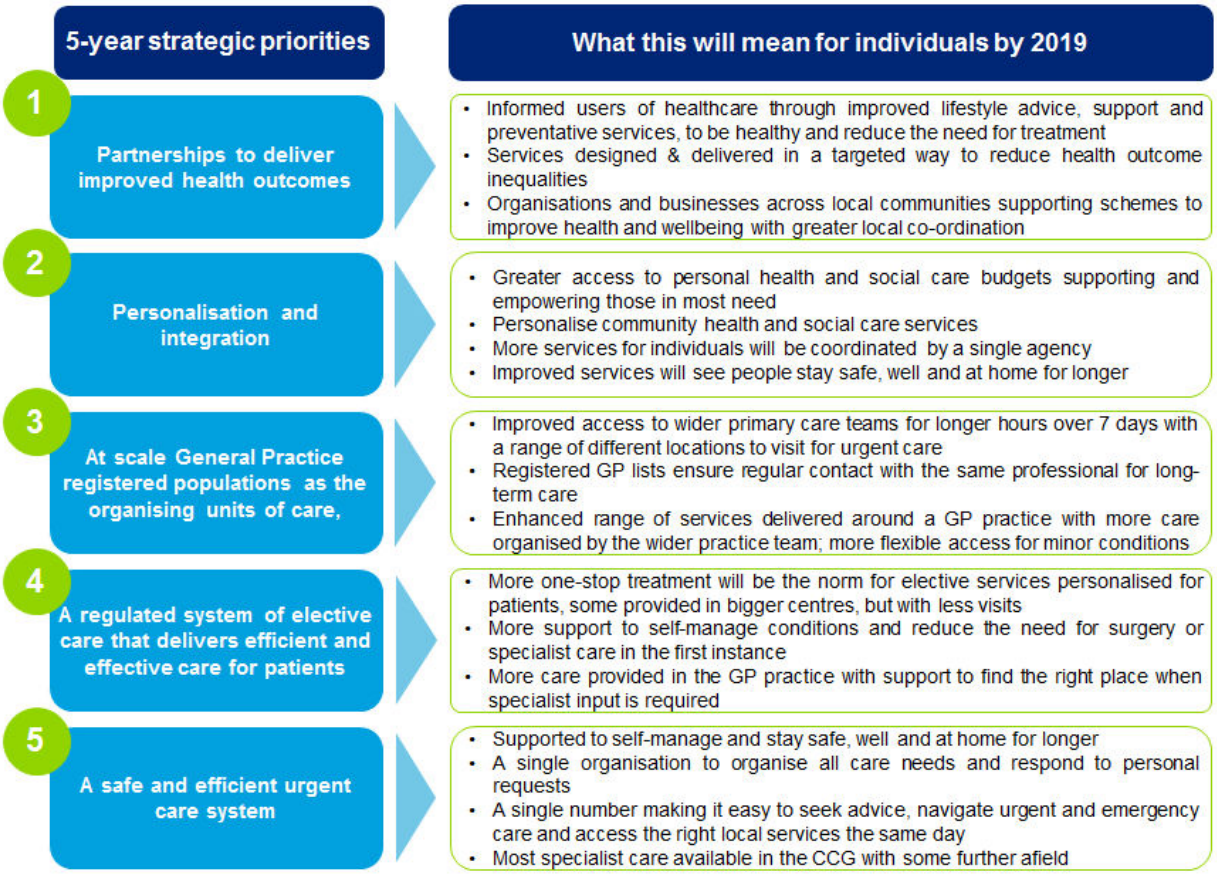
The Council has shown remarkable resilience in addressing reduced funding and increased demand in previous years, removing circa £30m of net revenue spend from 2011/12 to 2013/4 through proactive management and careful planning. However the Council has acknowledged that addressing further savings of the magnitude described above while delivering the ambitions of the Corporate Plan will require a radical change of approach.

Transforming Community Services:

NEW Devon CCG has initiated a programme, called Transforming Community Services, to remodel community health provision across each of its three localities. This programme aligns to the national Transforming Community Services programme, and the current programme plan involves the re-procurement of community services in Plymouth by April 2016.

The transforming communities consultation which has gathered feedback from people who use services and they described that they wanted 'Health care that does not stop at boundaries', services that see me as a person, not a condition', and 'safe and secure services with future proofing in mind'.

This engagement has resulted in the establishment of the key priorities which are depicted below:



Review of existing transformation programmes

The council commissioned Ernst and Young in June 2013 to:

- Examine the council's financial projections and provide expert external validation of our assumptions about costs and income in the medium term
- Review the council's existing transformation programmes and provide a view as to whether they will deliver against the Corporate Plan
- Provide advice as to how the council might achieve the maximum possible benefit through a revised approach to transformation

Ernst and Young validated the council's current Medium Term Financial Plan based on projections and assumptions jointly agreed, and judged it to be robust, taking into account the complex financial landscape and changing government policy.

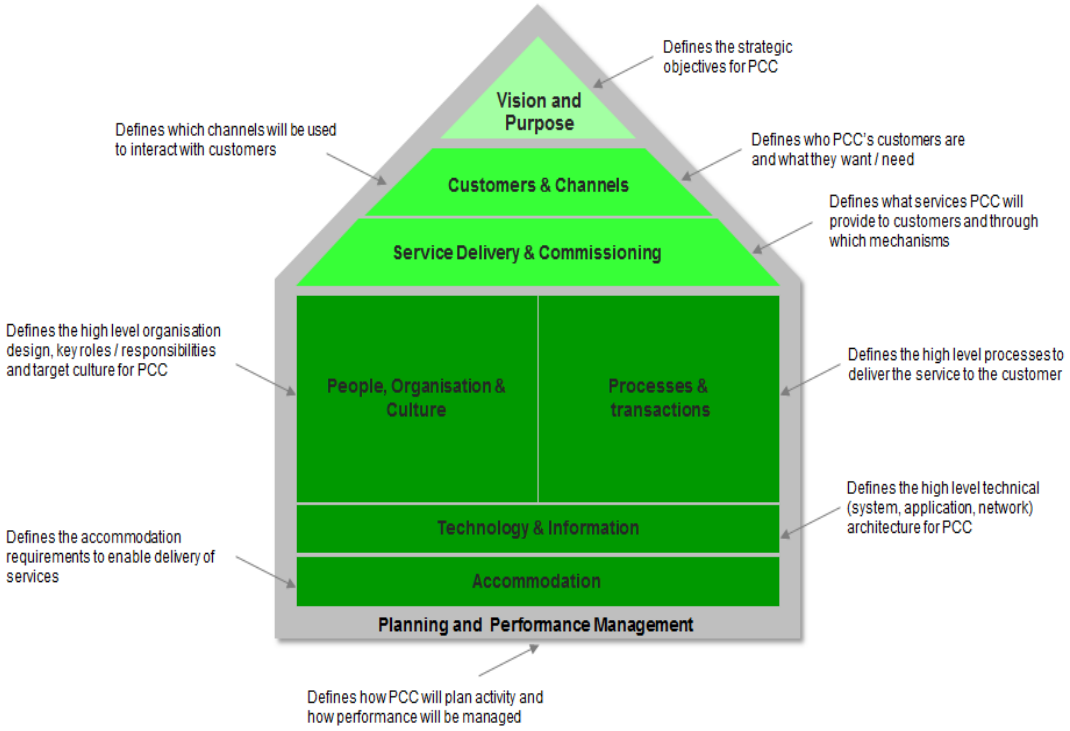
The council has initiated a number of far-reaching and ambitious change programmes over 2012-13 to address the twin aims of addressing financial constraints and improving service delivery. These include:

- Investment in Customer Transformation and Core ICT infrastructure (Cabinet approval September 2012)
- ICT Shared Services: DELT (Cabinet approval October 2013)
- Redevelopment of the Civic Centre and future accommodation requirements (Cabinet approval September 2013)
- Modernising Adult Social Care Provision (Cabinet approval January and August 2013)
- Co-location with Clinical Commissioning Group at Windsor House (Cabinet approval January 2013)

In addition to feedback and advice about individual programmes, the Council received advice that has been carefully considered, and which has informed the overall design of the Transformation Programme and the content of the business cases for the five programmes.

Vision and Direction: The Blueprint

The Council has responded to concerns that, despite strong support for the Corporate Plan from both officers and members, there was a lack of clarity about how the Corporate Plan translates into practical action and a danger that the council might be attempting to 'do the right things, but in the wrong way'. After significant consultation with Members and over 100 staff from all levels and disciplines within the organisation, the Council's vision for the Brilliant Co-operative Council has been translated into a Blueprint which describes the capabilities which the Council will need in the future. These capabilities will be commissioned by the council and will result in services being delivered by the Council and a variety of other organisations operating across the public, community and voluntary and private sectors. The components of the Blueprint are illustrated below:



To inform the development of the main components of the Blueprint, a number of principles have been developed co-operatively with Members, senior officers and staff to ensure that the values set out in the Corporate Plan guide how the Blueprint is developed.

There are 5 programmes to deliver the transformation.

Customer and Service Transformation: This programme will transform the way the council interacts with customers to meet their demands and preferences, and transform the services that the Council decides to retain in-house.

Co-operative Centre of Operations: Creating the business as usual strategic 'centre' for the Council, which uses the co-operative principles and intelligence to co-ordinate organisational decision making and activity.

Integrated Health and Well Being: The Council can engage with partners to deliver services at a lower cost, whilst also improving outcomes and customer satisfaction. The aim of the programme is to achieve "One system, one budget to deliver integrated, personal and sustainable care".

People and Organisational Development: The programme will enable the Council to define and deliver the required workforce and accommodation capability change.

The **Growth, Assets and Municipal Enterprise** programme has been developed to:

- Contribute to the growth of the City and the move towards a brilliant co-operative council.
- Generate and accelerate additional income for Plymouth City Council from economic and housing growth across the Council
- Create a brilliant co-operative street service which will :
    - Make operational changes to enhance service delivery
    - Provide evidence to design and deliver new service delivery models
    - Identify and deliver new opportunities for commercialism, new income streams

- Realise opportunities to bring in additional income from the commercialisation and increased trading of services.

1. BACKGROUND AND OPPORTUNITY

1.1 Background and Context

Plymouth City Council and Northern, Eastern and Western Devon CCG are facing a combination of severe budget pressures, and rising demand for services. The Integrated Approach to Health and Wellbeing Programme aims to engage with commissioning and delivery partners to establish a more collaborative, integrated and strategic approach to how the organisations commission and deliver services, with the aim of reducing costs, improving patient/service user experience and improving outcomes for residents in Plymouth. As part of this, the programme recognises the importance of investing in preventative and early intervention services in order to reduce demand on higher cost community and bed based services, particularly acute services, which have been under sustained pressure for much of the last 12 months. This approach fits with PCC's ambition of being a co-operative council, underpins the CCG's Community Services Strategy, and supports the ethos of collaboration set down by all partners and will help to achieve the Health & Wellbeing Board's vision of "Healthy, happy, aspiring communities".

1.2 Overview of Existing Situation

Within the People Directorate there is a Co-operative Commissioning Team which leads on much of the Commissioning across the directorate principally around Early Years, Children's Housing Related Support and Adult Social Care. However beyond this team, as the Ernst and Young Outline Business Case highlighted there is still a considerable amount of Commissioning activity undertaken in individual teams and service areas. This can lead to multiple strategic approaches and duplication of time and resources.

NEW Devon CCG was authorised to commission healthcare services from 1st April 2013. The authorisation to do this was granted by the NHS Commissioning Board on 6th March 2013 without conditions, which placed it in the top 20% of CCGs nationwide. Overall NEW Devon CCG is responsible for commissioning £1.1bn of healthcare services.

The CCG is organised around three localities: Northern, Eastern and Western. The western locality spans about 260 square miles and stretches from Lifton to Salcombe and Plymouth to North Bovey. More than 350,000 people live in the western locality and 18% of them (almost 63,000) are aged over 65 years compared with a national average of 16%. The Western locality and also the Partnerships directorate work across both Devon and Plymouth local authorities.

There are differences in the ways that both the CCG and PCC commission services which need to be recognised. The CCG organisational structure means that as a commissioning organisation, as well as having commissioning staff, there are also contracts staffs, finance support, communications and performance. In contrast Finance, Performance, Communications are centralised functions in Plymouth City Council.

Plymouth City Council has recently adopted a **Co-operative Commissioning** approach which is a new approach to planning and delivering public services. Cooperative commissioning is based on the values of being democratic, responsible, fair and partners. At the heart of the process are citizens and communities, which means that commissioning is co-developed, co-designed, co-produced and co-evaluated. In doing so there is a greater focus on outcomes, social value and creating a co-operative market. Such an approach will drive an integrated commissioning approach.

1.3 Defining Integrated Commissioning

A useful definition which captures the key elements of commissioning has been provided by the Audit Commission:

"Commissioning is the process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies, or by the private and voluntary sectors" (2003)

Joint Commissioning has been defined as the process in which two or more organisations act together to co-ordinate the commissioning of services, taking joint responsibility for the translation of strategy into action. (North West Joint Improvement Partnership, November 2009). Whereas **Integrated Commissioning** takes the joint health and social care approach further, to encompass a wider range of partners, with the aim of addressing the complex needs of individual and communities in a holistic way.

Hudson[1] has helpfully described integrated commissioning as different to joint commissioning in terms of:

- Scale – from margin to mainstream
- Ambition – from single service to multi-service and systemic change
- Governance – from individual „charismatic lead to system-wide, transparent governance and accountability
- Stake holding – from few to many

Hudson further reports that integrated commissioning is being pushed by five factors:

- Efficiency / VFM – achieving efficiency through shared strategic planning and pooled budgets
- The Place Agenda – under Local Area Agreements, Total Place – local delivery focus
- Personalisation – to develop coherent services tailored to individual needs
- Prevention – to drive efficiency and improve individual's quality of life
- Care Closer to Home – integrated systems to enable more care closer to home

1. Hudson, B., *'Integrated Commissioning – The missing Link?'*, North West JIP and University of Durham, November 2009.

1.4 Opportunities and Outcomes

There are already strong relationships between the CCG and Plymouth City Council which can act as a solid foundation to support closer integration. Colocation has brought commissioning teams into the same building at Windsor House, and this has enabled the development of lead commissioning arrangements, some pooled budgets, joint commissioning partnership, joint commissioning strategies.

The outcome of this project will be a single, integrated and co-ordinated approach to commissioning across the social care and health system.

This single commissioning function will more easily enable investment to be targeted at a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge, preventing escalation of needs.

Established protocols and pathways to ensure clear governance agreements are in place will increase efficiency. The transparent performance and financial framework, supported by this joint governance, will ensure robust management of quality and costs.

Savings will be made through having shared management, system, overheads, etc. and financial risk sharing will also ensure value for money.

Providers will experience more integrated back-office support due to the removal of organisational boundaries, enabling flexibility and efficiencies. There will also be greater opportunity for providers to invest due to greater financial certainty.

In line with the strategic aims for integration set down by the Health & Wellbeing Board, the programme has the following five aims:

- Building on co-location and existing joint commissioning arrangements, the focus will be to establish a single commissioning function, the development of integrated commissioning strategies and pooling of budgets

- Integrated commissioning will provide the opportunity to commission an integrated provider function stretching across health and social care providing the right care at the right time in the right place.

- An emphasis on those who would benefit most from person-centred care such as intensive users of services and those who cross organisational boundaries

- A focus on developing joined up population based, public health, preventative and early intervention strategies

- An asset based approach to providing an integrated system of health and wellbeing, focusing on increasing the capacity and assets of people and place

2. PROJECT CATEGORISATION/STRATEGIC FIT

2.1 Strategic Case

Public sector organisations across the country are facing a combination of severe budget pressures and increasing demand for services. The NHS as a whole is committed to finding £20bn of savings from its budget by 2014/15, whilst Local Authorities are seeing budget reductions of approximately 26% as a result of this year's Comprehensive Spending Review, to go with a similar reduction implemented as part of the last Comprehensive Spending Review in 2010.

System wide changes will be needed in order to meet these combined challenges. Plymouth City Council (PCC) and Northern, Eastern and Western Devon CCG ('NEW Devon CCG' or 'the CCG') are looking to seize the opportunity created by sector wide reform, to create a vision for integrated commissioning and service provision that will help to improve outcomes, reduce cost in the system and align to the Health & Wellbeing Strategy.

It is widely recognised that there is no blueprint for integrated care, however, there is recognition that a whole system approach is needed. This means not only working across the whole of the local health, public health and social care systems but also working with other local authority services, key stakeholders, people and communities. This approach fits with PCC's ambition of being a co-operative council and supports the ethos of collaboration set down by all partners.

2.2 Local Strategic Drivers for Health & Social Care Integration

Local demographics and demand

The city of Plymouth has a population of approximately 260,000, which is projected to increase by 2.4% by 2017. The population of those aged 65 and over, who as a group are more likely to have long term conditions or social care needs, is projected to increase to 46,700 by 2016, an increase of 4.7%.

Public Health outcomes in Plymouth are worse than elsewhere in England in 28/32 of the measures shown in Plymouth's 2013 Health Profile and, according to Public Health England, the health of people in Plymouth is generally worse than the England average. Deprivation is higher than average and about 10,200 children live in poverty. Life expectancy for both men and women is lower than the England average. Estimated levels of adult 'healthy eating' and smoking are worse than the England average. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are worse than the England average.

The increase in population, and particularly the increase in older people, is likely to put significant strain on both health and social care services in years to come. Winter 2012/13 saw significant pressure on Plymouth Hospitals NHS Trust (PHNT), the main acute hospital in the region, with the hospital frequently being placed on black alert due to surges in demand. Unless significant action is taken to relieve pressure on admissions and increase the flow of discharges where possible, this pressure is likely to be present again this winter and in future years.

Financial imperative

At a local level there are considerable financial pressures. Plymouth City Council is committed to reducing spend by £65m over the next three years, of which approximately £16m may be allocated to reduced spend on Social Care service delivery.

In addition, the CCG is forecasting a 1% reduction in acute spend, and flat budgets for community and mental health services, in 2014/15. There are likely to be similar budget positions in future years and recently, Devon and Plymouth has been designated as one of eleven Financially Challenged Health Economies.

Therefore of key concern for both organisations is the on-going sustainability of the services and service quality in the face of the financial targets, and both organisations recognise that there is a need for a strategic and innovative response to achieve the level of savings required.

Health & Wellbeing Strategy

The Health and Wellbeing Board's vision is **"Happy, Healthy, Aspiring Communities"**. The purpose of the Board is "To promote the health and wellbeing of all citizens in the City of Plymouth". The Health and Wellbeing Board has set out three parallel core programmes to promote integration, with the aim of delivering healthy, happy, aspiring communities.

- Integrated Commissioning: Building on co-location and existing joint commissioning arrangements the focus will be to establish a single commissioning function, the development of integrated commissioning strategies and pooling of budgets.

- Integrated Health and Care Services: Focus on developing an integrated provider function stretching across health and social care providing the right care at the right time in the right place; and an emphasis on those who would benefit most from person centred care such as intensive users of services and those who cross organisational boundaries

- Integrated system of health and wellbeing: A focus on developing joined up population based, public health, preventative and early intervention strategies; and based on an asset based approach focusing on increasing the capacity and assets of people and place

Underpinning the board and its aims are three key principles of working together, which are:

- Working together and with those that the Board serves to take joint ownership of the sustainability agenda

- Ensuring systems and processes are developed and used to make the best use of limited resources

- Ensuring partners move resources (both fiscal and human) to the prevention, and health and wellbeing agenda

PCC Transformation Programme

Plymouth City Council has an extremely large funding gap which has the potential to increase over the next three years without significant intervention. A review of existing transformation work identified the following issues within the People Directorate which needed intervention in the guise of transformational change in order to achieve the objectives outlined in the organisation's corporate plan:

- PCC's adult social care service has gone through a major transformation but has not been fully integrated with health provision with services provided around the customer.
- Joint Commissioning is in place for some services but not all and there are opportunities to identify ways to achieve this and deliver value for money and more effective decision making.
- The cooperative commissioning centre of excellence has not been fully developed and there needs to be an agreed approach to integrated commissioning with health and other partners
- Services for children and young people could be integrated with schools, health and other partners in a more cost effective way which would deliver services cooperatively.
- Some social care services that Plymouth City Council delivers could be more cost effective if they were delivered in an alternative way.

The Fairness Commission Recommendations

The Plymouth Fairness Commission, launched in April 2013, was set up as an independent body to help make the city a fairer place to live and work. Chaired by Dame Suzi Leather, it was made up of professionals with a variety of expertise, including representatives from the police, health, private companies, charities, social enterprises and community groups.

Following the lead of other areas across the UK, Plymouth Fairness Commission made a number of recommendations to city leaders in March 2014, with the aim that they will be implemented across the city and reduce inequality. It is recognised that a systems leadership approach must be adopted to tackle the issues and recommendations raised by the Fairness Commission, which clearly aligns to the approach and principles of Integrated Commissioning.

