#caringplymouth

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CARING PLYMOUTH

Thursday 3 April 2014
2 pm
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor James, Vice Chair
Councillors Mrs Foster, Fox, Gordon, Dr. Mahony, Monahan, Parker, Ricketts, Jon Taylor, Kate Taylor and Wright.

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

Tracey Lee
Chief Executive

CARING PLYMOUTH

PART I (PUBLIC COMMITTEE)

1. APOLOGIES

To receive apologies for non-attendance by Caring Plymouth members.

2. DECLARATIONS OF INTEREST

Members will be asked to make any declarations of interest in respect of items on this agenda.

3. CHAIR'S URGENT BUSINESS

To receive reports on business, which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. MINUTES (Pages 1 - 6)

To confirm the minutes of the last meeting held on the 6 March 2014.

5. PLYMOUTH HOSPITALS NHS TRUST QUALITY ACCOUNTS (Pages 7 - 10)

The panel will consider the Plymouth Hospital NHS Trust Quality Accounts.

6. CHILDREN'S HEALTH (Pages 11 - 42)

The panel to given an overview of children's health.

7. TRANSFORMATION PROGRAMME (INTEGRATED APPROACH TO HEALTH AND WELLBEING) (Pages 43 - 118)

The Panel to receive an overview of the Transformation Programme (Integrated Approach to Health and Wellbeing).

8. TRACKING RESOLUTIONS (Pages 119 - 122)

The panel to review and monitor the progress of tracking resolutions and receive any relevant feedback from the Cooperative Scrutiny Board.

9. WORK PROGRAMME (Pages 123 - 126)

To review the Caring Plymouth work programme for 2013 – 14.

10. EXEMPT BUSINESS

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve the likely disclosure of exempt information as defined in paragraph(s) of Part of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

PART II (PRIVATE COMMITTEE)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

Nil.

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Caring Plymouth

Thursday 6 March 2014

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor James, Vice Chair.
Councillors Mrs Foster, Fox, Gordon, Dr. Mahony, Monahan, Parker, Ricketts, Jon Taylor, Kate Taylor and Wright.

Also in attendance: Jim Gould – Independent Chair, Safeguarding Adults Board, Debbie Butcher – Head of Safeguarding, Rob Nelder – Public Health Consultant, Councillor Sue McDonald – Cabinet Member for Adult Social Care and Public Health, Carol Green – Commissioning Manager, Complex Care, NEW Devon CCG, Candice Sainsbury – Lead Officer and Amelia Boulter – Democratic Support Officer.

The meeting started at 2.00 pm and finished at 4.25 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

41. DECLARATIONS OF INTEREST

In accordance with the code of conduct, the following declarations of interest were made –

Name	Subject	Reason	Interest
Councillor Jon Taylor	Minute 45 – Public Health Outcomes Minute 46 – Continuing Healthcare	Employed by NEW Devon CCG	Private

42. CHAIR'S URGENT BUSINESS

The Chair and Vice Chair informed the panel that they would be completing a consultation document on the New Offence of ill-treatment or wilful neglect.

43. MINUTES

Agreed that the minutes of the meeting held on 30 January 2014 be confirmed.

44. SAFEGUARDING ADULTS BOARD

Jim Gould, Independent Chair of the Safeguarding Adults Board and Debbie Butcher, Head of Safeguarding provided the panel with an overview of the Safeguarding Adults Board (SAB). It was reported that –

a. Plymouth City Council co-ordinate the SAB and the board is made up of multi-agency partners who work together to keep safe the most vulnerable adults in the city;

b. there were two Serious Case Reviews currently taking place that involved vulnerable adults;

c. the SAB has a good relationship with Care Quality Commission (CQC). They meet quarterly with a senior manager from CQC, the meeting also involves health colleagues and the Cabinet member;

d. 1,700 people undertook the alerter training programme last year; this training is for anyone working within the Plymouth boundaries that come into contact with vulnerable adults. The training covers how to report abuse and recognise signs of abuse.