PCC Corporate Plan – The Brilliant Co-operative Council

On its adoption of a new Corporate Plan in July 2013, the council set the bar still higher, to become a Brilliant Co-operative Council, in spite of decreasing resources. This 'Plan on a Page' commits the Council to achieving stretching objectives with measurable outcomes, and also sets out a Co-operative vision for the Council, creating a value-driven framework for the way that it will operate as well as the outcomes that it is committed to achieve.

Transforming Community Services

NEW Devon CCG has initiated a programme, called Transforming Community Services, to remodel community health provision across each of its three localities. This programme aligns to the national Transforming Community Services programme, and the current programme plan involves the re-procurement of community services in Plymouth by April 2016.

The transforming communities consultation which has gathered feedback from people who use services and they described that they wanted 'Health care that does not stop at boundaries', services that see me as a person, not a condition', and 'safe and secure services with future proofing in mind'.

Integrated, personal and sustainable- Community Services for the 21st Century- A Strategic Framework 2014

NEW Devon CCG strategic framework developed through Transforming Community Services engagement has set down the priority areas for a future integrated commissioning of services. These priorities are:

- Help people to stay well
- Integrate care
- Personalise support
- Coordinate pathways
- Think carer, think family
- Home as the first choice

2.3 National Strategic Drivers for Health & Social Care Integration

Many users of health and social care services experience care that is fragmented, with services reflecting professional and institutional boundaries when it should be co-ordinated around the needs of patients. This can result in duplication, inefficiency, gaps in care, feelings that 'no-one is in charge' and ultimately poor outcomes. This has been the context within which health and social care integration has been promoted as a model of care in recent legislation, policy and academic commentary by key stakeholders.

Research suggests current health and social care arrangements have failed to keep up with increasing population and patient expectations. It is clear that a more strategic approach needs to be taken to Health and Social care. The Kings Fund (*Transforming the delivery of Health and Social Care; The case for Change, September 2012*) has commented that partaking organisations should be prepared to de-commission outdated models of care, support NHS organisations to innovate and adopt established best practices; recognise the potential of new providers as an important source of innovation; develop a culture that values peer support for learning and innovation and encourage players at the local level to test new models of care.

Health & Social Care Act 2012

The Health and Social Care Act 2012 contains a number of provisions to enable the NHS, local government and other sectors, to improve patient outcomes through more effective and co-ordinated

working within the context of economic austerity. The Act provides the basis for better collaboration, partnership working and integration across local government and the NHS at all levels. The Bill identifies Clinical Commissioning Groups (CCGs) as being best placed to promote integration given their knowledge of patient needs, and the commissioning power to design new services around these needs. This is endorsed by early findings from the Department of Health's 16 Integrated Care Pilots (evaluated independently in the RAND report, 2012) which suggest that GPs in particular are taking on responsibility not only for the individual patient but also for that person's journey through the system.

The Care Act 2014

The Care Act takes account of the Dilnot Commission Report into the funding of care and support and the Law Commission report to codify Community Care law into a single piece of legislation. The Care Bill addresses the fact that the current social care system is inadequate, unfair and unsustainable. The Care Bill is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. It also places a new duty on Local Authorities to promote integrated care, mirroring the duties in the Health and Social Care Act 2012. The Act makes it clear that this refers to housing, health and social care delivery/commissioning and not just health and social care. It will have profound delivery and financial implications, not just for social care but for the whole Council, through the new duty to assess self-funders, requiring a commensurate increased social work resource, and the new financial thresholds for care requiring the Council to track the care payments of people self-funders and step-in with financial support at a much earlier point than is currently the case.

The Better Care Fund

The Better Care Fund (BCF) is a 'game changer', according to the Department of Health. It creates a substantial ring-fenced budget for investment in out-of-hospital care and sees the establishment of a pooled budget of £3.8bn, which will be committed at local level with the agreement of Health & Wellbeing Boards. Investment should be targeted at a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge - taking advantage, for example, of new collaborative technologies to give patients more control of their care and transform the cost effectiveness of local services. This will require investment in social care and other Local Authority services, primary care services and community health services. CCGs and Local Authorities are required to develop a shared view of the future shape of services and a condition of accessing the money in the fund is that CCGs and local authorities must jointly agree an Integration Plan for how the money will be spent.

National Quality Board

In the context of a vastly changing NHS landscape, the National Quality Board has issued a report; *'Quality in the new health system; Maintain and improving quality from April 2013'* which describes how quality will operate in the new system. This will have implications for both health and social care organisations regarding how best to align these systems in terms of quality assurance.

3. PROJECT SCOPE

3.1 Integrating Commissioning

The integrated commissioning project aims to deliver an integrated approach to commissioning across the CCG and PCC, in order to affect system change, to improve outcomes for people and communities. The table below highlights the initial areas of both organisations that are considered in scope

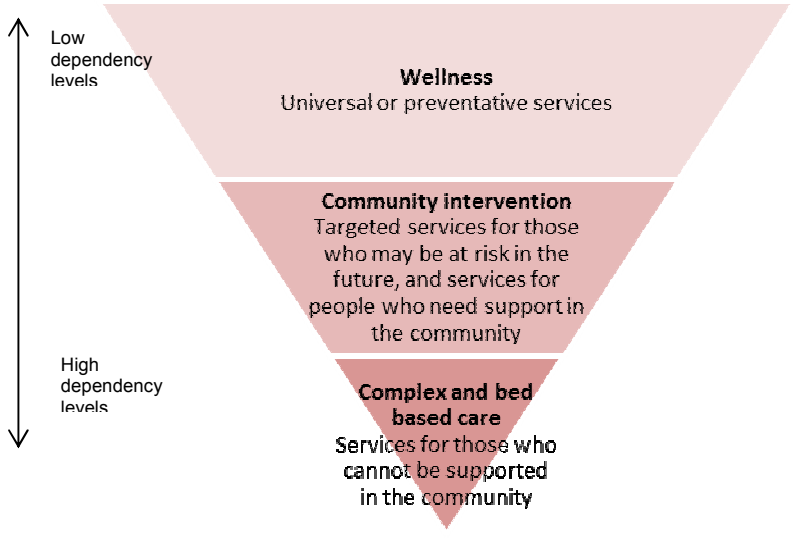
PCC	CCG
The following commissioning functions including but not limited to: Cooperative Commissioning Team; Homes and Communities including Community Safety ODPH Certain Policy and Performance elements	Western Locality (Plymouth facing); Partnerships (Plymouth facing) Potentially other commissioners and support services who work predominantly in Plymouth/Western Locality

As an initial step towards establishing a more integrated approach to commissioning Plymouth City Council will complete a review of its own Commissioning approach first. Presently Commissioning across the People directorate is still often undertaken by individual departments and team which can lead to duplication and lack of strategic planning. The aim of the review will be to reduce duplication, clarify roles and bring commissioning for People into one co-operative commissioning unit. The process is likely to lead to a reduction in roles and change competencies and skill sets of staff.

3.2 Integrating Delivery through Commissioning

Integrated commissioning is not an end in itself and the primary driver of this project is to improve service delivery and provision with the aim of improving outcomes and value for money. Integrated commissioning must deliver integrated wellbeing.

In order to achieve a more holistic and integrated provision services have been grouped into three categories, which correspond to differing levels of need and complexity.

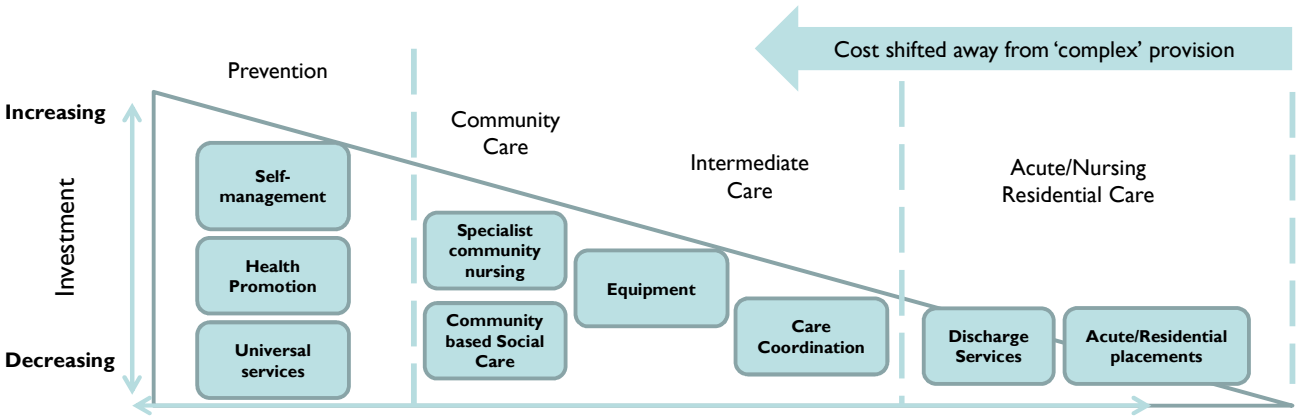


The top of the triangle represents patients or service users with lower levels of need and therefore lower levels of dependency on Council and CCG services. The bottom of the triangle represents service users with higher levels of needs and higher levels of dependency. Services are mapped to this framework to provide a common baseline of services in scope:

- *Wellbeing* - Universal or preventative services. This includes many Public Health services, such as smoking cessation and sexual health campaigns, and PCC services that do not require a FACS assessment. The category also includes early years prevention and early intervention services, and best start to life services
- *Community intervention* - Targeted services for those who may be at risk in the future, and services for people who need support in the community. This includes community nursing, domiciliary care and supported living
- *Complex and bed based care* - Services people with complex needs, who cannot be supported in the community. This includes acute, residential and nursing care

The scope of the programme will cover a range of services currently commissioned or provided by PCC's People Directorate, and a range of services that are commissioned by the Western Locality and Partnerships Locality of NEW Devon CCG.

It is important to recognise that, although there may be some services which will not be redesigned and will continue to be delivered in the same or a similar way, it is likely that changes in other parts of the economy will have an impact on the demand and spend in these services areas. This project will develop three co-dependent commissioning strategies with the intention that integrated commissioning activity is to move the balance of spend away from Complex provision towards services in Community and Wellbeing, in order to manage the demand and avoid costs incurred:

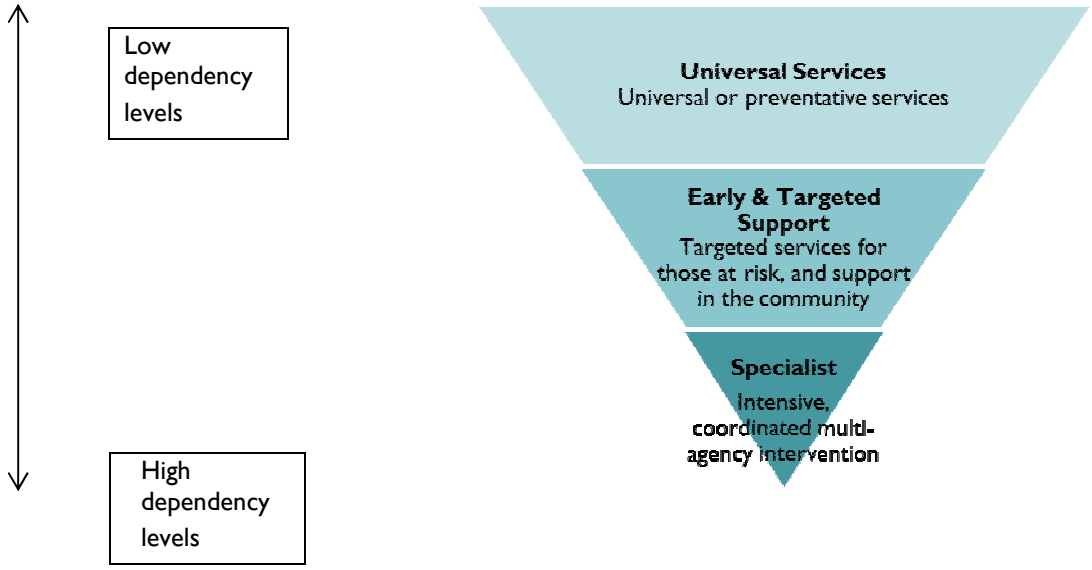


In redesigning the system the following principle will remain central-

- Help people to stay well
- Integrate care
- Personalise support
- Coordinate pathways
- Think carer, think family
- Home as the first choice

3.3 Integrated Commissioning for the Best Start to Life

Integrated commissioning will also have a key role in ensuring that every Child in the City achieves the Best Start to Life. In doing so it is recognised that similar whole system approach to Children's and Young Persons Services needs to be adopted, based on the following model.



In order to make this step change towards delivering enhanced prevention and early intervention capability, then NEW Devon CCG and PCC are committed to the pooling of budgets and the developing of an overarching Commissioning Strategy. Working through the Co-operative Children and Young People's Services transformation work stream priority areas for redesign have been identified in the following areas-

- Development of the Cooperative Community Partnership and the five cluster components
- Family Support Review
- Review of Youth Services

- Implementation of Children Social Care Service Redesign Pilots
- Early Help Coordination Unit
- SEND reforms

Co-operative commissioning principles and values will be central to the Children's Services redesign however the detailed implementation is subject to a separate business case.

3.4 Out of scope

The scope of the programme will not include certain Children's Social Care services (including assessment and case management of Looked After Children or those subject to a Child Protection Plan) that are currently provided in-house by PCC, although it will include the budget for commissioned children's services (e.g. Looked After Children placements).

The programme will not include in its scope any services commissioned by the Northern or Eastern Localities of the CCG, or any services commissioned by the Western or Partnerships Localities where there is an obvious geographical disconnect between the service commissioned and Plymouth city boundaries (e.g. mental health services in Devon County Council's area).

GPs and Primary Care services are assumed to be out of scope initially, although strong links to these providers will need to be maintained to engage them throughout the process of developing the new operating model for health and social care provision. The scope may be widened to directly include these services if a change in commissioning responsibilities for these (CCG co-commissioning primary care with NHS England) takes place within the timescale of this programme.

Other public sector commissioning organisations such as Police and Crime Commissioner, Probation, NHS England or other neighbouring Local Authorities, are presently out of scope however the programme will retain the flexibility to incorporate other public bodies at any stage if efficiencies and outcomes would be improved.

4. OPTIONS APPRAISAL

4.1 Overview of Options

All potential options for the structure of an integrated commissioning function were developed through the Outline Business Case process.

These options have been considered in detail through a range of different mechanisms including:

- Integrated Commissioning Project Board Meetings
- Specialist advice from subject matter experts (e.g. HR, Legal, Finance)
- Options Appraisal Workshop attended by stakeholders
- Discussion at individual management team meetings
- Written feedback
- Research into other commissioning models / L.As / good practice (e.g. Commissioning for Social Value Conference)

Through this process, strengths and weaknesses of each option were identified against a range of evaluation criteria, including how person-centred the approach is, viability from a HR/Legal point of view, financial aspects and sustainability.

The below table summarises the perceived benefits and risks of each of the options that were identified (N.B. The perceived benefits of option 1 and 2 culminate in option 3 also):

Scope of Opportunity	Option	Perceived Benefits	Perceived Risks
Minimum	Commissioners come together with shared line management but commissioning budgets remain separate	• Budget reduction through reduced management function • Ability to retain control of own organisation spend • Commissioners can be aligned to particular services/groups of services to manage total spend • Potential for 'cross-fertilisation' through commissioners sharing skills and expertise across service areas • Support joint commissioning, maintains expertise and ensures relationship management across partners	• No oversight of complete budget so unable to manage integrated spend strategically • Potential risk of destabilisation as organisations can still act independently • Providers have to deal with more than one organisation to discuss contracts • Commissioners can retain a 'silo' mentality Low ability to extend to include further organisations

		Can develop consistent approach	
	Commissioners come together with shared line management and pooled commissioning budgets (for services in scope of integration) but employer remains the existing organisation	• Budget reduction through reduced management function • Strategic and operational oversight of complete integrated budget so can plan effectively • Minimise transactional costs of moving staff across organisations • Minimise risk of challenge on grounds of TUPE Legal agreement binding pooled budget to promote stabilisation	• Retention of original employer may create artificial barriers, preventing holistic service delivery • Can cause operational confusion through different T&Cs
	Commissioners and pooled budgets transfer into one existing organisation (via TUPE), thereby changing employer for some staff	• Alignment of roles and grades across the function • Budget reduction through reduced management function • Strategic and operational oversight of complete integrated budget so can plan effectively • Single organisation is responsible for all commissioning – simpler for providers • Greater opportunities for career specialisation and progression for staff Could be divested into a separate entity at a later date	• Will require robust shared governance • Receiving 'host' organisation assumes superior position in decision-making • Loss of influence by transferring organisation • Potential for destabilisation if trust breaks down between the two organisations • Potential negative impact on staff T&Cs • Risk of challenge over redundancies if TUPE follows a restructure Transactional time and cost of transferring staff
Maximum	Commissioners and pooled budgets come together to create a new commissioning entity with potential to grow in terms of geography, scope and partners	• Potential to sell services to other organisations/broaden remit of commissioning function • Potential to broaden membership to other organisations • Perception of independence makes partners equal • Strategic and operational	• Cost of creating a new entity • Cost of overheads of operating a new entity • Potential increased procurement costs • Lack of accountability for the commissioning entity • Potential challenge under terms of 'state aid' Perception of 'outsourcing'

		oversight of complete integrated budget so can plan effectively • Single organisation is responsible for all commissioning – simpler for providers Greater opportunities for career progression for staff	the commissioning function is politically unsavoury

Given the stated ambition of Plymouth City Council and NEW Devon CCG to achieve a step change in the way public services are planned and delivered, a key finding of the options appraisal process was that only three of the four are now considered to be a possibility. The minimum scope of opportunity has been rejected due to the level of integration not being sufficient enough to deliver the desired outcomes and the significant and time-critical budget pressures facing the two organisations.

Option 1	Option 2	Option 3
Commissioners come together with shared line management and pooled commissioning budgets (for services in scope of integration) but employer remains the existing organisation	***Commissioners and pooled budgets transfer into one existing organisation (via TUPE), thereby changing employer for some staff (PCC lead or CCG lead)***	***Commissioners and pooled budgets come together to create a new commissioning entity with potential to grow in terms of geography, scope and partners***

4.2 Recommended Option

Partners are committed to improving services and outcomes for individuals and communities and recognise that to achieve this, a commitment to option 3, therefore achieving the largest scale of commissioning change possible is required. However, it is also recognised that due diligence will need to be undertaken, with measurable steps along the way.

Therefore in order to build momentum to achieve change at scale and pace it is recommended that Option 3 is achieved, with Option 1 progressed between now and March 2015, acting as a transitional option. The options appraisal concluded this recommendation because it:

- Will maximise the opportunity to deliver a truly joint up approach to delivering services and meeting individual needs, consequently improving health and wellbeing outcomes for the people of Plymouth
- Enables most efficient use of resources

- Allows maximum oversight of budget and systems
- Simplifies governance and accountability structures

Whilst also mitigation against key risks identified, which were:

- Staffing discrepancies across different organisations
- Protects against future organisational changes
- 'Silo' mentality working

4.3 Integrated Commissioning Function

Presently NEW Devon CCG and Plymouth City Council have different approaches to commissioning and have consequently structured commissioning delivery differently. Part of the Integrated Commissioning Project will be to map the "as is" process of both organisations, build on best practice and work with staff and stakeholders to co-produce and co-design a new commissioning function. The component parts of the new function are not at this stage known however a useful guide of what an integrated commissioning function may contain has been provided by Institute of Public Care

Areas	Integrated approaches, objectives, plans, decisions, and actions are arrived at through a single organisation or network.
Purpose and Strategy	• Inclusive planning and decision process as an integral partner • A transparent relationship between integrated bodies • Single agency with one commissioning function
Stakeholder Engagement	• A single team is responsible for systematic planning and delivery of provider consultation to inform a single strategy.
Needs and Market Intelligence	• Single projects undertaking needs and market analysis and using these to inform commissioning and contracting priorities. • Single research, analysis, public health teams.
Resource allocation and management	• Pooled budgets within a single agency or network, to meet combined needs identified for the population.
Market management and monitoring	• Integrated monitoring and review arrangements that result in a shared understanding of the effectiveness of current services and the evidence for changes in the future.
Contracting	• Single function responsible for managing contracts to meet a single commissioning agenda.

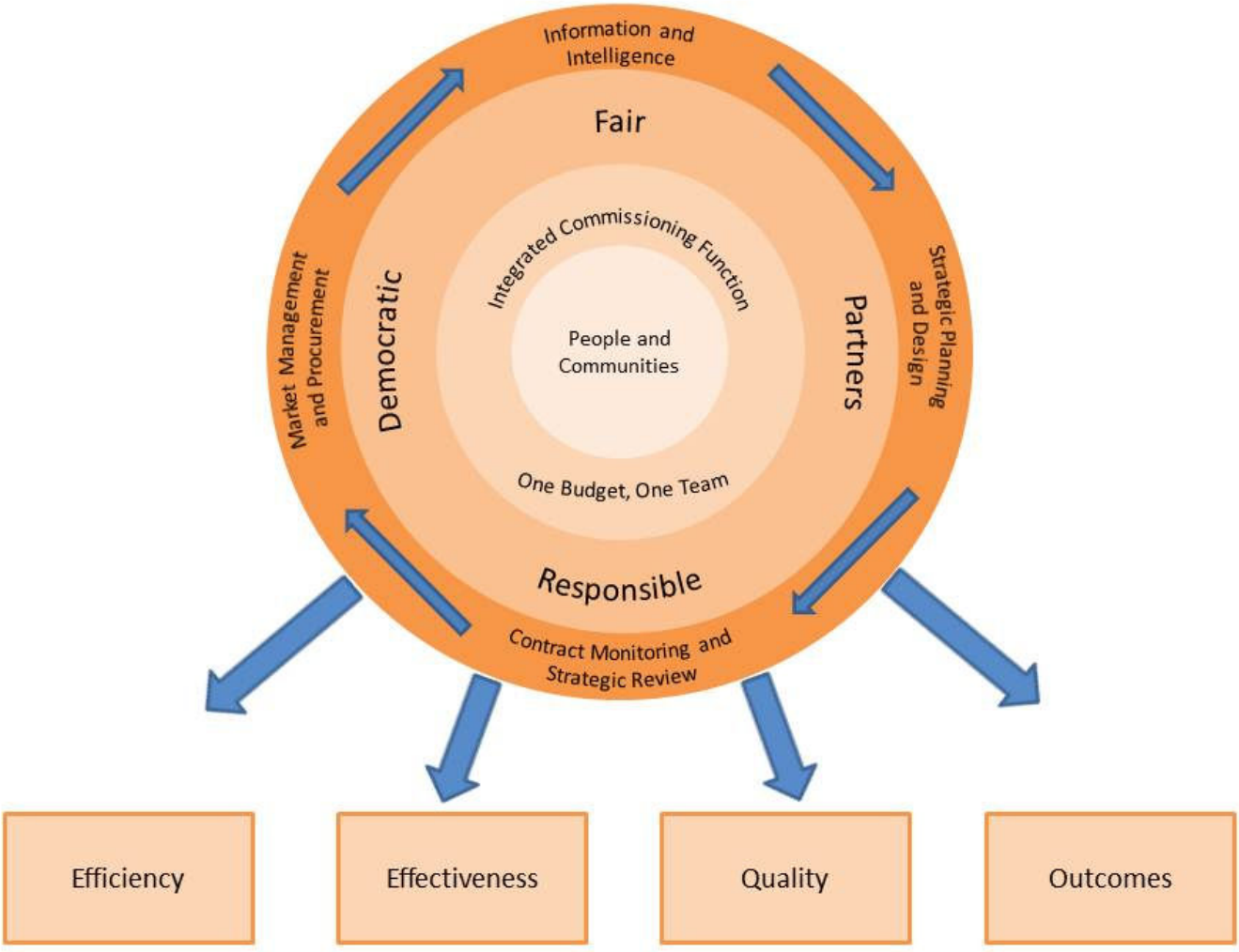
Commissioning Functions	• Integrated commissioning function, e.g. a single manager with responsibility for managing commissioning and contracting within a single organisation or network.

Fundamental to the new commissioning function will be an enhanced role for an integrated intelligence function that will drive prioritisation of resources, evidence based interventions and innovative models of care and support.

Underpinning this design will also be a commitment to organisational development by supporting the emergence of core competencies, skills and behaviours necessary to make integrated commissioning sustainable and successful.

And of course at the heart of this commissioning approach will be co-operative values of being democratic, responsible, fair and partners.

Based on these factors the following diagram illustrates the potential design of the integrated commissioning function:



Governance and risk sharing arrangements will be developed during the delivery phase during the period September – October 2014.

Extensive legal input will be required during the next phase of the project.

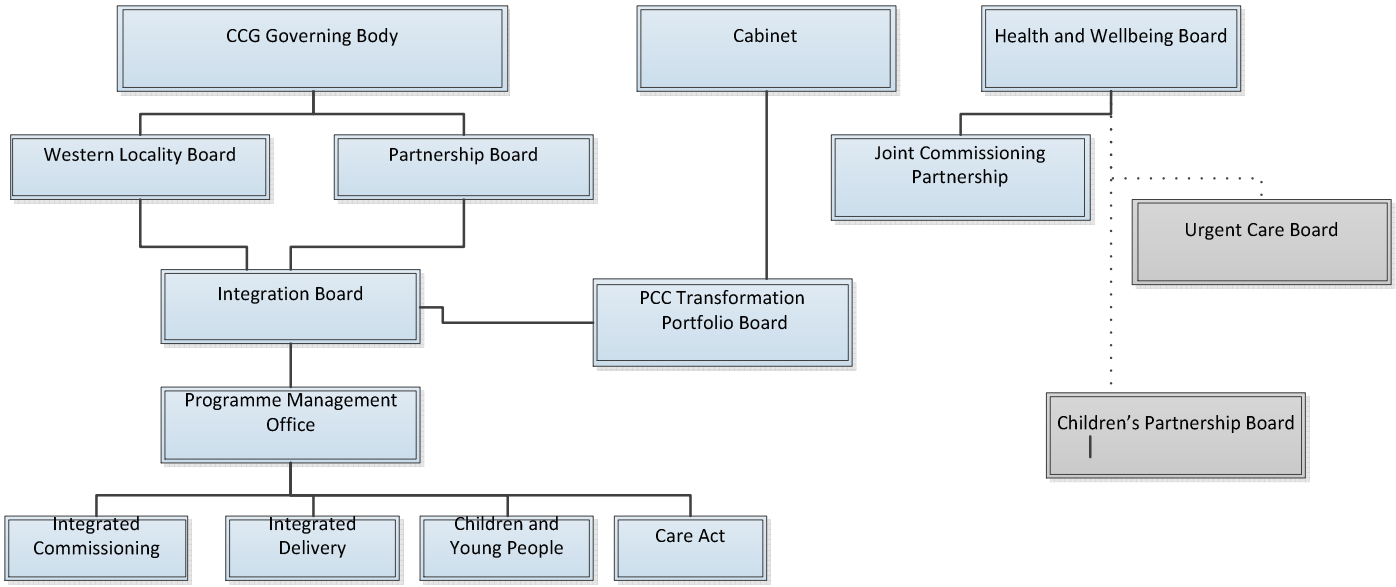
Transformation Portfolio Assurance and Enterprise Architecture

Formal sign off to the project will be granted in November 2014 following detailed design and project plan development.

5. PROJECT APPROACH

5.1 Programme Organisation

The programme has the following governance structure:



This is the indicative role and membership of the new HWB Integration Programme Board and its relationship with other governing bodies. Size and composition are built to enable swift change and can be supplemented to broaden representation:

HWB Integration Board

Responsible for steer and sign-off of programme initiatives

Members:

- MD- Western Locality, CCG (Vice-chair & SRO)
- Director of People, PCC (Vice-chair & SRO)
- Director of Public Health
- Chair of CCG
- MD – Partnerships, CCG
- AD - Joint Commissioning, PCC
- AD - Education, Learning & Families, PCC
- Area Team representative, NHS

PCC Portfolio Board

Responsible for ensuring compliance with overall transformation blueprint and monitoring delivery and benefits

NEW Devon CCG Board

Responsible for ensuring compliance with overall CCG requirements and monitoring delivery and benefits

Health & Wellbeing Board

Responsible for oversight of transformation programme and ensuring alignment with other initiatives and H&WB strategy

Joint Commissioning Partnership

Responsible for BAU commissioning during transformation, but after can merge with HWB Integration Board

Urgent Care Board

Responsible for oversight of BAU functions for urgent care delivery

Project groups

Responsible for designing solution, identifying benefits, resource requirements and delivering the projects

Programme Management Office

Responsible for co-ordination of the transformation projects

Children's Partnership Board

Responsible for BAU function but reporting into the Health & Wellbeing Board for oversight

The following table provides an overview of the responsibilities of each of these bodies in relation to the HWB Integration Programme:

Programme Activity	PCC transformation	CCG Board	HWB	Integration	PMO	Project Group
Ensure alignment to transformation blueprint	□					
Ensure alignment to NEW Devon CCG priorities and strategy		□				
Ensure alignment to Health & Wellbeing Strategy			□			
Set programme vision and strategy				□		
Define Programme Scope				□		
Identify improvement opportunities				□		□
Design solution & plan						□
Identify investment & resource requirements					□	□
Sign-off on investment, plan and resources				□		
Deliver project initiatives						□
Report on progress, benefits and risks						□
Monitor progress against plan					□	
Manage integration interdependencies					□	

5.2 Proposed Governance & Structure

Senior Responsible Officer: Carole Burgoyne (PCC), Jerry Clough (NEW Devon CCG)

Project Executives: Nicola Jones, Craig McArdle

Programme Manager: Craig Williams

Project Managers: Anna Coles, Lynne Kilner

Project Support: Alex Mehaffey

Finance: Paul Hardwick, Ben Chilcott

Business Architect: Mark Appleby

Communications: Nicola Morgan, Sam Sposito

Business Change: Lisa Woodman

Legal: Linda Torney

HR: Emma Rose

6. COMMUNICATION APPROACH

A Communications Plan for the Project and Programme has been developed jointly by The CCG and PCC. This will form the basis of the overarching communication strategy for this project, which will be continuously developed. Key activities in relation to this project include:

- Briefings and workshops with Members and GPs
- Communication Sessions, with Staff, Stakeholders and Partners
- Regular written and face to face briefings
- Co-design workshops with staff

7. HIGH LEVEL ROAD MAP TO INTEGRATING COMMISSIONING

Activity	Timeframe
Approval of Detailed Business Cases	
Cabinet (PCC)	15th July 2014
NEW Devon CCG Governing Body	16th July 2014
Development of Project Initiation Document	June- July 2014
Mapping of "As Is" Commissioning Process	June-July 2014
Establishment of shadow Leadership Board and development of shadow budgets	June 2014
Consultation and Engagement with staff	June 2014 - Onwards
Consultation and Engagement with partners	June 2014 - Onwards
Review of Commissioning Activity across the whole of the People Directorate	July- August 2014
Redesign and Remodel PCC People Co-operative Commissioning Hub	September 2014
Design of competencies, skills and behaviours matrix	September-October 2014
Member and GP Governance Workshops	September 2014
Develop New Integrated Commissioning Governance Architecture	September – October 2014
Develop Section 75 agreement	September – October 2014
Section 75 to Cabinet	November
Design function and form of new Commissioning Organisation	September – October 2014
New Integrated Commissioning Function in place	March 2015
Develop of Commissioning Strategies (bed based/communities/wellness)	Now - March 2015

Commissioning in line with Strategic Framework	2015-2016
Development of Integrated Commissioning Organisation	2015-2016

8. VALUE ANALYSIS – COSTS, BENEFITS & RISKS

8.1 Finance Commentary

1) Figures detailed in the outline business case for integrated commissioning were indicative figures based on the evidence and research provided by Ernst Young. The financial benefits envisaged over the three financial years of 2014/15 to 2016/17 are detailed in the table below and have been built into the council's three year balanced budget (as approved by Full Council in February 2014).

Financial benefits as detailed in 3 year balanced budget

	2014/15 £000	2015/16 £000	2016/17 £000	Total for 3 years £000
Integrated Health & Wellbeing budget savings (PCC element only)	1,500	5,900	9,500	16,900
Planned savings attributable to 'integrated commissioning' strand	325			

2) Financial benefits from this programme clearly accrue for both Plymouth City Council and the Clinical Commissioning Group in terms of how we join up our services and focus on the combined right outcomes for people. Savings mainly relate to two key areas:

(a) Staffing and administrative savings through integrating commissioning teams. We will drive savings by rationalising management and streamlining process and supporting systems to reflect best practice resulting in improved operational efficiencies and;

(b) Adopting smarter practice on how, and what we commission. Focused around supporting people in the community, investing more in self enabling, early intervention and preventative services and reducing spend on traditional council and health run services.

3) Due to the complexity of integrating two large commissioning functions, implementation will be phased in a structured way. Within this financial summary we have detailed a potential range of savings linked to each phase of implementation. Savings are calculated using 2014/15 approved revenue budgets as a base. It is difficult at this stage to determine the exact split of financial savings between PCC and CCG. For modelling purposes, we have applied a standard percentage range for each organisation until the future shape of commissioning is better defined. These percentages will be tested and updated as we progress through the implementation.

4) Clearly, the level of combined spend and service commissioning offers an opportunity to drive significant financial and non-financial benefit. However, it should be noted that both organisations are facing considerable financial pressures whilst operating as single entities. These pressures will remain under close scrutiny to ensure that financial savings are fully delivered against 2014/15 base budgets as opposed to just absorbing spend from increased demand.

5) Staffing rationalisation and driving efficient operations. The integration between the two organisations will phase in from the 2015/16 financial year. Within 2014/15, both organisations will refine and re-align their existing practices and structures in preparation for the integration.

Integrated Commissioning – estimated staffing savings

Staffing	Existing spend £000	2014/15		2015/16		2016/17	
		Lower @ 2% £000	Higher @ 5% £000	Lower @ 5% £000	Higher @ 8% £000	Lower @ 7% £000	Higher @ 10% £000
PCC 14/15 base	1,629	32	81	81	130	114	163
CCG 14/15 base	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Total savings							

6) The biggest bulk of spend, and therefore associated savings are the actual commissioning budgets relevant to this transformation programme. For PCC, our base budget for 2014/15 amounts to £22.2m with a further XXXm attributable to the CCG.

7) We will be working to pool all resources and budgets for the provision of:

(a) Wellness services;
(b) Community intervention;
(c) Complex and bed based care (excluding acute);

8) There are a range of planned activities that will deliver financial benefit through integrated commissioning. At this stage, we have not assigned a financial value to each specific activity, but have specified a range of potential savings based on phased implementation of all of the planned actions across the three years. The core activities that will deliver the savings are:

- In 2014/15 both organisations will constructively review and challenge existing contracted spend to include rationalisation of smaller contracts where relevant;
- Integrating well-being commissioning strategies will be co-designed, developed and implemented;
- Integrating health and social care community delivery;
- Providing high cost support to complex needs cases will be reviewed and modified;
- Out of area placements will be reviewed to evaluate more local, cost effective solutions whilst focussing on improving the level of care provided;
- Integrated strategies will retain a focus on reducing demand for high cost residential, nursing and hospital placements – placing a greater share of resources to early intervention, preventative services and enabling support;

9) The introduction of Telecare / Telehealth systems will also deliver significant financial benefits having proven to reduce visits to GPs by up to 69% and hospital admissions by up to 50%. Implementation of such self-management systems will commence in 2015/16.

10) Our estimated range of non-staffing savings attributable to the integrated commissioning project are detailed below:

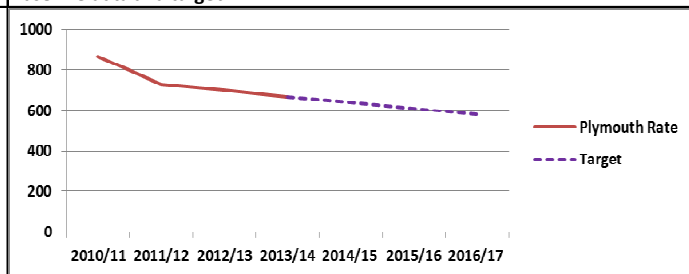
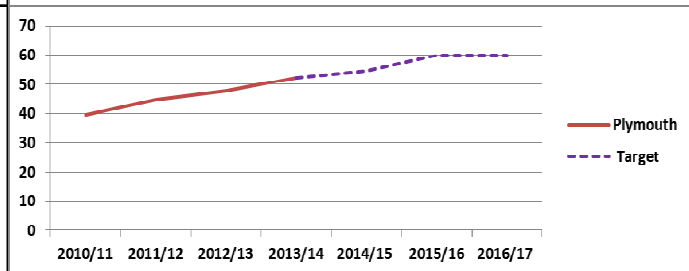
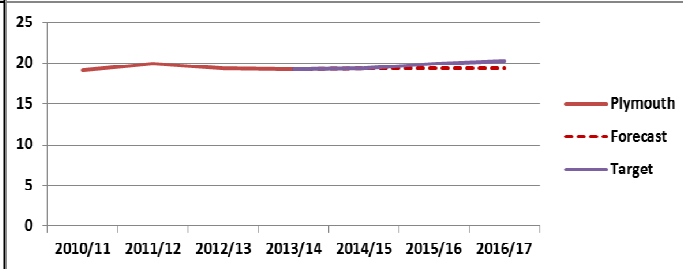
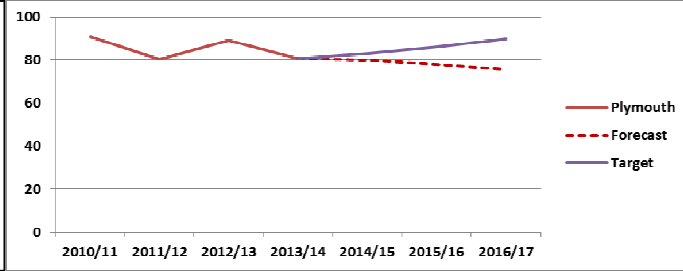
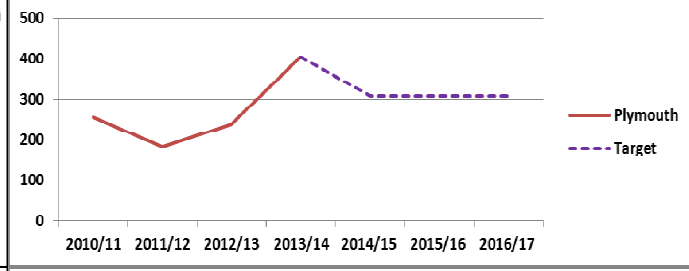
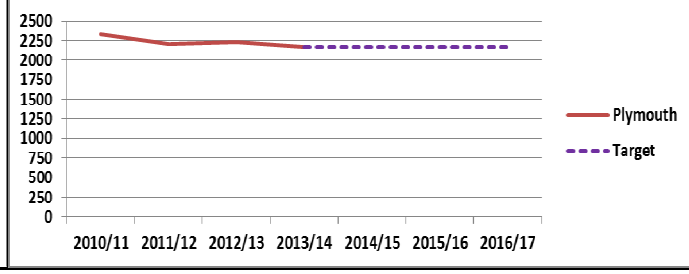
Integrated Commissioning – estimated non- staffing, commissioning savings

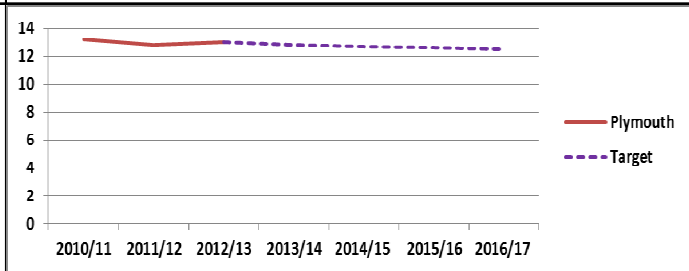
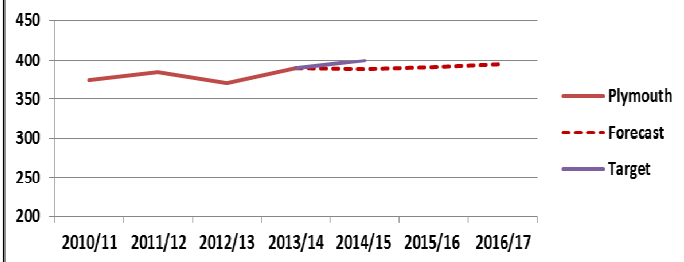
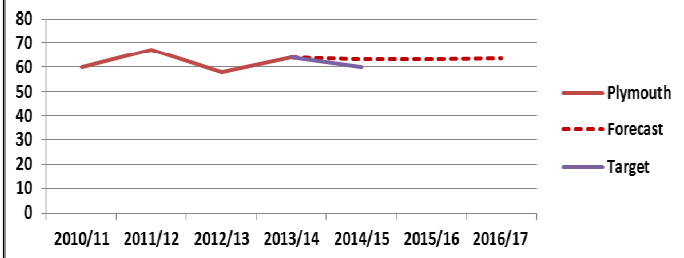
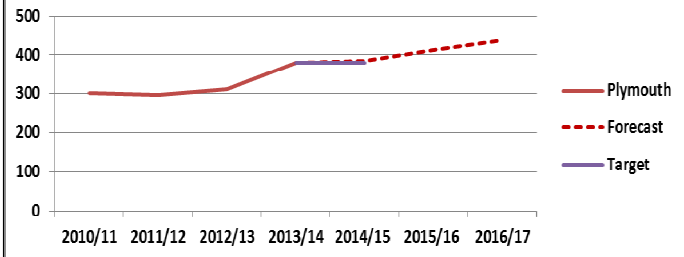
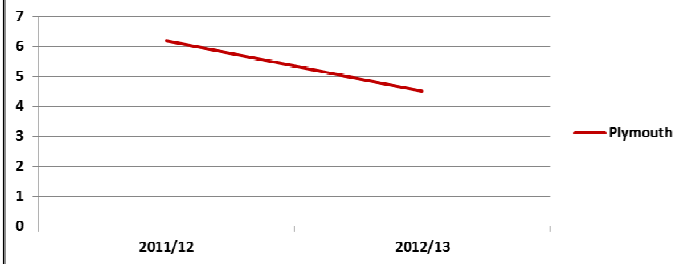
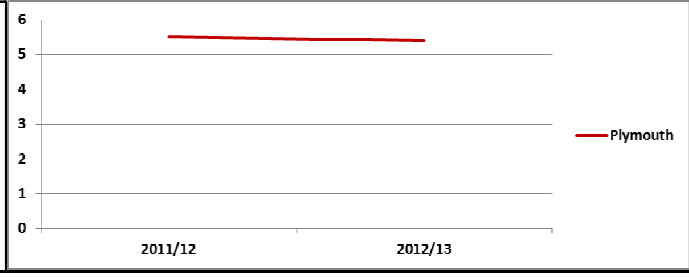
Commissioning function	Existing spend £000	2014/15		2015/16		2016/17	
		Lower @ 1% £000	Higher @ 2% £000	Lower @ 3% £000	Higher @ 7% £000	Lower @ 8% £000	Higher @ 12% £000
PCC 14/15 base	22,167	222	443	665	1,552	1,773	2,660
CCG 14/15 base	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Total savings							