In response to questions raised, it was reported that –

e. with domestic abuse cases they would look at any trends/patterns and work collaboratively with officers, social workers to identify domestic abuse. The Domestic Abuse Unit would be notified and if a child was involved they would always think child first;

f. there was a training budget of £33k and the training was based on policies and procedures produced by the SAB. They observe and adapt the training as required and quality assure the delivery;

g. it was highlighted that more communication was required to raise the awareness of safeguarding;

h. some of the priorities for the SAB –
   - personalised budgets;
   - move away from reactive and move to preventative safeguarding;
   - producing a multi-agency strategy;
   - place of safety.

i. once a call is received by contact centre reporting alleged abuse, more information would be gathered and the police contacted. A strategy meeting with partners (case conference) would take place. An Independent Chair would lead each case conference;

j. a lot agencies were involved in a SCR. Each agency would have to undertake an internal investigation, each investigation can take up to 12 months to complete;

k. with regard to police welfare checks on vulnerable people, it was reported that they would be undertaking a review of Section 136 and would be working very closely with the out of hours service. It was also highlighted that the safeguarding police should be disseminating the information regarding vulnerable people with their colleagues.

Agreed that –

1. the Safeguarding Business Plan and Annual Report to be brought back to a future meeting for review.

2. the panel be provided with a clearer understanding and awareness around safeguarding interventions and responsibilities to include –

   - Engagement with Care Homes;
   - Risk around personalised budgets;
   - The range of issues that cause safeguarding alerts.

3. a review of places of safety and use of Section 136 to be brought back to the panel for consideration.

4. a report on the risk associated with integration and the delegation of responsibilities to ensure the council retains control over safeguarding.

45. PUBLIC HEALTH OUTCOMES FRAMEWORK

Rob Nelder, Public Health Consultant and Councillor McDonald, Cabinet Member for Adult Social Care and Public Health, presented the Public Health Outcomes Framework quarterly report. It was reported that –

a. Plymouth's public health settlement was underfunded by £3m for 2013-14 and discussions were taking place on the poor settlement;

b. the Director for Public Health had been appointed and would commence on 1 April 2014. Further appointments were made which would increase the capacity within the team;

c. public health were working across the council and were currently undertaking 60 pieces of work. They were looking at the wider impact of public health across the council;

d. the Director of Public Health's Annual report would shortly be published.

In response to questions raised, it was reported that –

e. they were working with GP practices to promote men's health. The Live Well Team was commissioned to carry out specific health checks for the hard to reach groups;

f. Duncan Selbie, Chief Executive, Public Health England has requested to meet Tracey Lee, Chief Executive, Councillor Sue McDonald, Cabinet Member for Adult Social Care and Public Health and Councillor Tudor Evans, Leader of Plymouth City Council following receipt of letter sent to the Secretary of State for Health to discuss Plymouth's public health settlement;

g. with regard to air pollution, this was not an area that public health currently have responsibility for. The Public Protection Team which looks at air pollution would soon be part of public health.

Agreed that –

1. As part of the induction pack into Child's Health, preparation of briefs for the worst child health performance indicators including current resourcing, activities, barriers and opportunities –

- Breastfeeding
- Under 18 Conceptions
- Excess weight
- Unintentional injuries
- Vaccinations (MMR and HPV)
- Smoking in pregnancy

2. Quality of air to be brought back to a future meeting –

- Prior to the Energy from Waste Plant commencing operation that Public Health via Plymouth City Council's Environmental Protection Team or the appropriate agency, commissions baseline air quality testing at various points in the city to monitor future effects on air quality.

46. CONTINUING HEALTH CARE

Carol Green, Commissioning Manager, Complex Care (NEW Devon CCG) gave a presentation on Continuing Healthcare.

In response to questions raised, it was reported that -

a. with regard to understanding the process for the assessment criteria for continuing healthcare, it was reported that the Department of Health's leaflet and Age UK provides good guidance in this area;

b. it was a complicated framework and the CCG were aware of the need to improve their website links to Plymouth City Council's website;

c. those people that had issues with the assessment criteria, it was found that the process either was not followed correctly and/or was down to poor communication of the process.

Agreed that links are placed on Plymouth Online Directory (POD) on Plymouth City Council's website to information links about personal budgets (e.g. Department of Health's leaflet and Age UK leaflet) and that the link should also provide advice on when and how to claim continuing healthcare.

47. **RECOMMENDATIONS FROM BUDGET SCRUTINY**

The panel noted the recommendations from Budget Scrutiny, in particular recommendation 25.

Agreed that an action plan addressing the revised approach to health inequalities across the city is brought to the Caring Scrutiny panel within six months by the incoming Director of Public Health.