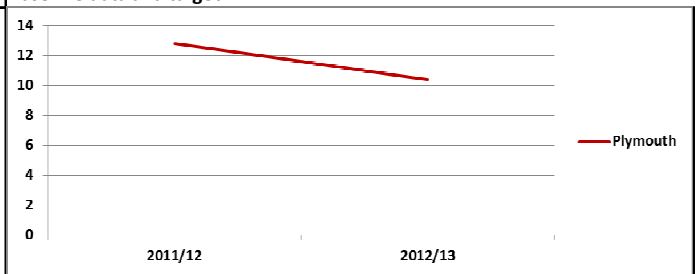
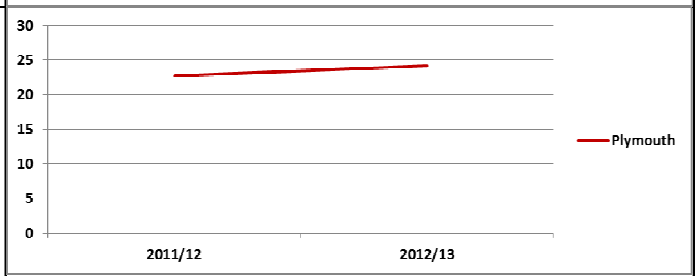
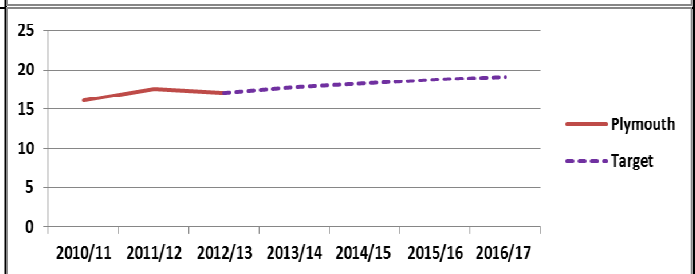
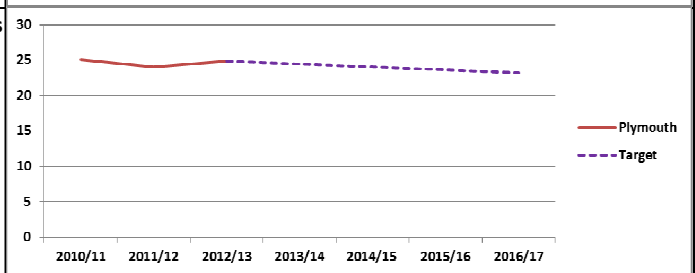
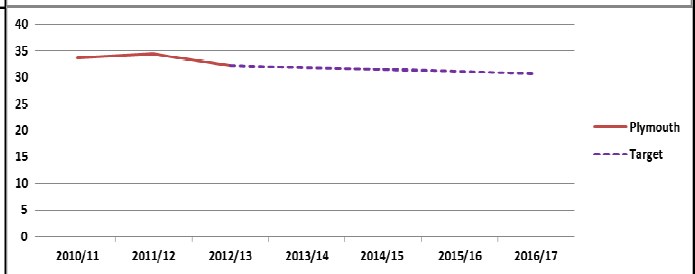
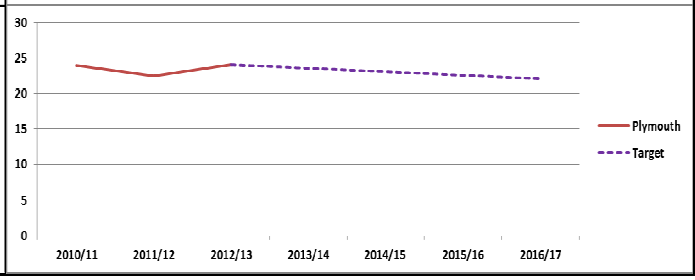
11) The combination of the potential savings across the integrated commissioning project and the wider health and wellbeing transformation programme has the potential to exceed the transformation benefit figures stated in PCC's 3 year balanced budget. However, based on existing increasing trends and complexity in client demand, it will be essential for the programme to over-achieve in order to offset escalating spend in both health and Adult Social Care. Resource assumptions and re-profiled client trend data will be fed into a refresh of the council's medium term financial strategy in September 2014.

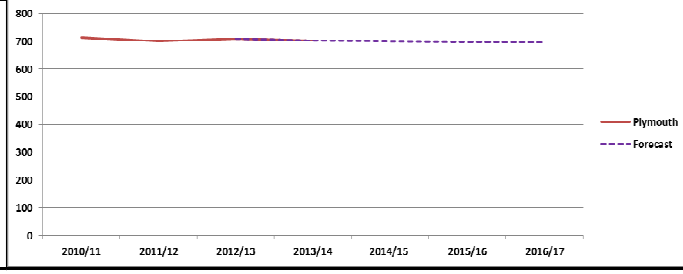
8.2 Benefits- Improved Health and Wellbeing Outcomes

A fundamental aim of the Integrated Commissioning Project is to drive system improvement to deliver improved outcomes for individuals and communities. Key measures that the project will impact on are set out below, including those in the BCF;

Category	Performance Measure	Baseline data and target	
Community	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population		To achieve the forecast reduction by 2016/17 equating to a 13% reduction in the rate per 100,000
Community	Estimated Diagnosis rate for people with Dementia		To achieve the national target of 60%
Community	Social Care related quality of life		To achieve a 5% improvement in quality of life score
Community	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services		To achieve Better Care Fund targets and return to 90% rehabilitation success
Bed Based	Delayed transfers of care from hospital per 100,000 population (average days per month)		Target - To reduce and return to national average by 2016/17
Bed Based	Avoidable emergency admissions		To maintain performance

Category	Performance Measure	Baseline data and target	
Bed Based	30 day readmissions		To achieve a 4% reduction
Childrens	Number of Children in Care - Overall		To achieve Children Social Care business targets for the next three years.
Childrens	Number of Children in Care - Independent		To achieve Children Social Care business targets for the next three years.
Childrens	Number of Children with a Child Protection Plan		To achieve Children Social Care business targets for the next three years.
Wellbeing	Self Reported Wellbeing - People with a low satisfaction score		To decrease and better the national and regional averages based on responses to ONS well-being survey.
Wellbeing	Self Reported Wellbeing - People with a low worthwhile score		To decrease and better the national and regional averages based on responses to ONS well-being survey.

Category	Performance Measure	Baseline data and target	
Wellbeing	Self Reported Wellbeing - People with a low happiness score		To decrease and better the national and regional averages based on responses to ONS well-being survey.
Wellbeing	Self Reported Wellbeing - People with a high anxiety score		To decrease and better the national and regional averages based on responses to ONS well-being survey.
Wellbeing	Emotional Wellbeing of looked after children		To maintain performance above the national and regional averages
Wellbeing	Excess weight in 4 - 5 year olds		To halt the increase of excess weight in childhood (reception) in Plymouth and then decrease it by 5.4% by 2021/22. Measured as a %
Wellbeing	Excess weight in 10 - 11 year olds		To halt the increase of excess weight in childhood (year six) in Plymouth and then decrease it by 15.3% by 2021/22. Measured as a %
Wellbeing	Smoking prevalance in adults		To decrease smoking prevalence in Plymouth by 24.4% by 2021/22

Category	Performance Measure	Baseline data and target	
Wellbeing	Alcohol related admissions to Hospital		To reduce admissions and achieve target set in 2014/15 using new national recording methodology

8.3 Benefits – Organisational

As well as delivering efficiencies and improved outcomes the project aims to deliver on a number of organisational ambitions:

For the workforce

- Providing greater and more flexible career opportunities and ability for up skilling/ skills transfer between professionals
- Integrated workforce plan designed to deliver service strategies
- Fewer barriers to effective decision making
- Ability to focus on delivering support to citizens
- Focus on culture change, empowering staff to take ownership of delivering high quality services

For commissioners

- Established protocols and pathways to ensure clear governance arrangements are in place
- A system that is accountable to users and has been designed with their involvement
- Joint investment in early identification, prevention and early intervention to prevent escalation of needs
- Financial risk sharing arrangement to ensure value for money
- Transparent performance and financial framework supported by joint governance to ensure robust management of quality and costs
- Development of strong working relationships between community services, acute services and Primary Care through implementation of Integrated Case Management

For providers

- Critical mass of services to enable flexible use of resources
- Opportunity to invest due to greater financial certainty and delivery flexibility
- Increasing productivity and accelerating improvements in service quality through working with all stakeholders to redesign services.
- Reducing waste in the system through eliminating the amount of duplication
- Making better use of community assets due to flexibility and removal of organisational boundaries
- More integrated back-office and support function to provide seamless support and enable efficiencies
- Simplified contracting arrangements and more focus on effective delivery

8.4 Benefits- Project End State

The project aims to bring about the following step change in the way services are commissioned and delivered and at the end of the project the following distinct elements will be in place:

- **Single commissioning**: Commissioners from both organisations will work together to produce single service specifications for the delivery of services funded from a single integrated budget.
- **Single decision-making**: Senior managers and clinicians from the local authority and CCG, guided by the Health and Wellbeing Board, will make evidence based and informed decisions together rather than as separate organisations.
- **Commissioning will be co- designed and co-produced with people, communities, and providers including** voluntary sector organisations and GP Practices: We need to work together to develop our providers and engage with GPs in Plymouth's communities.
- IT systems will work and speak to each other across organisational boundaries.
- "Whole system' measures of success will drive the integrated commissioning of services.

What will people in Plymouth see as a result?

- Easier and earlier access to services that promote wellbeing or that provide help in a crisis
- People empowered to take control of their own health and wellbeing
- Local communities in Plymouth are increasingly supported by strong links between GPs, schools, social workers and community organisations, which helps people like them to stay independent for longer.
- Older people who have come out of hospital are helped to stay at home.
- Families and carers will not have to chase professionals or ask them to talk to each other.
- Children with a learning disability and their families and carers are supported in managing their needs and can trust that when they turn 25 they will continue to receive the support they need.
- Developing social capital that enhances the lives of people in Plymouth through providing local resources that support a greater emphasis on prevention and early intervention.

9. RISKS AND DEPENDENCIES

9.1 Risks & Impact

Risk Description (A short summary of the event)	Current Risk Rating	Actions to reduce risk to target
Savings delivered from the integration are not sufficient to meet the funding gap		Scrutiny and validation of the business case, and the projected benefits in further phases Account for optimism bias in financial model when developed
Staff/union resistance to the proposed changes and service redesign		1. Early consultation with Unions 2. Union representation at key workshops.
Difficulty in securing agreement across the partners to service redesign causes delay in delivery leading to savings targets being leaked, and delaying benefits realisation		1. Areas of potential disagreement highlighted and discussed early in the process 2. Identification of key decision makers and a dispute resolution process 3. Formal agreements and protocols in place to enable teams to work together
Multiple parties involved leading to partial support for business case or different decisions being made, which delays implementation		1. Key stakeholders identified at the start of the project and engaged regularly 2. Communications plan in place and key stakeholders provided with regular updates
Assumptions made will be wrong due to baseline data not being robust and so the business case is undermined		1. Validation of the baseline data finance, the savings opportunities by service professionals 2. Validation and ownership of the financial model by finance and service areas
Statutory, regulatory or political differences between Health and Social Care or partners lead to tensions (e.g. footprint of NEW Devon CCG will delay approval of business case and implementation)		1. Potential areas of conflict identified early and formal protocols or agreements put in place
New legislation introduced which impacts on plans (e.g. Care Bill and Dilnot)		1.Remain well-informed of policy and legislative developments and build in necessary changes early and challenge solution development
Negative impact of procurement or tax requirements on new delivery mechanism, for example VAT regulations		1. Consider likely impact of during the Options Appraisal process if new delivery vehicles/alternative structures are considered
Legal challenge regarding competition, contracting and procurement		1. Ensure notice periods to providers are duly followed and all consultation is documented
Resources required to deliver integration are not available/ funding does not exist to commission external resources		1. Develop programme delivery plan and get cross party sign up to this 2.Cross- party investment planning meeting to agree resource commitment

Failing to reach agreed terms that are compliant with Teckal criteria, due to differing legal opinions		1. Follow a long term view or phased approach to delivery model design and implementation. (i.e. implementing one delivery model for a short term with a view of moving to another in the long term) 2. Regular compliance checks and discussions
CCO objectives may not be achieved in time to support planned 2014/15 service improvements in People & Place directorates (e.g. finance, HR, ICT, FM, business support). This has the potential to delay achieving cashable savings for the IHWB programme if not resolved		1. PCC / Portfolio guidance needed on what flexibility and freedom business areas have to determine what it can change independently and where it must follow the corporate line. Clarification over attribution of benefits: savings in support services are attributable to CCO irrespective of origin of the saving (in the same way as all premises savings are P&OD's)
Impact of OFSTED and other changes/request for changes on IT systems		1. Reinstating working group to prioritise changes
Market of providers lose confidence in commissioner		1. Early engagement of key partners and market in plans 2. Involvement of partners in development of clusters

9.2 Dependencies

NEW Devon CCG has a number of organisational interdependencies. These include those with Devon County Council, and West Devon and South Hams District Councils, since the Western Locality of the CCG (which includes the entire Plymouth footprint) also includes populations within Devon. There is also an interdependency to consider within the Partnerships Locality, which commissions a variety of services across the whole of the NEW Devon footprint, and it is therefore possible that commissioning decisions taken as a result of this programme may have an impact on those in other localities.

Organisation	The PCC Blueprint will drive the way in which The Council operates in the future, and as such it is vital that the project is compliant with this document.
Organisation	NEW Devon's relationship with Kernow CCG as an associate commissioner of e.g. the contract held with Plymouth Hospitals NHS Trust.
Programme/Project	Other programmes within The PCC Transformation Portfolio will provide support around engaging with staff, developing new ways of working and redesigning customer service.

9.3 Constraints

There is a constraint around delegated authority for approving decisions concerning integration within the CCG. Plymouth City is exclusively within the Western Locality of the CCG, but decisions around integrated commissioning and provision, and the alignment with the Transforming Community Services programme, will potentially affect other localities within the CCG, meaning that a decision will be needed by the CCG Governing Body as well as support from the Western Locality Board.

PLYMOUTH CITY COUNCIL

Subject:	Integrated Community Health and Social Care Delivery
Committee:	Cabinet
Date:	15 July 2014
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Carole Burgoyne (Strategic Director for People)
Authors:	Dave Simpkins (Assistant Director of Adult Social Care and Co-operative Commissioning, PCC) Nicola Jones (Head of Western Locality Programmes, NEW Devon CCG)
Contact details	Tel: 01752 306820 email: Dave.Simpkins@plymouth.gov.uk
Ref:	IHWB/SD
Key Decision:	Yes
Part:	I

Purpose of the report:

The purpose of this report is to seek Cabinet's approval of a Business Case that sets out how Plymouth City Council and Northern, Eastern and Western Devon CCG are to take forward Integrated Community Health and Social Care Delivery, in line with the Health and Wellbeing Board's vision of achieving Integration by 2016.

Many users of health and social care services experience care that is fragmented, with services reflecting professional and institutional boundaries when it should be co-ordinated around their needs. This can result in duplication, inefficiency, gaps in care, feelings that 'no-one is in charge' and ultimately poor outcomes.

National policy and guidance sets a clear direction that the services of the future must be based on simple pathways of care and support, focusing on individual outcomes and quality of life indices.

With the customer requirements combined with key drivers such as the Better Care Fund, Care Closer to Home, NEW Devon CCG strategy and initiatives such as Admission Avoidance the emphasis in setting up the integrated function requires a significant focus on services based in the Community.

The current service configuration and existing working relationships provides an opportunity to transform the community system to support more people in their own homes and to prevent admissions to more acute forms of provision.

DRAFT

Based on the personalisation agenda in 2011 Adult Social Care transformed and reconfigured to enable individuals requiring support to have timely access to advice, information and customer centred assistance. By providing personal budgets, the department has offered greater choice and control to the citizens of Plymouth.

In September 2013, Adult Social Care worked in partnership with Plymouth Community Healthcare, Plymouth Hospitals Trust and the voluntary sector to develop an integrated service to facilitate timely discharges from hospital and prevent hospital admissions when appropriate.

These approaches to the delivery of support have received extremely positive feedback from members of the public, users of the services and referrers to the service. The offers use the same key principles placing the individual in the centre whilst wrapping support around them, ensuring they have choice in how their care and support is delivered.

It is anticipated that by identifying and developing further areas where an integrated approach to service delivery will be beneficial, citizens of Plymouth will have improved access to the right support, at the right time and by the right person. This will remove current duplication and support statutory services to meet the growing demand of complex health and social care need across the city.

What will this Project mean for Plymouth?

In 2014-15 we shall work towards achieving the following:

- An offer which places the person in the centre and arranges appropriate support when needed 24/7
- An emphasis on self-management and prevention including the use of assistive technology
- A reduction in bed based support and a shift to community assistance
- A single contact point for all incoming work
- An integrated IT system
- A shared set of documentation
- A reconfiguration and remodelling of community services to deliver wrap around care
- Significant engagement with Voluntary sector to develop improved pathways
- Development of an Integrated Delivery specification

What will local people see as a result?

- Widespread engagement in how services are designed
- More care delivered in the community
- Better access to condition management information
- Only needing to tell their story once
- Improved sharing of information to enable people to make their own choices
- Support from an well informed professional worker who can provide information or assistance at the time it is needed
- Opportunity to take a lead in the on-going shaping of services

The Brilliant Co-operative Council Corporate Plan 2013/14 - 2016/17:

The propositions made in this business case align to the Plymouth City Council Corporate Plan by working co-operatively to meet the objectives of creating a Caring and Pioneering Plymouth. It also aligns to the Health and Wellbeing Board's vision of achieving Integration by 2016, as decided in June 2013.

This project will support the Corporate Vision through:

- Being **pioneering** in developing and delivering quality, innovative brilliant services with our citizens and partners that make a real difference to the health and well- being of the residents of Plymouth through challenging economic times.
- **Growing** Plymouth through learning and community development creating opportunities for vulnerable people to develop, making us and them stronger and more confident as a result.
- Putting citizens at the heart of their communities and work with our partners to help us **care for Plymouth**. We will achieve this together by supporting communities, help them develop existing and new enterprises, redesign existing services which will in turn create new jobs, raise aspirations, improve health and educational outcomes and make the city a brilliant place to live, to work and create a future for all that reflects our guiding co-operative values.
- Raising aspirations, improving education, increasing economic growth and regeneration people will have increased **confidence in Plymouth**. With citizens, visitors and investors identifying us as a "vibrant, confident, pioneering, brilliant place to live and work" with an outstanding quality of life.

The Fairness Commission Recommendations:

This report will contribute to the response to the Fairness Commission recommendations scheduled for August 2014.

The Council 50 Pledges that the Delivery Project will address:

Caring Plymouth

44. Continue our pioneering work to make Plymouth a dementia friendly city.
45. Continue to work closely with the NHS to provide a seamless service for older people's care including smoother discharge from hospitals.

Implications for Medium Term Financial Plan and Resource Implications:

Including finance, human, IT and land

Transformation resources will be required for the duration of the project. These should be internal where possible and so will rely on staff being temporarily released from other areas of the organisation.

Requirement for Corporate Support (Legal, HR, Finance, etc.) will need to be managed due to the current high volume of requests for their support.

Project costs should be equally split between CCG and PCC.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

The report strengthens our approach to both Child Poverty and Community Safety by focusing on early intervention and prevention and giving every child the best start to life. In line with our Co-operative commissioning principles the approach adopted aims to build both community and individual capacity. Children living in families affected by poverty will feel the benefit of improved family health and wellbeing which directly and indirectly affects economic stability and resilience.

This report will contribute to the response to the Fairness Commission recommendations scheduled for August 2014.

The project will follow the Risk Management Strategy set out for Transformation Programmes and Projects by the Portfolio Office.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? Yes

When considering this proposal it is important to have due regard to the public sector equalities duties imposed upon the Council by section 149 Equalities Act 2010 to

- Eliminate unlawful discrimination, harassment and victimisation and
- Advance equality of opportunity between people who share a protected characteristic from those who do not and to
- Foster good relations between people who share protected characteristics and others

The relevant protected characteristics for this purpose are: (a) age; (b) disability; (c) gender reassignment; (d) pregnancy and maternity; (e) race; (f) religion or belief; (g) sex; (h) sexual orientation.

Compliance with the duties in this section may involve treating some persons more favourably than others.

A programme wide detailed equality impact assessment has been completed and will be updated throughout the process.

Recommendations and Reasons for recommended action:

Public Services are facing challenges from rising demand, increased complexity and financial pressures. To address these concerns and improve outcomes for service users and patients, Plymouth City Council and NEW Devon CCG propose to integrate health and social care services.

The recommendations drawn from the analysis are:

1. Plymouth City Council to work with NEW Devon CCG to develop a Section 75 agreement that pools relevant Adult Social Care and CCG budgets to facilitate the creation of a single community health and social care delivery model
2. Plymouth City Council to work with NEW Devon CCG to develop robust governance, contractual and financial systems that provide appropriate assurance to both organisations
3. Plymouth City Council works with NEW Devon CCG and Plymouth Community Healthcare (PCH) as the incumbent local community health provider, on developing and evaluating options for the integration of Community Health and Adult Social service delivery in the City by April 2015.
4. To consult with staff, unions and stakeholders in developing the new service model.
5. The final position to be presented to Cabinet and NEW Devon CCG Governing Body in November 2014 for decision.

Alternative options considered and rejected:

1. *'Do Nothing'*

This option has been considered however this has been rejected due to the significant and time-critical budget pressures facing Plymouth City Council and NEW Devon CCG meaning that this option is not feasible.

2. *Delivery workforce remains in existing structures. Pathways for people requiring support are reviewed and streamlined. Budgets are re-profiled to follow individuals.*

And;

Delivery workforce is re-configured to sit with shared line management arrangements linked to individual pathways. Staffing budgets are aligned accordingly.

Agreement was made during the options appraisal process that these two options would not generate the customer benefit or financial savings that we are aspiring to achieve, and so were discounted as options.

3. *Delivery services' staff come together under single management with some provision budgets joined to support specific pathways.*
This option raised concerns regarding achievable benefits, which would only be achieved through pooling budgets, as in the recommended option.

Partners are committed to improving services and outcomes for individuals and communities and recognise that to achieve this, a commitment to achieving the largest scale of integration possible is required.

Published work / information:

Corporate Plan 2013/2014 – 2016/2017, Report to City Council, 22nd July 2013.
http://www.plymouth.gov.uk/mgInternet/documents/s48110/Corporate%20Plan%20Full20Council%2022.07.13.pdf

The Brilliant Cooperative Council Three Year Plan, Report to City Council, 16th September 2013.
http://www.plymouth.gov.uk/mgInternet/documents/s48110/Corporate%20Plan%20Full%20Council%2
022.07.13.pdf

The Brilliant Cooperative Council Three Year Plan, Report to Cooperative Scrutiny Board, 16th October 2013.
http://www.plymouth.gov.uk/modgov?modgovlink=http%3A%2F%2Fwww.plymouth.gov.uk%2FmgInten
et%2FieListDocuments.aspx%3FCId%3D1071%26amp%3BMId%3D5544%26amp%3BVer%3D4

Transformation Programme, Report to Cabinet 25th March 2014, including the IHWB Outline Business Case.
http://www.plymouth.gov.uk/mgInternet/documents/s53610/transformation%20cabinet%20march%222014%20final%20MCv1%202.pdf

Health and Wellbeing Strategy, Published by Plymouth City Council, February 2014
http://www.plymouth.gov.uk/healthwellbeingstrategy.pdf

Co-operative Commissioning Framework, Published by Plymouth City Council
http://www.plymouth.gov.uk/cooperative_commissioning.pdf

NHS NEW Devon CCG Five-year Strategic Plan (draft), 4 April 2014

http://www.newdevonccg.nhs.uk/who-we-are/what-is-clinical-commissioning/commissioning-framework/100925

Your health, your future, your say – Western Locality's engagement report on Transforming Community Services
http://www.newdevonccg.nhs.uk/permanent-link/?rid=101537

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off:

Fin	mc14 15.20	Leg		Mon Off		HR	HR-CS2 5.6.14.	Assets		IT		Strat Proc	
Originating SMT Member: Dave Simpkins (Assistant Director of Adult Social Care and Co-operative Commissioning)													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

Integrated Health and Wellbeing

Business Case

Project Name:	**Integrated Community Health and Social Care Delivery**		
Date:	18-06-2014	**Version:**	1.7
Author:	Paul Walshe, Anna Coles, Dave Simpkins, Nicola Jones, Craig Williams, Mark Appleby		
Owner (SRO):	Jerry Clough/Carole Burgoyne		

Version	Date	Summary of Changes	Changes Marked
V1	14-05-2014	Initial Draft	PW
V1.2	22-05-2014	General amendments	PW
V1.3	03-06-2014	Feedback incorporated	PW
V1.4	18-06-2014	Amendments following feedback	PW/AC
V1.5	19-06-2014	Amendments following feedback	PW/AC/NJ/CW/MA
V1.6	23-06-2014	Amendments following feedback, also additions (Cabinet Front Sheet and Exec Summary)	PW/AC/CW
V1.7	24-06-2014	General Amendments	AM

Approvals				
Name	**Title**	**Signature**	**Date**	**Version**
Mark Appleby	Business Architect	E-mail	13-06-2014	V 1.03
Malcolm Coe				

This document has been distributed to:

Distribution			
Name	**Title**	**Date**	**Version**

CONTENTS

An introduction to the Plymouth City Council's Transformation Programme and NEW Devon CCG Transforming Community Services Strategy

Context:

2002-12: A Decade of Improvement

The City of Plymouth has had an extra-ordinary journey over the past ten years. A decade ago, it had a reputation as a city of low aspiration with a lack of vision, weak financial and strategic planning, poor relationships between agencies, and service delivery arrangements that did not meet the needs of all of its citizens. An acknowledgement of the determined and sometimes inspired effort that was then made to improve the city came in 2010 when the Council was voted 'Highest Achieving Council of the Year' by the Municipal Journal. Behind that accolade, foundations had been laid by successive political administrations of a clear, ambitious vision for the city, sound financial management arrangements, the development of strong strategic partnerships and a determined focus on the improvement of service delivery. The Council has acknowledged and embraced its role as a key player in influencing the broader city and regional agenda, driving economic growth and making coherent contributions to broader policy-making.

Drivers for Transformation:

The Brilliant Co-operative Council with less resources

On its adoption of a new Corporate Plan in July 2013, the council set the bar still higher, to become a Brilliant Co-operative Council. This 'Plan on a Page' commits the Council to achieving stretching objectives with measurable outcomes, and also sets out a Co-operative vision for the Council, creating a value-driven framework for the way that it will operate as well as the outcomes that it is committed to achieve.

The Corporate Plan was developed using the principles of a Co-operative Council. It is a short and focused document, but does not compromise on its evidence base, and was co-developed with the Cabinet of the Council, before being presented in person by members of the Corporate Management Team to every member of staff throughout the council at a series of 74 roadshows. The positive results of this commitment to strong communications and engagement were evidenced by 81% of council staff responding to the workplace survey conducted in October 2013 agreeing that they understand and support the values and objectives set out in the Corporate Plan.

The economic, demographic and policy environment affecting public services is accepted as the most challenging in a generation. At the same time as an aging population is placing increased demand on health and social care services, the UK is facing the longest, deepest and most sustained period of cuts to public services spending at least since World War II. The Council's Medium Term Financial plan identified in June 2013 funding cuts of £33million over the next three years which, when added to essential spend on service delivery amount to an estimated funding shortfall of circa £64.5million from 2014/15 to 2016/17, representing 30% of the Council's overall net revenue budget.

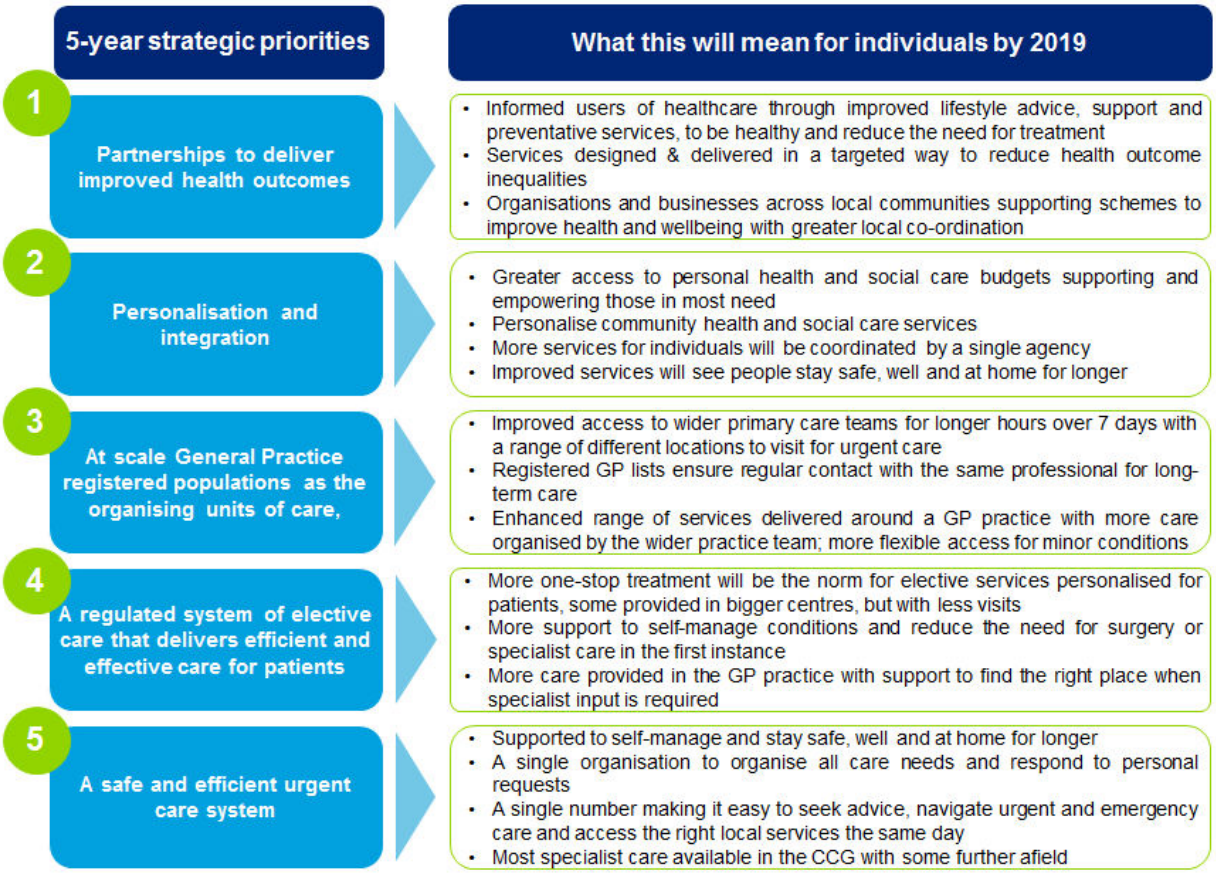
The Council has shown remarkable resilience in addressing reduced funding and increased demand in previous years, removing circa £30m of net revenue spend from 2011/12 to 2013/4 through proactive management and careful planning. However the Council has acknowledged that addressing further savings of the magnitude described above while delivering the ambitions of the Corporate Plan will require a radical change of approach.

Transforming Community Services:

NEW Devon CCG has initiated a programme, called Transforming Community Services, to remodel community health provision across each of its three localities. This programme aligns to the national Transforming Community Services programme, and the current programme plan involves the re-procurement of community services in Plymouth by April 2016.

The transforming communities consultation which has gathered feedback from people who use services and they described that they wanted 'Health care that does not stop at boundaries', services that see me as a person, not a condition', and 'safe and secure services with future proofing in mind'.

This engagement has resulted in the establishment of the key priorities which are depicted below:



Review of existing transformation programmes

The council commissioned Ernst and Young in June 2013 to:

- Examine the council's financial projections and provide expert external validation of our assumptions about costs and income in the medium term
- Review the council's existing transformation programmes and provide a view as to whether they will deliver against the Corporate Plan
- Provide advice as to how the council might achieve the maximum possible benefit through a revised approach to transformation

Ernst and Young validated the council's current Medium Term Financial Plan based on projections and assumptions jointly agreed, and judged it to be robust, taking into account the complex financial landscape and changing government policy.

The council has initiated a number of far-reaching and ambitious change programmes over 2012-13 to address the twin aims of addressing financial constraints and improving service delivery. These include:

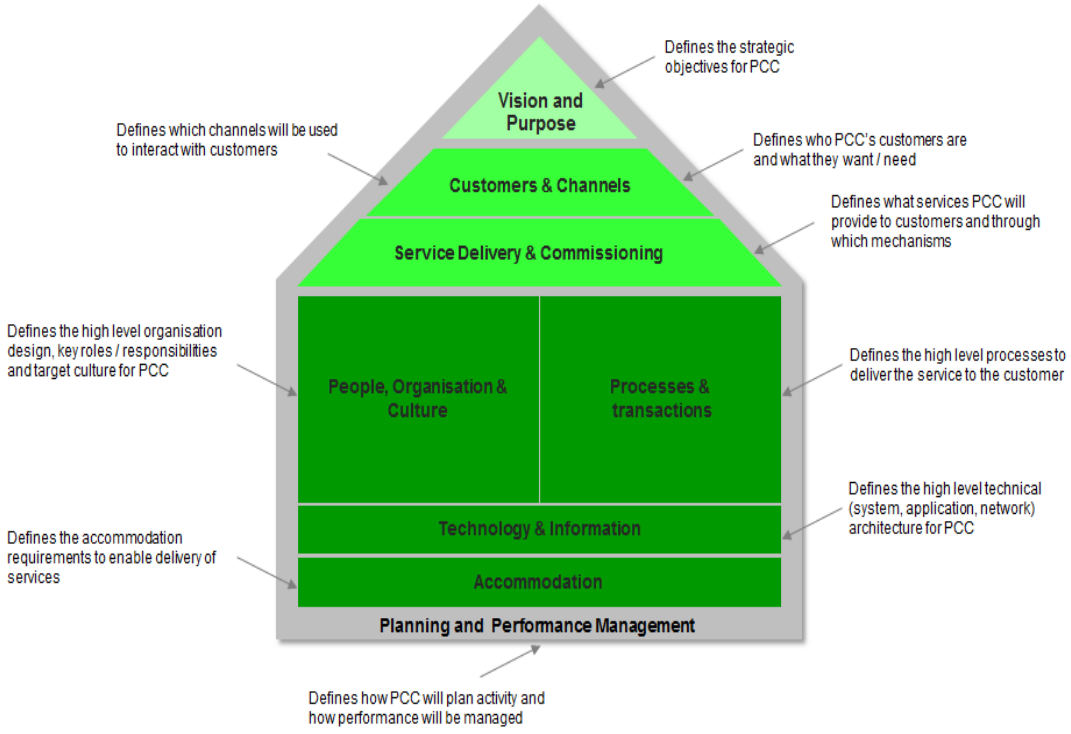
- Investment in Customer Transformation and Core ICT infrastructure (Cabinet approval September 2012)
- ICT Shared Services: DELT (Cabinet approval October 2013)
- Redevelopment of the Civic Centre and future accommodation requirements (Cabinet approval September 2013)
- Modernising Adult Social Care Provision (Cabinet approval January and August 2013)
- Co-location with Clinical Commissioning Group at Windsor House (Cabinet approval January 2013)

In addition to feedback and advice about individual programmes, the Council received advice that has been carefully considered, and which has informed the overall design of the Transformation Programme and the content of the business cases for the five programmes.

Vision and Direction: The Blueprint

The Council has responded to concerns that, despite strong support for the Corporate Plan from both officers and members, there was a lack of clarity about how the Corporate Plan translates into practical action and a danger that the council might be attempting to 'do the right things, but in the wrong way'. After significant consultation with Members and over 100

staff from all levels and disciplines within the organisation, the Council's vision for the Brilliant Co-operative Council has been translated into a Blueprint which describes the capabilities which the Council will need in the future. These capabilities will be commissioned by the council and will result in services being delivered by the Council and a variety of other organisations operating across the public, community and voluntary and private sectors. The components of the Blueprint are illustrated below:



To inform the development of the main components of the Blueprint, a number of principles have been developed co-operatively with Members, senior officers and staff to ensure that the values set out in the Corporate Plan guide how the Blueprint is developed.

There are 5 programmes to deliver the transformation:

Customer and Service Transformation: This programme will transform the way the council interacts with customers to meet their demands and preferences, and transform the services that the Council decides to retain in-house.

Co-operative Centre of Operations: Creating the business as usual strategic 'centre' for the Council, which uses the co-operative principles and intelligence to co-ordinate organisational decision making and activity.

Integrated Health and Well Being: The Council can engage with partners to deliver services at a lower cost, whilst also improving outcomes and customer satisfaction. The aim of

the programme is to achieve "One system, one budget to deliver integrated, personal and sustainable care".

People and Organisational Development: The programme will enable the Council to define and deliver the required workforce and accommodation capability change.

The **Growth, Assets and Municipal Enterprise** programme has been developed to:

- Contribute to the growth of the City and the move towards a brilliant co-operative council.
- Generate and accelerate additional income for Plymouth City Council from economic and housing growth across the Council
- Create a brilliant co-operative street service which will :
    - Make operational changes to enhance service delivery
    - Provide evidence to design and deliver new service delivery models
    - Identify and deliver new opportunities for commercialism, new income streams
- Realise opportunities to bring in additional income from the commercialisation and increased trading of services.

1. BACKGROUND AND OPPORTUNITY

1.1Background and Context

NEW Devon CCG is the largest in the country, serving a total population of 898,523. As we look ahead we are focussed on ensuring that our existing services providers develop joined up services which are sustainable to address our future demands across the Health and Social Care system. Through engagement with local people via the Transforming Community Services agenda, the need to ensure that community services are integrated and person centred is paramount. National policy and guidance sets a clear direction that the services of the future must be based on simple pathways of care and support, focusing on individual outcomes and quality of life indices. It is imperative that any new service delivery model can demonstrate how to support individuals to self-manage their health and social care needs with greater awareness of the voluntary sector, better use of assistive technology and an increased emphasis on education programmes and empowerment. In order to achieve this ambition, the role of statutory community services cannot be considered in isolation since the functions currently delivered by acute and specialist health care, voluntary agencies and general practice are co-determinant to improving health and wellbeing.

The strategic framework developed through transforming community services engagement will be used to describe the priority areas for a future integrated delivery vehicle.

These priorities are:

- Help people to stay well
- Integrate care
- Personalised support
- Coordinate pathways
- Think carer, think family
- Home as the first choice

PCC and NEW Devon CCG are facing significant financial challenges coupled with rising demand for services. The Integrated delivery project will establish a more integrated, strategic approach to how the organisation deliver services with the aim of ensuring excellent people experiences, improving outcomes for residents in Plymouth and reducing costs. This approach fits with PCC's ambition of being a co-operative council; the CCG's vision of 'Healthy People Living Healthy Lives in Healthy Communities'; Plymouth Community Healthcare's vision of 'Safe, Well and at Home', and Health & Wellbeing Board's vision of 'Healthy, Happy, Aspiring Communities'.

1.2 Overview of Existing Situation

Many users of health and social care services experience care that is fragmented, with services reflecting professional and institutional boundaries when it should be co-ordinated around their needs. This can result in duplication, inefficiency, gaps in care, feelings that 'no-one is in charge' and ultimately poor outcomes.

The current configuration of the statutory provider market in Plymouth provides an opportunity to specify how the one acute trust, one community health provider and unitary adult social care department deliver joined up services, with shared outcomes in the future.