48. **TRACKING RESOLUTIONS**

The panel noted the progress on the tracking resolutions. With regard to –

Minute 18 – Social Care Budget – information as requested by the panel would be circulated to the panel.

Minute 28 – Public Health Outcomes – the panel were provided with a quarterly update on the Public Health Outcomes Framework.

Minute 36 – Better Care Fund (BCF) – progress on the BCF provision would be reviewed by the panel when more information is available.

Agreed that –

1. The Better Care Fund plan to be brought back to a future meeting. Specific areas the panel would like to review in more detail, such as the 7 day working will be shared at a later date, once the plan has been published.

2. the Chair of the Caring Plymouth panel to send a letter in support of the Leader to the Secretary of State regarding Plymouth's Public Health Settlement and its subsequent impact on the BCF.

49. **WORK PROGRAMME**

The panel noted the work programme.

50. **EXEMPT BUSINESS**

There were no items of exempt business.

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Plymouth Hospitals NHS
NHS Trust

Caring Plymouth - 2 April 2014

Plymouth Hospitals NHS Trust
Quality Account 2013-14 Priorities

Plymouth Hospitals NHS Trust is currently in the process of drafting our annual Quality Account for the year 2013-2014.

As in previous years the Trust is very keen to seek the involvement and feedback of key stakeholders in order to ensure that the final document reflects the needs of the healthcare community.

Potential quality priorities for inclusion in Plymouth Hospitals NHS Trust Quality Account for 2013/14 and for delivery in 2014-15 are set out below. These priorities reflect the organisation's commitment to improvement over the coming year. A number of key documents were considered when selecting the draft priorities including the Trust Assurance Framework, current operational and quality performance data, and external reports including Francis, Keogh, Berwick and CQC areas of focus in the past year.

Members are asked to consider and comment on the potential quality priorities set out below and select the top five which you believe should be the key priorities. Once all feedback has been received finalised quality priorities will be included as part of the Quality Account and plans defined to ensure their delivery.

Aim	Rationale
Patient Experience We will actively seek and respond to the views of patients and improve their experience.	A positive patient experience is an essential component of the care that we provide.
Patient Harm We will reduce the incidence of patient harm events including pressure sores, falls, hospital-acquired pneumonia and infections. We will also maintain safety in our operating theatres.	It is essential that we protect our patients by making every effort to reduce avoidable harm.

Plymouth Hospitals NHS
NHS Trust

Aim	Rationale
Operational Flow We will enhance operational capacity and optimise patient flow throughout the Trust with a view to reducing the number of outliers and the number of patients moved at night.	Effective and efficient systems and patient pathways are critical in maintaining a safe environment for our patients.
Access We will develop and implement robust plans for addressing RTT and follow up backlog issues.	There are national standards associated with RTT and the Trust has faced significant challenges in meeting these standards in 2013/14.
Diagnostics We will improve the timeliness and quality of our diagnostics services.	This is an area which is critical to the patient pathway and the Trust has not consistently met national targets in conducting and reporting in a timely manner.
Mortality We will review all hospital deaths to identify those which may have been avoidable or where the care could have been improved.	It is good practice to review all deaths to identify those which may have been avoidable or where the care could have been improved. There is a national expectation that Trusts have such arrangements in place.
7 Day Working We will develop an appropriate response to the current national debate on the implementation of 7 day working.	There is currently a national debate on the implementation of 7 day working as it provides greater flexibility and planning for delivery of care
Quality Governance We will transform our quality governance arrangements and ensure that it meets best practice.	Effective quality governance is the foundation upon which we promote and implement sustained learning and improvement.
Clinical Administration We will transform our clinical administration services to ensure that patients receive accurate and timely notification of appointments.	Effective and timely clinical administration is critical in ensuring that patients are seen in at the right time. This is one of our transformation programmes.

Plymouth Hospitals NHS
NHS Trust

Aim	Rationale
Staffing We will improve our approach to workforce planning and ensure that we have the right staff in the right place and at the right time.	Having the right staff in the right place at the right time is a fundamental element to the delivery of safe high quality care for our patients. Patient survey results show us patients do not always feel the wards are adequately staffed.
Safety Culture We will develop and implement an approach to conducting safety culture assessments throughout the Trust and improving the outcomes from these assessments.	The Francis Report highlighted the critical importance of culture in maintaining safe services for patients. We have already undertaken some work across the Trust in this area.
Health Records We will improve the quality of our health records and ensure that we are compliant with national standards in this regard.	The CQC found the Trust to be non-compliant with the essential standard associated with health records. Whilst a lot of work has been undertaken in this area further improvements are required.