The personalisation agenda acted as a catalyst to bring about significant changes to how the adult social care service delivered community care assessments and support plans. Traditionally these had been undertaken after a significant waiting time and resulted in the provision of a service led response. Through extensive remodelling the service now delivers it's statutory functions via a single contact point, which affords callers timely access to social workers and occupational therapists who can provide advice and information, undertake assessments of risk, engage with partner agencies and arrange rapid support if required. The development of personal budgets for individuals who are eligible for financial assistance has enabled staff to work alongside individuals to develop holistic plans to meet needs, harnessing the wider community infrastructure in terms of voluntary agencies, families, friends as well as statutory services. This flexible approach has empowered individuals to have greater choice and control over how their care is arranged.

The Integrated Delivery Project will build upon the ASC Transformation and Care Co-ordination (CCT) approach. The new intermediate care service (CCT) was launched in September 2013. In this team staff from community healthcare and social services work alongside each other wrapping support around individuals at time of crisis or to expedite hospital admissions. Working from a single access point, the team have adopted the same values and principles as the ASC teams, focusing on putting the person at the heart of the care planning process, linking with existing support systems, ensuring wherever possible that individuals only need to describe their needs once. Both services have been subject to evaluations; feedback from people who have worked with the teams or been supported by them has been extremely positive and on this basis it is intended that the Integrated Delivery project will expect providers to utilise these existing platforms to develop a wider offer across all health and social care services; providing the right care at the right time in the right place. It is expected that whilst emphasis will be placed on those who would benefit most from person centred care, such as intensive users of services and those who cross organisational boundaries, organisations will assist in achieving the required shift from crisis to preventative support services.

Section 75 partnership agreements, legally provided by the NHS Act 2006, allow budgets to be pooled between health organisations and local authorities. It is anticipated that this arrangement will be used to allow for the transfer of staff and budgets. The future provider will then be contracted to deliver statutory functions in terms of community care assessments and to deliver an integrated response to other individuals across the city for examples those with long term conditions, end of life support needs and those requiring therapy support.

1.3 Opportunities and Outcomes

PCC, the Western Locality of the NEW Devon CCG and Community partners are committed to the development of an integrated model for the delivery of services for the City of Plymouth. This has been endorsed at the Plymouth Health and Wellbeing Board as an agreed work stream as a priority for 2014.

In order to promote integrated whole person care that improves outcomes it is recognised that an integrated approach to commissioning is a pre-requisite with commissioners being required to develop "one system, one budget". There are already strong relationships between the CCG and PCC which can act as a solid foundation to support closer integration, through the development of a specification describing outcomes to be delivered by a joined up health and social care service.

These outcomes will serve to address the Better Care Fund requirements but also ensure that the delivery vehicle is able to respond to changing needs and demands across the system. Whilst the development of this specification will enable the providers to develop detailed plans of how best to configure their approach to respond to individual needs across the city it is anticipated that savings will be made through having shared management, systems, overheads, and via a reduction in duplication of effort. These areas will ensure an approach which delivers for now and the future.

The project creates a significant opportunity to fundamentally redesign how community services look in the future but with the current unsustainable pressures it is imperative that it achieves:

- An offer which places the person in the centre and arranges appropriate support when needed
- An emphasis on self-management including the use of assistive technology
- A reduction in bed based support and a shift to community assistance
- A single contact point for all incoming work
- It must be available 24/7 to offer assistance when a crisis occurs
- It will have an integrated IT system that delivers a single individual assessment which is accessible for primary and secondary care, the ambulance service and voluntary sector. It will allow people to describe their needs once and then using a unique identifier (NHS number) this can be shared.
- A workforce which is remodelled to ensure the right skills are in the right place, this will include significant investment in workforce development to increase generic skills, thus minimising duplication of effort.

What will local people see as a result?

- Widespread engagement in how services are designed
- More care delivered in the community
- Better access to condition management information
- Only needing to tell their story once
- Improved sharing of information to enable people to make their own choices
- Support from an well informed professional worker who can provide information or assistance at the time it is needed
- Opportunity to take a lead in the on-going shaping of services

The following 'I statements' have been developed nationally and approved by the Plymouth Health & Wellbeing Board, they describe the desired outcomes which people who use integrated health and wellbeing services will experience:

More than a condition

"I want services that support me to manage my situation in life not just my condition"

Existing services

"I want the services I value now to be strengthened"

Transport

"I want to be able to get to the services in my community"

Service Opening times

"I want to be able to get to my community services at times that are convenient for me"

Carers

"I want what my carer does to be recognised and for them to have the support they need to have a full, healthy life of their own"

Educate and inform

"I want the information I need to make healthy choices and stay healthy"

Work with others

"I want to be able to have services provided in lots of different places not just health centres"

Communication

"I want to be able to talk to healthcare providers when I need to."

Talk to each other

"I want to tell my story once - share my information with colleagues"


Technology

"I want to be able to use new technology to help me manage my own health"


The voluntary sector

"I want to continue to get the services I value that are provided by the voluntary sector"

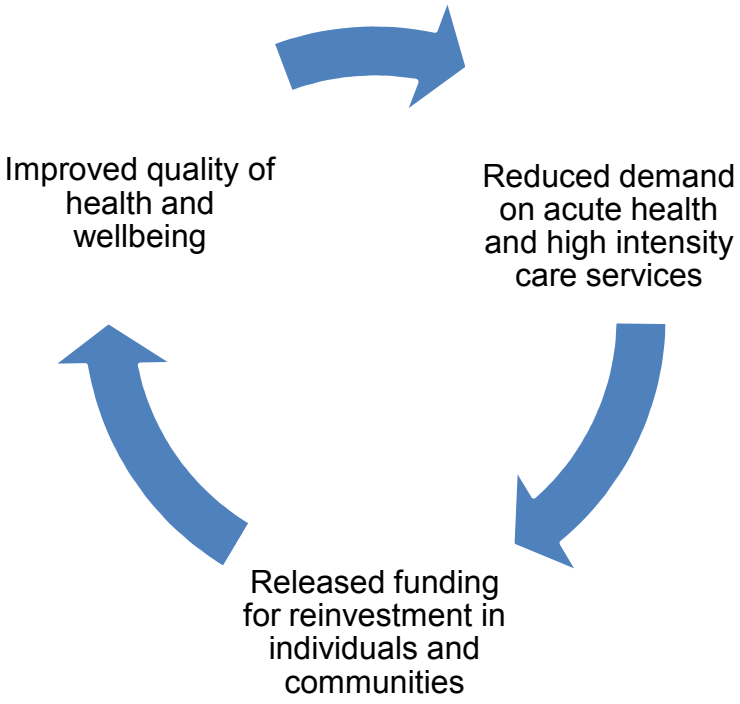
Boundaries

"I want a health care service that doesn't stop at the boundaries"

The overall outcome of the Integrated Health & Social Service Delivery Project will be alternative delivery models for health and social care services, and to facilitate the development of an integrated health and social care economy within Plymouth.

The results of this will be:

- Improved patient experience – more seamless care
- Single community provider delivering improved local health and wellbeing
- Shared commitment to common vision and goals.
- Improved ability to manage the whole system, reduce duplication and wastage and manage variations in demand
- Simplified collaborative arrangements, with lower barriers to entry, meaning opportunities for integration with a greater number/range of partners



So what will it look like?

Scenario 1

Mrs X has respiratory disease and with her Long Term Condition (LTC) matron has developed a usual plan of care which describes how she manages her condition and the care she receives in the community. She also has a crisis care plan in the event that she becomes unwell.

As she becomes unwell she contacts the LTC matron who liaises with the single access point who are able to share information about existing support services and arrange for a temporary increase in care. The LTC matron retains the co-ordination, liaison with primary care and is responsible for reducing the care when Mrs X stabilises.

Therefore in this scenario the LTC Matron is providing the clinical support and the centralised team provide access to advice, information and short term reablement support.

Scenario 2

June a homecare worker attends Mrs A at her normal time. Mrs A appears listless and unwell, June contacts the GP. The GP is unable to attend immediately but rather than advising her to call the ambulance he asks June to contact the centralised service for an assessment. The rapid team arrange to visit Mrs A and complete an assessment, arranging support to assist her through this short term illness.

The GP retains clinical responsibility for Mrs A and visits later that day to prescribe a short term course of antibiotics. Once Mrs A has stabilised the additional care is stepped down but the support worker assists Mrs A to develop a contingency plan for the future, the draws together information about her family, friends and neighbours who support her.

2. PROJECT CATEGORISATION/STRATEGIC FIT

2.1 Strategic Case

Public sector organisations across the country are facing a combination of severe budget pressures and increasing demand for services. The NHS as a whole is committed to finding £20bn of savings from its budget by 2014/15, whilst Local Authorities are seeing budget reductions of approximately 26% as a result of this year's Comprehensive Spending Review, to go with a similar reduction implemented as part of the last Comprehensive Spending Review in 2010.

System wide changes will be needed in order to meet these combined challenges. PCC and NEW Devon CCG are looking to seize the opportunity created by sector wide reform, to create a vision for integrated delivery that will help to improve outcomes, reduce cost in the system and align to the Health & Wellbeing Strategy.

It is widely recognised that there is no blueprint for integrated care; however, there is recognition that a whole system approach is needed. This means not only working across the whole of the local health, public health and social care systems but also working with other local authority services, key stakeholders, people and communities. This approach fits with PCC's ambition of being a co-operative council and supports the ethos of collaboration set down by all partners.

2.2 Local Strategic Drivers for Health & Social Care Integration

Local demographics and demand

The city of Plymouth has a population of approximately 260,000, which is projected to increase by 2.4% by 2017. The population of those aged 65 and over, who as a group are more likely to have long term conditions or social care needs, is projected to increase to 46,700 by 2016, an increase of 4.7%.

Public Health outcomes in Plymouth are worse than elsewhere in England in 28/32 of the measures shown in Plymouth's 2013 Health Profile. The health of people in Plymouth is generally worse than the England average: deprivation is higher than average and about 10,200 children live in poverty. Life expectancy for both men and women is lower than the England average. Estimated levels of adult 'healthy eating' and smoking are worse than the England average. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are worse than the England average.

The increase in population, and particularly the increase in older people, is likely to put significant strain on both health and social care services in years to come.

This analysis, which does not factor in inflation or the impact of the Care Bill, projects a deficit of over £12m in 2016/17 for adult social care provision alone in a 'do nothing' scenario.

Winter 2012/13 saw significant pressure on Derriford Hospital. Unless significant action is taken to relieve pressure on admissions and increase the flow of discharges where possible, this pressure is likely to be present again this winter and in future years.

Financial imperative

At a local level there are considerable financial pressures. Plymouth City Council is committed to reducing spend by £65m over the next three years, of which approximately £16m may be allocated to reduced spend on Social Care service delivery.

In addition, the CCG is forecasting a 1% reduction in acute spend, and flat budgets for community and mental health services, in 2014/15 (to be confirmed). There are likely to be similar budget positions in future years.

Therefore of key concern for both organisations is the on-going sustainability of the services and service quality in the face of the financial targets, and both organisations recognise that there is a need for a strategic and innovative response to achieve the level of savings required.

Health & Wellbeing Strategy

The Health and Wellbeing Board's aim is to "promote the health and wellbeing of all citizens in the City of Plymouth". The vision "Happy, Healthy, Aspiring Communities".

The Health and Wellbeing Board has set out a core programme to promote integration of Health and Social Care delivery. The focus is on developing an integrated provider function stretching across health and social care providing the right care at the right time in the right place; and an emphasis on those who would benefit most from person centred care such as intensive users of services and those who cross organisational boundaries.

Underpinning the board and its aims are three key principles of working together, which are:

- Working together and with those that the Board serves to take joint ownership of the sustainability agenda.
- Ensuring systems and processes are developed and used to make the best use of limited resources.
- Ensuring partners move resources (both fiscal and human) to the prevention, and health and wellbeing agenda.

PCC Transformation Programme

Although PCC's adult social care service has gone through a major transformation, it has not integrated with health provision to ensure services are wrapped around customer. By removing duplication, profiling existing and future demand, developing a culture of trust between various professional groups, it is clear that service delivery can develop further to best address the needs of the population of Plymouth.

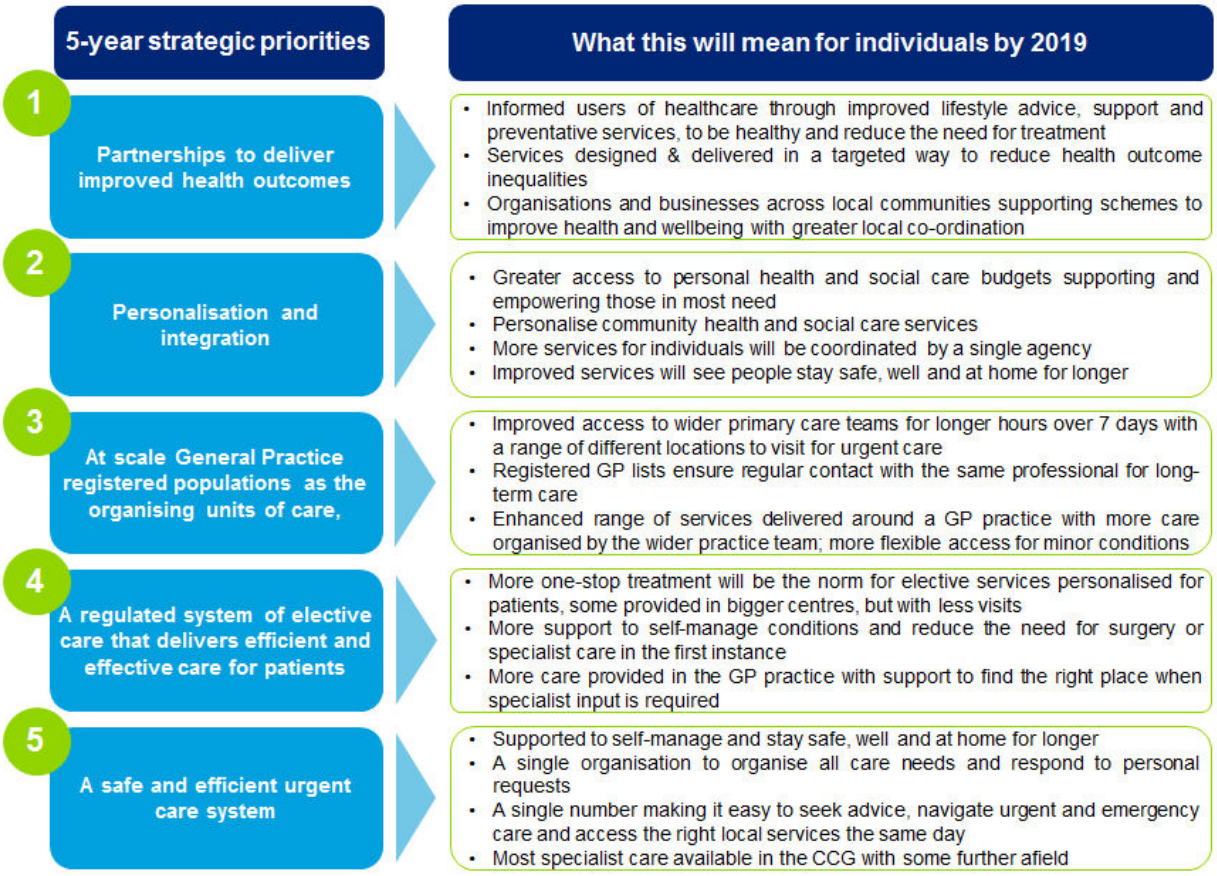
The development of joined up services will be one mechanism to address the significant funding gap across health and social care services which early indications suggest has the potential to further increase over the next three years without significant intervention.

Transforming Community Services

NEW Devon CCG has initiated a programme, called Transforming Community Services, to remodel community health provision across each of its three localities. This programme aligns to the national Transforming Community Services programme, and the current programme plan involves the re-procurement of community services in Plymouth by April 2016.

The transforming communities consultation which has gathered feedback from people who use services and they described that they wanted 'Health care that does not stop at boundaries', services that see me as a person, not a condition', and 'safe and secure services with future proofing in mind'.

This engagement has resulted in the establishment of the key priorities which are depicted below:



2.3 National Strategic Drivers for Health & Social Care Integration

Many users of health and social care services experience care that is fragmented, with services reflecting professional and institutional boundaries when it should be co-ordinated around the needs of patients. This can result in duplication, inefficiency, gaps in care, feelings that 'no-one is in charge' and ultimately poor outcomes. This has been the context within which health and social care integration has been promoted as a model of care in recent legislation, policy and academic commentary by key stakeholders.

Research suggests current health and social care arrangements have failed to keep up with increasing population and patient expectations. It is clear that a more strategic approach needs to be taken to Health and Social care. The Kings Fund (*Transforming the delivery of Health and Social Care;The case for Change, September 2012*) has commented that partaking organisations should be prepared to de-commission out-dated models of care, support NHS organisations to innovate and adopt established best practices; recognise the potential of new providers as an important source of innovation; develop a culture that values peer support for learning and innovation and encourage players at the local level to test new models of care.

Below details a number of national drivers for integration;

- **Health & Social Care Act 2012**; Contains a number of provisions to enable the NHS, local government and other sectors, to improve patient outcomes through more effective and co-ordinated working (improved collaboration, partnership working and integration).
- **The Care Act**; aims to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. The Bill makes it clear that this refers to housing, health and social care delivery/commissioning and not just health and social care.
- **The Better Care Fund**; creates a substantial ring-fenced budget for investment in out-of-hospital care to target a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge.
- **National Quality Board**; In the context of a vastly changing NHS landscape, the National Quality Board has issued a report; 'Quality in the new health system; Maintain and improving quality from April 2013' which describes how quality will operate in the new system.
- **Public Health Outcomes Framework 2013-1016**; aims to address two key outcomes: Increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities. It requires the NHS, social care and voluntary sector communities to all work together to make this happen using a whole system approach.
- **Adult Social Care Outcomes Framework (ASCOF)**; used to demonstrate the achievements and strengths of adult social care in delivering better outcomes through describing a set of outcome measures.
- **NHS Outcomes Framework 2014/15 (NHSOF)**; describes a set of outcome measures to highlight risks and report success.
- **NHS Call to Action**; focuses on the changing dynamics of supply of, and demand for, NHS services, and there is a particular emphasis on the increase in the proportion of the population with long term conditions. The paper makes the point that it is important to manage patients with long term conditions differently, by supporting them to provide their own care.
- **Closing the NHS Funding Gap**; This report details ways in which NHS commissioners and providers may close the anticipated funding gap in the NHS (by improving productivity

of existing services, delivering the right care in the right setting, developing new ways of delivering care and allocating spending more rationally).

- **Transfer of Public Health to Local Authority control**; From April 2013, Public Health functions have moved to be under the control of local authorities. In the context of this programme, this provides a significant opportunity to improve public health indicators in Plymouth.

In response to financial and strategic challenges, PCC and NEW Devon CCG have explored the potential for health & social care integration across Plymouth City and the wider Derriford Hospital footprint, and have reached a joint decision that integration by both parties is a key mechanism to meet their respective financial challenges whilst also complying with legislative and political requirements and improving outcomes for service users and patients.

3. PROJECT SCOPE

3.1 Integrating Delivery

The project will facilitate the development of an integrated health and social care system within Plymouth. This will be achieved through the development of a commissioning specification that sets out the delivery of key outcomes and targets.

The commissioning specification will be based on the clear "customer" requirements recorded in the work carried out by NEW Devon CCG's initiative Transforming Community Services. The diagram below providing examples of the services that customers expect.

The outline business case stated that this workstream should, "*Focus on developing an integrated provider function stretching across health and social care providing the right care at the right time in the right place; and an emphasis on those who would benefit most from person centred care such as intensive users of services and those who cross organisational boundaries*".

With the customer requirements combined with key drivers such as the Better Care Fund, Care Closer to Home, NEW Devon CCG strategy and initiatives such as Admission Avoidance the emphasis in setting up the integrated function requires a significant focus on services based in the Community.

Services in scope

The PCC services impacted by this project are those within the Adult Social Care part of the People Directorate. The specific teams that are to be considered for this transformation are:

- Social Care Assessment and Support Planning Service, including Social Workers, Occupational Therapists and Community Care Workers
- The services in scope of the project are those available in the community including District Nursing, Long Term Condition Management, Intermediate Care, Therapy Services, Continence services, Falls Provision. (Note: This is list is not exhaustive and it is anticipated that through the redesign process other services may achieve efficiencies once the points of duplication are removed.)

To develop and deliver a community based approach requires the following:

Business Analysis and Design

- capturing of existing demand data and access points for referrals
- the identification of areas of duplication
- the evaluation of existing workforce,
- the completion of skills gap analysis
- the development of workforce development plans
- the reconfiguring of existing teams
- the redesign of the IT infrastructure and performance reporting
- the development of the Section 75 arrangements, the development of the appropriate governance arrangements to ensure robust procedures to manage areas which are not delegated.

3.2 Out of scope

The scope of the programme will not include certain Children's Social Care services (including assessment and case management of Looked After Children or those subject to a Child Protection Plan) that are currently provided in-house by PCC, however consideration will be required to ensure detailed pathways for individuals moving through transitions are in place.

GPs and Primary Care services are assumed to be out of scope initially, although strong links to these providers will need to be maintained to engage them throughout the process of developing the new operating model for health and social care delivery. It is anticipated that these key stakeholders will have an active role in the redesign of community. The scope may be widened to directly include these services if a change in commissioning responsibilities for these (e.g. co-commissioning of primary care with NHS England) takes place within the timescale of this programme.

4. OPTIONS APPRAISAL

4.1 Overview of Options

Integrating Health and Social Care service delivery is a complex activity and results in a number of options. The business case has previously discussed horizontal versus vertical integration

4.2 Community Service Delivery or Acute Service Delivery

In developing the project, two options were considered:

- Integration with Community Provider – PCH (Horizontal integration)
- Integration with Acute Provider – Derriford Hospital (Vertical integration)

During the options workshop (see Section 4 below), significant consideration was made in relation to the adoption of a horizontal (Community based) or vertical (Acute) model of integration. NEW Devon CCG's preferred option following the Transforming Community Services engagement is for horizontal integration in the Western Locality.

With health, public health, primary, community health and social care all moving towards an outcome focused approach, they can design and develop pathways which prevent crisis, minimise delays and meet increasing demands. This can be done best from the person's own home.

It was acknowledged the provision of bed based acute care is expensive and delivers poor outcomes for many individuals, particularly older people who experience lengthy hospital admissions. In order to address this challenge services need to be configured close to people's home, supporting individuals at the onset of their needs through prevention and early intervention, it was agreed that a horizontal approach who best achieve this. The historical approach of uncoordinated multiple assessments by health and social care not only leads to duplication but creates delay in provision of support, often tipping individuals into secondary care arrangements where the outcomes are frequently poor as pathways and transfers are unreliable at best.

4.3 Community Based Approach

The agreed approach to be taken with service delivery is to horizontally integrate with the community based health provider. This will deliver the best whole system approach to joined up care, since creates flexibility and enables a range of services to be brought together to wrap around individuals. The option of vertical integration was discounted as the preferred choice since it was unlikely to achieve the community focussed outcomes described through the Transforming Community Services consultation.

The current community services provider is Plymouth Community Healthcare (PCH). The community services are mainly commissioned by NEW Devon CCG. A further option appraisal was undertaken to determine the level of integration with PCH (see Section 4 below).

4.4 Extent of Integration

Having determined that the current priority for Plymouth is to integrate service delivery in the community, the next option appraisal undertaken was determine the degree of integration to be undertaken.

The table below describes the four levels of potential integration from minimal (option 1) to maximum (option 4).

Option	Description
1	Delivery workforce remains in existing structures. Pathways for people requiring support are reviewed and streamlined. Budgets are re-profiled to follow individuals
2	Delivery workforce is re-configured to sit with shared line management arrangements linked to individual pathways. Staffing budgets are aligned accordingly
3	Delivery services staff come together under single management with some provision budgets joined to support specific pathways
4	Delivery services staff come together under single management structure. Budgets across the system are transferred to delivery service

These options have been appraised through workshops with the Programme Board and an options workshop with key stakeholders from PCC, NEW Devon CCG and PCH.

In that workshop members were provided with a matrix detailing the 4 options with a list of factors to consider (a copy of the matrix can be found in Appendix).

These topics were discussed and the highlights were as follows:

- Agreement was made that the first two options would not generate the customer benefit or financial savings that we are aspiring to achieve, and so were discounted as options.
- Option 3 raised concerns regarding achievable benefits, which would only be achieved through pooling budgets in option 4.
- Consistencies between options were identified, such as strategic and operational oversight of budgets and associated costs.
- Operationally option 4 would place more focus on the individual, provided opportunities and scope for staff. For consideration; working hours, recruitment processes, TUPE, the impact of the care bill, pay scales and early communications.
- Discussions centred on creating a delivery vehicle/partnership versus TUPE. It was agreed that TUPE would be preferable and for adult social care to be delivered via PCH and governed through a commissioning structure. This will be influenced by the commissioning outcome. Councillors would require represented on the board to monitor the Local Authority statutory responsibilities and have direct access to address any constituent issues. Discussion continued around the roles and responsibilities of the ASC Director role and how this is monitored and possibly a strategic lead to have oversight of budgets, quality and performance. Option 4 is the logical place to go with any further work.

- Discussions made to create savings through mapping across work streams, to review lessons learnt from others and not repeat.
- SystmOne or the new system and how this could be promoted to GPS and the existing localities and structures against a citywide model of operation and how this will need to be teased out along with the vision of what the future organisation will look like.
- Discussions around commissioning and what this means. Point added that this would need further discussions around local authority responsibilities and how they could be delivered.

4.5 Recommended Option

Option 4 above received the greatest level of support as an accepted model of co-design. This will establish a single integrated provider of community health and social care.

The delivery of an integrated system will have a positive impact ensuring people feel more confident to manage their condition, engage with GP's less and ensure that risk stratification is used to identify those at highest risk. This approach needs to be developed within the community, preventing acute admissions but also pulling people out and ensuring timely access to support services.

The current community providers propose to develop options to horizontally integrate in order to meet the desired outcomes. This is supported by the Transforming Community Services agenda, the Better Care Fund requirements and members of the community. Business Architecture support will be required in how two disparate systems come together so we can achieve the outcomes that our customers require of a single approach assessment and planning of care and subsequent storing and sharing of information. Work has started to develop a blueprint for a technology solution to support this.

To further explore option 4, the following operational models have been considered for a preferred model to be used to deliver a single integrated provider:

Description	Benefits	Risks
Providers come together (legal construct unspecified) into a single entity	• Fully integrated processes for finance, performance management and governance • Full integration/ centralisation of back office and business functions (HR, IT, medical records and assessment) • Legally binding arrangement, restricting opportunities for entry /exit • Integrated budget avoids cost shunting • Seamless organisation from patient perspective • Staff within one organisation • Opportunity to create single organisational culture, vision and strategy • Commissioner will need to manage only one provider relationship and contract	• Costs associated with the transaction process and the management of organisations change and requires full support of merging organisations • Increased risk on a single provider, posing a threat to local economy and required savings • Divestment – may lose core areas of provision to integrating organisation • Regulation (transitional) – meeting service standards during protracted period of integration.

Providers come together (legal construct unspecified) but not into a single entity	• Shared commitment to common vision and goals • Separate statutory bodies – retain autonomy and identity • Finance, performance and governance arrangements stabilised by e.g. S75, SLA • Multiplicity – simplified partnership arrangements, with lower barriers to entry, mean opportunities for integration with a greater number/ range of partners • No staff transfer – continuity of pensions and job specifications, and avoidance of TUPE liability • Local partnerships strengthened, as possible precursor to more extensive integration	• Costs associated with the transaction process and the management of organisations change and requires full support of merging organisations • Continuation of operational status quo – i.e. executive sponsorship but partner organisations view themselves as separate and distinct • Planning of which organisational departments will integrate, and organisational management of integration process is both time consuming and has additional costs associated
Accountable lead provider model	• Centralised governance and management • Single point of responsibility to improve care and deliver better outcomes and better health • Incentives to invest in 'upstream' disease prevention and health promotion as well as diagnosis/treatment • Promotes 'make or buy' decisions, hence creating opportunities to align clinicians across traditional boundaries and to encourage clinical collaboration • Greater incentive and freedom to innovate • Stronger accountability for patient-oriented outcomes • Commissioning of individual services shifts from commissioner to lead provider hence giving the principal provider greater autonomy and lower resource requirement for the commissioner to manage contracts • Allows for sub-contracting with the third sector, therefore potential opportunity to attract new providers who can offer better quality of care at reduced prices	• Require extensive reconfiguration of services, contracts and payment mechanisms , especially for the lead provider and therefore has its own cost and risk implications • Increased financial risk on lead provider • Risk of creating new silos centred on conditions and diseases in place of existing silos • Staffing transition costs and implications where lead provider chooses to 'make' the service – potential TUPE

It is recognised that following the options appraisal undertaken so far, further work will be required between NEW Devon CCG and PCC as the commissioners further develop the options and evaluation of the preferred delivery model. This will be co-developed with PCH as the incumbent community based provider and PCC (Adult Social Care). Once a preferred option has been developed it will be subject to due diligence and governance approval and this will be presented to Cabinet and NEW Devon CCG Governing Body for final agreement in November 2014.

Extensive legal input will be required during the next phase of the project.

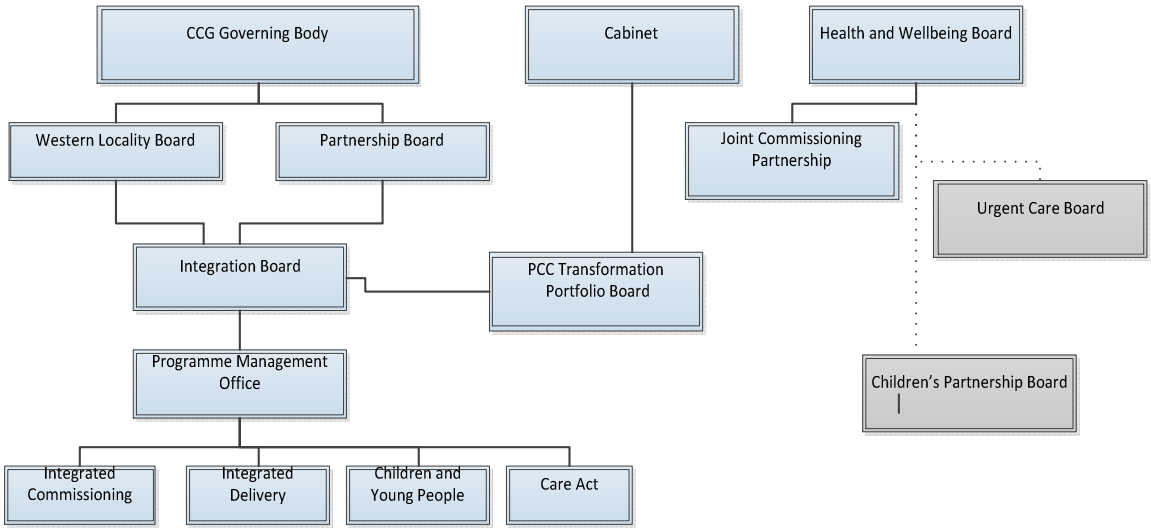
Transformation Portfolio Assurance and Enterprise Architecture

Formal sign off to the project will be granted in November 2014 following detailed design and project plan development.

5. PROJECT APPROACH

5.1 Programme Organisation

The programme has the following governance structure:



This is the indicative role and membership of the new HWB Integration Programme Board and its relationship with other governing bodies. Size and composition are built to enable swift change and can be supplemented to broaden representation:

HWB Integration Board

Responsible for steer and sign-off of programme initiatives

Members:

- MD- Western Locality, CCG (Vice-chair & SRO)
- Director of People, PCC (Vice-chair & SRO)
- Director of Public Health
- Chair of CCG
- MD – Partnerships, CCG
- AD - Joint Commissioning, PCC
- AD - Education, Learning & Families, PCC
- Area Team representative, NHS

PCC Portfolio Board

Responsible for ensuring compliance with overall transformation blueprint and monitoring delivery and benefits

NEW Devon CCG Board

Responsible for ensuring compliance with overall CCG requirements and monitoring delivery and benefits

Health & Wellbeing Board

Responsible for oversight of transformation programme and ensuring alignment with other initiatives and H&WB strategy

Joint Commissioning Partnership

Responsible for BAU commissioning during transformation, but after can merge with HWB Integration Board

Urgent Care Board

Responsible for oversight of BAU functions for urgent care delivery

Project groups

Responsible for designing solution, identifying benefits, resource requirements and delivering the projects

Programme Management Office

Responsible for co-ordination of the transformation projects

Children's Partnership Board

Responsible for BAU function but reporting into the Health & Wellbeing Board for oversight

Proposed Governance & Structure

Senior Responsible Officer: Carole Burgoyne (Plymouth City Council), Jerry Clough (NEW Devon CCG)

Project Executive: Dave Simpkins, Nicola Jones, Michelle Thomas

Chair of Delivery Board: Steve Waite

Programme Manager: Craig Williams

Project Manager: Anna Coles (Lead), Paul Walshe, Lee Grant, Jacqui Wagner

Project Support: Jenni Doudoulakis

Finance: Paul Hardwick, Helen Foote, Dan O'Toole, Ben Chilcott

Business Architect: Mark Appleby

Communications: Nicola Morgan, Sam Sposito

Business Change: Lisa Woodman

Legal: Linda Torney

HR: Emma Rose

5.2 Governance arrangements:

The development of a Section 75 arrangement between the Local Authority and CCG will enable the establishment of a single health and social care community, with the contract then being jointly managed via the Integrated Commissioning Hub. This will be evaluated and presented back to PCC and NEW Devon CCG for final approval.

A detailed target operating model covering governance, staffing, finance, operational systems, funding and contracting will need to be developed in partnership with the proposed provider.

Staff Engagement and Development

The integrated service delivery project will continue to build on the existing ASC transformed service model and the CCT model to engage with users of services, stakeholders and staff currently delivering services to co-design the future operational model.

In order to support the new integrated model of service delivery there will be a requirement that the delivery workforce is remodelled to support the new operational framework. The intention is that staff are aligned in a way that ensures the right skills are in the right place to achieve this.

The current delivery offer structure consists of Plymouth City Council Adult Social Care's 167 individuals (149.24 FTE) not including vacancies. This is split across a range of professional, semi-professional, clerical and management staff.

The new operating model will be co-designed with current and future users of services along with frontline staff who will be affected by the changes.

As part of the operational design process work that will take place there will be an emphasis on identifying areas of duplication and cross over removing these to maximise efficiencies throughout the process. Once the redesign work is complete then the project will progress to consultation stage with staff.

6. Communication Approach

A Communications Plan for the Project and Programme has been developed jointly by The CCG and PCC. This will form the basis of the overarching communication strategy for this project, which will be continuously developed. Key activities in relation to this project include:

- Briefings and workshops with Members, GPs, Delivery Providers
- Communication Sessions, with Staff, Stakeholders and Partners
- Co-design workshops with current and future users of services
- Co-design workshops with frontline staff
- Co-design sessions with voluntary sector
- Regular written and face to face briefings

7. High Level "Stage" Plan

Activity	Timeframe
Review of access points across the Health and Social Care system to understand current demands, potential points for join up and facilitate future demand trend analysis	End of July 2014
Review of existing team configurations, locations and assessment frameworks to identify points of potential duplication and areas of efficiency for integration	End of July 2014
Arrange staff workshops to shape workstreams (such as IT, accommodation) to identify duplication, develop best practice and redesign pathways.	End of September 2014
Consultation and Engagement with staff and partners to support remodelling work	End of July 2014
Develop New Integrated delivery governance architecture	End of August 2014
Design function and form of new Organisation	End of September 2014
Plymouth City Council Cabinet	11th November 2014
Staff consultation	Beginning of October 2014
Due diligence process	Beginning of November 2014
PCH / CCG contract update	Beginning of November 2014
Develop Section 75 agreement	End of November 2014
New Integrated delivery structure in place	End of April 2015

7.1 Activity Management:

Activity will be managed through a project management office and underpinned by a number of enabling workstreams:

Activity	
Purpose: To develop detailed activity projections and resource requirements in order to inform the final redesign specifications.	
Key activities	**Key outputs**
Work with Operational design leads to agree target areas and assumptions	Agreed parameters and identify capacity requirements
Develop or modify approach to ensure required information is gathered	Demand and capacity model to be utilised to develop future service requirements
Understand and assess national policy initiatives and relevant legislative changes	Activity projections linked to primary, community and social care services

Finance	
Purpose: To work with service areas to inform the service reconfiguration and develop the Financial business case	
Key activities	**Key outputs**
Detailed financial analysis to define costs of new operating model.	FBC Financial Case including: • Cost benefit analysis • Transitional costs • Long Term Financial Model (LTFM)
Review, track and update the benefits throughout the project.	Updated benefits appraisal and visibility of transitional costs including consideration of double running costs and redundancy costs
Identify resources required to deliver the implementation	Workstream implementation plan including transitional costs and benefits
Develop benefit realisation mechanism	Ensure relevant efficiencies are tracked

Operational redesign	
Purpose: To undertake a detailed analysis of the current pathways/service clusters and develop detailed specifications for the reconfiguration of services in the themed workstreams listed in the table above	
Key activities	**Key outputs**
Challenge, validate and update system assumptions underpinning the development of an integrated	Updated, consistent and tested assumptions underpinning operational redesign and

Health and Social Care response	information gaps added to workstream plan
Working with Activity workstreams, analyse existing pathways and redesign the service for each person pathway As the service redesign component of this project begins there will be involvement of business architecture to ensure the options design achieves the outcomes required.	Complete analysis and inform future service specification based on a modernised, sustainable and integrated approach
Develop cost benefit analysis of the new operational model	Detailed cost and benefit analysis
Contribute to the development of final business case	Relevant technical input to: - strategic content - option appraisal - preferred option.

Legal and contractual	
Purpose: To deliver the activity required to provide the appropriate legal and technical support	
Key activities	**Key outputs**
Work with leads from each Workstream to identify legal and contractual issues	Milestone plan for legal and contractual engagement
Ensure employment issues e.g. (TUPE, Redundancy) are planned for correctly	Legal compliance with employment law requirements

Communication and Engagement	
Purpose: To develop and coordinate the activity required to communicate and engage with stakeholders	
Key activities	**Key outputs**
Work with leads from each service and workstream area to develop a Communications plan	Stakeholder engagement plan
Review map of key stakeholders and evaluate their interests, attitudes and influence to collate into interest groups	Stakeholder map
Manage stakeholders and develop appropriate communication and engagement toolkit	Communication and engagement toolkit
Liaise with relevant communication and Engagement Teams	Coordinated communication and engagement activity

Work with HR where appropriate, to support and enable communication and engagement with internal stakeholders (e.g. staff)	Newsletters, intranet, email bulletins, workshops, roadshows, documented meetings

8. VALUE ANALYSIS – COSTS, BENEFITS & RISKS

8.1 Financial schedule

1) Figures detailed in the outline business case for integrated adult service delivery were indicative figures based on the evidence and research provided by Ernst Young. The financial benefits envisaged over the three financial years of 2014/15 to 2016/17 are detailed in the table below and have been built into the council's three year balanced budget (as approved by Full Council in February 2014).

Financial benefits as detailed in 3 year balanced budget

	2014/15 £000	2015/16 £000	2016/17 £000	Total for 3 years £000
Integrated Health & Wellbeing budget savings (PCC element only)	1,500	5,900	9,500	16,900
Planned savings attributable to 'integrated adult service delivery'	525			

2) Financial benefits from this programme clearly accrue for both Plymouth City Council and the Clinical Commissioning Group in terms of how we join up our services and focus on the combined right outcomes for people. Savings mainly relate to two key areas:

(a) Staffing and administrative savings through integrating all relevant delivery staff within a single entity, adopting standard systems, procedures and practices. We will drive savings by rationalising management, streamlining processes and improving operational efficiencies and;

(b) Adopting a unique care approach where health and social care staff work alongside one another focussing on a client's needs around early intervention and prevention – hence reducing demand on higher cost placement services.

3) We are planning to implement an integrated service delivery model with effect from April 2015. However, it will take a longer time period to optimise the full extent of savings from this transformation project. Within this financial summary we have detailed a range of savings that could be realised. Savings are calculated using 2014/15 approved revenue budgets as a base. It is difficult at this stage to determine the exact split of financial savings between PCC and CCG. For modelling purposes, we have applied a standard percentage range for each organisation until the future shape of the delivery vehicle is better defined. These percentages will be tested and updated as we progress through the implementation.

4) Clearly, the level of combined spend on integrated health delivery offers an opportunity to drive significant financial and non-financial benefit. However, it should be noted that both organisations are facing considerable financial pressures whilst operating as single entities. These pressures will remain under close scrutiny to ensure that financial savings are fully delivered against 2014/15 base budgets as opposed to just absorbing spend from increased demand.

5) Staffing rationalisation and driving efficient operations. The integration between the two organisations will be implemented from April 2015. Within 2014/15, the new vehicle will refine and re-align existing practices and structures which will further develop over time.

Integrated Adult Provision – estimated staffing savings

Staffing	Existing spend £000	2014/15		2015/16		2016/17	
		Lower @ 1% £000	Higher @ 3% £000	Lower @ 2% £000	Higher @ 5% £000	Lower @ 3% £000	Higher @ 7% £000
PCC 14/15 base	11,028	110	331	221	551	331	772
CCG 14/15 base	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Total savings							

6) The biggest bulk of spend, and therefore associated savings, are the actual services in scope for the newly formed integrated delivery function. For PCC, our base budget for 2014/15 amounts to £44.3m with a further XXXm attributable to the CCG.

7) There are a range of planned activities that will deliver financial benefit through integrated adult service delivery. At this stage, we have not assigned a financial value to each specific activity, but have specified a range of potential savings based on phased implementation of all of the planned actions across the three years. The core activities that will deliver the savings are:

- In 2014/15 both organisations will constructively review and challenge existing service delivery arrangements – mainly focussing on those with long term care needs;
- Out of area placements will be reviewed to evaluate more local, cost effective solutions whilst focussing on improving the level of care provided;
- Develop and adopt integrated strategies reflecting a different operating model;
- Adopt a single assessment process;
- Process re-design and adoption of integrated ICT systems;
- Introduce a single point of client contact;

- Undertake service and pathway reviews – admission prevention, discharge and out of hours rapid response;
- Adopt a fully integrated case management system – significantly reducing the number of client visits required;
- Implementing fully combined, blended packages of care around the client's needs
- Integrated strategies will retain a focus on reducing demand for high cost residential, nursing and hospital placements – placing a greater share of resources to early intervention, preventative services and enabling support;

8) A key initiative that will be considered is one known as Unique Care Approach. This approach is considered to be a best practice example and is based on the Integrated Care Model, based in Castlefields Health Centre in Runcorn, Halton PCT (Lyon et al. 2006). At Castlefields, a social worker was introduced to work alongside a district nurse to introduce an integrated case management approach for patients who have been identified as potentially high users of hospital services. Over 4 years, hospitals saw a 15% fall in unplanned hospital admissions from a baseline in 1999. A&E attendees and GP visits fell by 30% and there was a 41% drop in bed days, which has led to approximately £1million of savings

9) Our estimated range of non-staffing savings attributable to the integrated adult service delivery are detailed below:

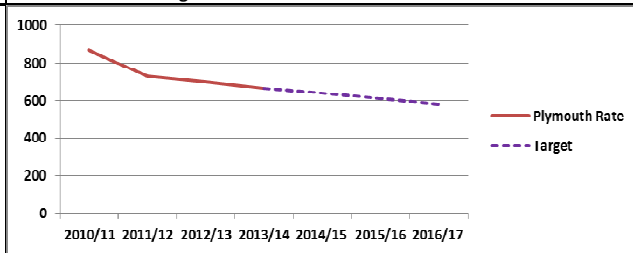
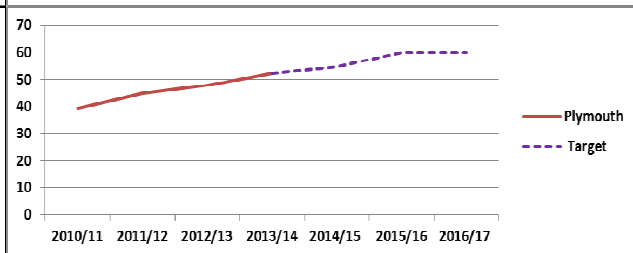
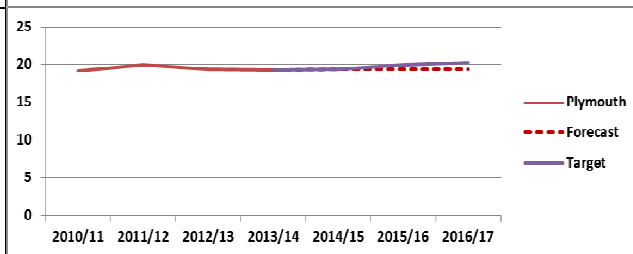
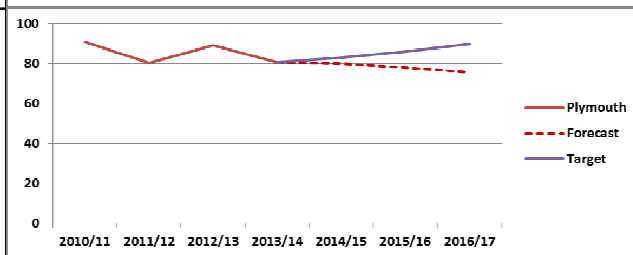
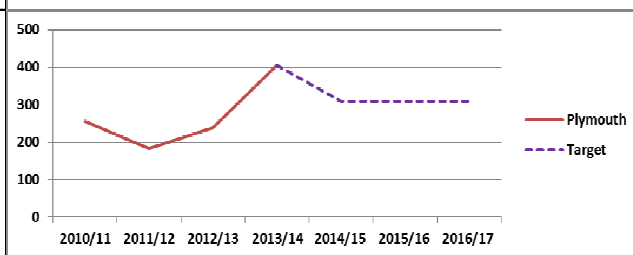
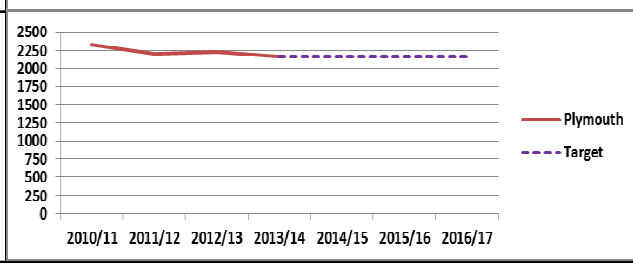
Integrated Adult Service Delivery – estimated integrated delivery savings

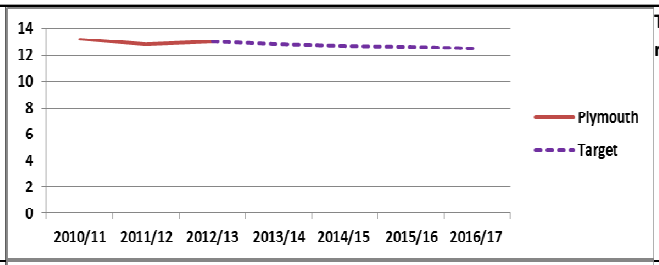
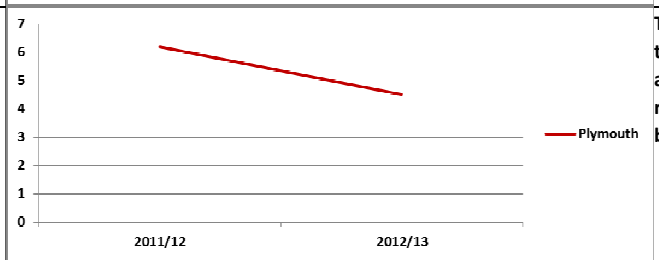
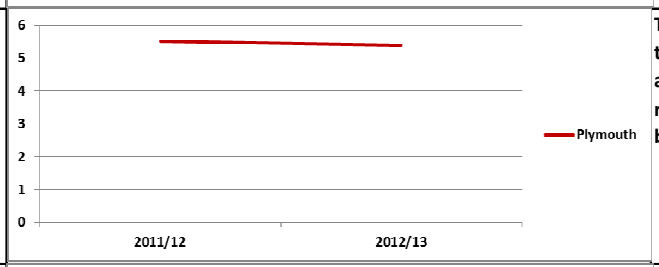
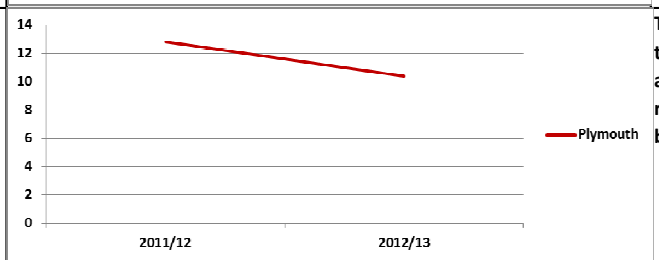
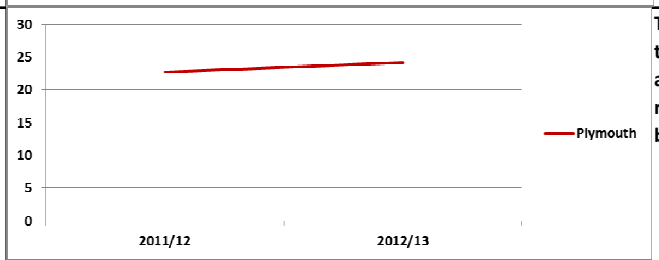
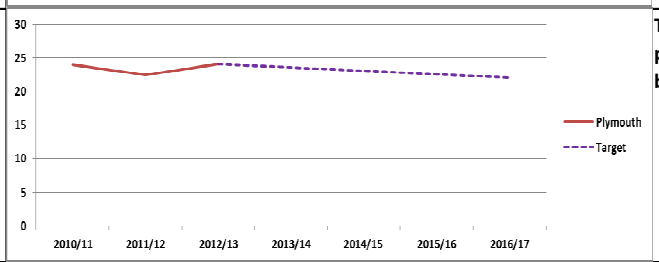
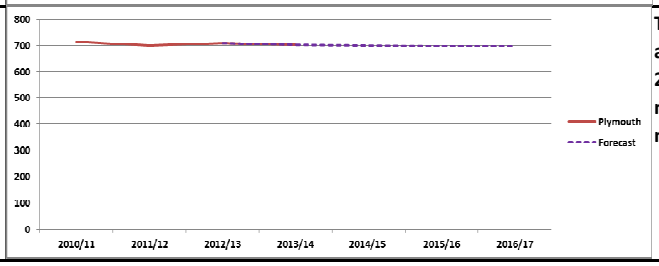
Commissioning function	Existing spend £000	2014/15		2015/16		2016/17	
		Lower @ 1% £000	Higher @ 3% £000	Lower @ 4% £000	Higher @ 7% £000	Lower @ 8% £000	Higher @ 12% £000
PCC 14/15 base	44,336	443	1,330	1,773	3,104	3,547	5,320
CCG 14/15 base	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Total savings							

10) The combination of the potential savings across the integrated adult service delivery project and the wider health and wellbeing transformation programme has the potential to exceed the transformation benefit figures stated in PCC's 3 year balanced budget. However, based on existing increasing trends and complexity in client demand, it will be essential for the programme to over-achieve in order to offset escalating spend in both health and Adult Social Care. Resource assumptions and re-profiled client trend data will be fed into a refresh of the council's medium term financial strategy in September 2014.

8.2 Benefits- Improved Health and Wellbeing Outcomes:

The performance measures detailed below will form part of the contract for the Integrated Delivery Provider and are in line with our priorities to address the health and social care needs across the city. It is anticipated that additional key performance indicators will be developed by the Integrated Commissioning Hub and added to the integrated provider specification.

Category	Performance Measure	Baseline data and target	
Community	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population		To achieve the forecast reduction by 2016/17 equating to a 13% reduction in the rate per 100,000
Community	Estimated Diagnosis rate for people with Dementia		To achieve the national target of 60%
Community	Social Care related quality of life		To achieve a 5% improvement in quality of life score
Community	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services		To achieve Better Care Fund targets and return to 90% rehabilitation success
Bed Based	Delayed transfers of care from hospital per 100,000 population (average days per month)		Target - To reduce and return to national average by 2016/17
Bed Based	Avoidable emergency admissions		To maintain performance

Bed Based	**30 day readmissions**		**To achieve a 4% reduction**
Wellbeing	**Self Reported Wellbeing - People with a low satisfaction score**		**To decrease and better the national and regional averages based on responses to ONS well-being survey.**
Wellbeing	**Self Reported Wellbeing - People with a low worthwhile score**		**To decrease and better the national and regional averages based on responses to ONS well-being survey.**
Wellbeing	**Self Reported Wellbeing - People with a low happiness score**		**To decrease and better the national and regional averages based on responses to ONS well-being survey.**
Wellbeing	**Self Reported Wellbeing - People with a high anxiety score**		**To decrease and better the national and regional averages based on responses to ONS well-being survey.**
Wellbeing	**Smoking prevalance in adults**		**To decrease smoking prevalence in Plymouth by 24.4% by 2021/22**
Wellbeing	**Alcohol related admissions to Hospital**		**To reduce admissions and achieve target set in 2014/15 using new national recording methodology**

8.3 Benefits – Organisational

For the workforce	• Providing greater and more flexible career opportunities and ability for up skilling/ skills transfer between professionals • Integrated workforce plan designed to deliver service strategies • Fewer barriers to effective decision making • Ability to focus on delivering support to citizens • Focus on culture change, empowering staff to take ownership of delivering high quality services
For commissioners	• Established protocols and pathways to ensure clear governance arrangements are in place • A system that is accountable to users and has been designed with their involvement • Joint investment in early identification, prevention and early intervention to prevent escalation of needs • Financial risk sharing arrangement to ensure value for money • Transparent performance and financial framework supported by joint governance to ensure robust management of quality and costs • Development of strong working relationships between community services, acute services and Primary Care through implementation of Integrated Case Management
For providers	• Critical mass of services to enable flexible use of resources • Opportunity to invest due to greater financial certainty and delivery flexibility • Increasing productivity and accelerating improvements in service quality through working with all stakeholders to redesign services. • Reducing waste in the system through eliminating the amount of duplication • Making better use of community assets due to flexibility and removal of organisational boundaries • More integrated back-office and support function to provide seamless support and enable efficiencies • Simplified contracting arrangements and more focus on effective delivery

9. RISKS AND DEPENDENCIES

9.1 Risks & Impact

Risk Description (A short summary of the event)	Current Risk Rating	Actions to reduce risk to target
Savings delivered from the integration are not sufficient to meet the funding gap	Red	Scrutiny and validation of the business case, and the projected benefits in further phases Account for optimism bias in financial model when developed
Disruption to service delivery with an impact on service quality and reputation	Red	1. As part of business case phase contingency planning undertaken as part of implementation planning 2. Key scenarios identified and mitigation plans developed
Staff/union resistance to the proposed changes and service redesign	Amber	1. Early consultation with Unions 2. Union representation at key workshops.
Difficulty in securing agreement across the partners to service redesign causes delay in delivery leading to savings targets being leaked, and delaying benefits realisation	Amber	1. Areas of potential disagreement highlighted and discussed early in the process 2. Identification of key decision makers and a dispute resolution process 3. Formal agreements and protocols in place to enable teams to work together
Multiple parties involved leading to partial support for business case or different decisions being made, which delays implementation	Amber	1. Key stakeholders identified at the start of the project and engaged regularly 2. Communications plan in place and key stakeholders provided with regular updates
Assumptions made will be wrong due to baseline data not being robust and so the business case is undermined	Red	1. Validation of the baseline data finance, the savings opportunities by service professionals2. Validation and ownership of the financial model by finance and service areas
Statutory, regulatory or political differences between Health and Social Care or partners lead to tensions (e.g.footprint of NEW Devon CCG will delay approval of business case and implementation)	Red	1. Potential areas of conflict identified early and formal protocols or agreements put in place
New legislation introduced which impacts on plans (e.g. Care Bill and Dilnot)	Red	1.Remain well-informed of policy and legislative developments and build in necessary changes early and challenge solution development
Negative impact of procurement or tax requirements on new delivery mechanism, for example VAT regulations	Amber	1. Consider likely impact of during the Options Appraisal process if new delivery vehicles/alternative structures are considered
Legal challenge regarding competition, contracting and procurement	Amber	1. Ensure notice periods to providers are duly followed and all consultation is documented
Resources required to deliver integration are not available/ funding does not exist to commission external resources	Amber	1. Develop programme delivery plan and get cross party sign up to this

		2.Cross- party investment planning meeting to agree resource commitment
Transforming Community Services programme does not support this level of integration or procure an integrated suite of community services	Red	1. Prioritise certain aspects of full business case development that provide a view on what services should be procured along with those provided by PCH
Failing to reach agreed terms that are compliant with Teckal criteria, due to differing legal opinions	Amber	1. Follow a long term view or phased approach to delivery model design and implementation. (i.e. implementing one delivery model for a short term with a view of moving to another in the long term) 2. Regular compliance checks and discussions
CCO objectives may not be achieved in time to support planned 2014/15 service improvements in People & Place directorates (e.g. finance, HR, ICT, FM, business support). This has the potential to delay achieving cashable savings for the IHWB programme if not resolved	Red	1. PCC / Portfolio guidance needed on what flexibility and freedom business areas have to determine what it can change independently and where it must follow the corporate line. Clarification over attribution of benefits: savings in support services are attributable to CCO irrespective of origin of the saving (in the same way as all premises savings are P&OD's)
Requirement for Corporate Support (Legal, HR, Finance etc) needs to be managed as there will be a lot of requests for their support and the Transformation 'pot' should be equally split between CCG and PCC.	Red	Early identification of work streams, careful profiling of resources, identify duplications of effort and mitigation accordingly

9.2 Dependencies

NEW Devon CCG has a number of organisational interdependencies. These include those with Devon County Council, and West Devon and South Hams District Councils, since the Western Locality of the CCG (which includes the entire Plymouth footprint) also includes populations within Devon.

The CCG are exploring different models of community health provision through its community services strategy.

Organisational dependency with NEW Devon's relationship with Kernow CCG as an associate commissioner e.g. the contract held with Plymouth Hospitals NHS Trust.

Another key interdependency is with the Better Care Fund (BCF) submission from Devon County Council, due to the CCG footprint covering both DCC and PCC (and an associated interdependency with South Devon CCG, due to part of their footprint being within DCC).

Within PCC, there are key dependencies with the Blueprint, version 2.0 of which is currently being developed, and the other programmes within the Transformation Portfolio. The Blueprint will drive the way in which the Council operates in the future, and as such it is vital that any options and recommendations are compliant with this document.

9.3 Constraints

There is a constraint around delegated authority for approving decisions concerning integration within the CCG. Plymouth City is exclusively within the Western Locality of the CCG, but decisions around integrated commissioning and provision, and the alignment with the Transforming Community Services programme, will potentially affect other localities within the CCG, meaning that a decision will be needed by the CCG Governing Body as well as support from the Western Locality Board.

As part of the project plan for achieving integration there will be work stream leads covering the following areas to ensure that any constraints that arise can be resolved by the end of Oct14 to allow for a decision to progress with integration in Nov 2014:

- Legal
- HR and Pensions
- Finance
- Business Intelligence
- Contracts and Commissioning
- Operations
- Communications
- Assets
- Risks
- IT
- Governance
- Clinical Governance and Quality

Current known constraints include the options and evaluation of the recommended approach of using a Section 75 agreement with CCG to consider the integration of the Adult Social Care delivery service with Plymouth Community Healthcare. In these agreements there are known challenges such as TUPE, staff pensions, the need to develop an integrated IT solution and to ensure the financial systems between Plymouth Community Healthcare and Plymouth City Council can be put in place. Based on experience of other sites that have integrated in this manner this is achievable in the time scales proposed.

There is a concern that there may be procurement issues with the adopted approach. This is being tested out with external legal advice.

A comprehensive human resource process and plan will be available and the relevant unions will be consulted with prior to the commencement of consultation with staff. Plans will set out in detail each step of the process, the timeframes involved and all the support and information staff will receive during the process. Our intentions are to support staff through the proposed changes if this decision is made following the consultation process.

10. Appendices

Integrated Delivery Criteria	Options			
	Delivery workforce remain in existing structures. Pathways for people requiring support are reviewed and streamlined. Budgets are re-profiled to follow individuals	Delivery workforce are re-configured to sit with shared line management arrangements linked to individual pathways. Staffing budgets are aligned accordingly	Delivery services staff come together under single management with some provision budgets joined to support specific pathways	Delivery services staff come together under single management structure. Budgets across the system are transferred to delivery service
	Strengths/ Weaknesses	**Strengths/ Weaknesses**	**Strengths/ Weaknesses**	**Strengths/ Weaknesses**
Person-Centred / Individual at Centre				
Improved customer experience - Person to receive seamless provision of care				
Co-ordinated care around the individual leading to improved customer outcomes				
Single point of contact				
Finance				
Influence over all spend to ensure resources are allocated effectively				
Ability to manage integrated spend strategically				
Achievement of savings target				
Strategic and operational oversight of complete integrated budget				
Set up costs (procurement, moving staff, etc.)				
Sustainability				
Stability (Future-proof) (low risk of trust breakdown or organisations still acting independently)				
Shared commitment to common vision and goals				

Potential to expand and improve services				
Meets the strategic objectives of the programme and organisations				
Human Resources				
Employer of Choice - e.g. staff benefits, staff decision making, opportunity for progression, etc.				
Potential issues around training , experience, recruitment, retention				
Clarity for staff of HROD process/terms and conditions/benefits, etc.				
Skills/expertise sharing				
Governance				
A clear governance structure that Council members support				
A clear governance structure that GPs support				
Appropriately managing risks				
Operational				
Information Management and Technology available to support this option				
Clear Leadership				
Full integration/centralisation of back office and business functions (HR, IT, medical records and assessment)				
Reduced Duplication				
Single organisation for providers to deal with				
Legal				
Is the option legal?				

Risk of challenge (TUPE, state aid, political (e.g. if seen as outsourcing), etc.)				
Miscellaneous				
Fit with national policy direction for local authorities and NHS				
Commissioner/Provider relationship				
Allows for sub-contracting with the third sector, therefore potential opportunity to attract new providers who can offer better quality of care at reduced prices				
Incentive and freedom to innovate				