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CARING PLYMOUTH

Introduction to Child Health

3rd April 2014

Author(s): Robert Nelder and Julie Frier

Job Title: Consultant in Public Health (Intelligence), Consultant in Public Health (Medicine)

Department: Office of the Director of Public Health

Date: 3 April 2014

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1. Introduction and setting the scene

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The report of this review was published in February 2010 and contained nine key messages:

(1) Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.

(2) There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.

(3) Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

(4) Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism.

(5) Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

(6) Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.

(7) Reducing health inequalities will require action on six policy objectives:

(A) Give every child the best start in life
(B) Enable all children young people and adults to maximise their capabilities and have control over their lives
(C) Create fair employment and good work for all
(D) Ensure healthy standard of living for all
(E) Create and develop healthy and sustainable places and communities
(F) Strengthen the role and impact of ill health prevention

(8) Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.

(9) Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

The Marmot review is clear that tackling inequalities is something we cannot afford to neglect. Persistent inequalities across a wide range of areas provide clear examples of the wider costs to society of the impact of inequalities from early childhood development and education, employment and working conditions, housing and local neighbourhood conditions, ever increasing health and social care costs and, more generally, the freedom to participate equally in the wider benefits of society. The benefits of reducing health inequalities are economic as well as social. More than three-quarters of the population nationally do not have disability-free life expectancy up to the age of 68. If Plymouth wants to have a healthy population, working until 68 years, it is essential to take action now to raise the general level of health and flatten the social gradient in health. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.

To reduce the steepness of the social gradient in health, action must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is known as proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem. The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources.

However economic growth without reducing relative inequality will not reduce health inequalities. The economic growth of the last 30 years has not narrowed income inequalities. Although there is far more to inequality than just income, income is linked to life chances in a number of salient ways. A fair society would give people more equal freedom to lead flourishing lives. To achieve this, the Marmot Review contained two policy goals:

(1) To create an enabling society that maximises individual and community potential.

(2) To ensure social justice, health and sustainability should be at the heart of all policies.

Health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.

The central subject of the Marmot review is that avoidable health inequalities are unfair and putting them right is a matter of social justice. Finding a way to do this in the current economic climate will not be easy. But to do nothing is not an option if the human and economic costs are too high. The health and well-being of today's children as they grow into adults depend on having the courage and imagination to rise

to the challenge of doing things differently, to put sustainability and well-being before economic growth and bring about a more equal and fair society.

Policy objective (A): Give every child the best start in life

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective if they have not had good early foundations.

- Investment in early years is vital to reducing health inequalities and needs to be sustained, otherwise its effect is lessened.

- Returns on investment in early childhood are higher than in adolescence.

- Currently, spending is higher in later childhood years and needs to be rebalanced towards the early years.

- Gaps between individuals and social groups emerge early in the life course.

- Early interventions during pregnancy and on-going support in early years are critical to the long-term health of the child and other long-term outcomes.

- Universal and proportionately targeted interventions are necessary.

- Emerging evidence shows that Sure Start Children's Centres have a positive impact on child outcomes.

- Families have the most influence on their children.

- Adequate levels of income and material and psychological support and advice for parents across the social gradient are critical.

- Intensive home visiting is effective in improving maternal and child health.

- Good parent–child relationships in the first year of life are associated with stronger cognitive skills in young children and enhanced competence and work skills in schools.

- Good quality early childhood education has enduring effects on health and other outcomes

- These outcomes are particularly strong for those from disadvantaged backgrounds

- A good quality workforce makes a difference to health outcomes but the childcare workforce remains low paid and low status

- Pre and postnatal policy and services should be integrated.

2. The child health journey

Policy objective (A): Give every child the best start in life

2.1 Pregnancy

Pregnancy is one of the most important stages in the life cycle. This is when the foundations of future health and wellbeing are laid down, and is a time when parents are particularly receptive to learning and making changes. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy.

The 'Healthy Child Programme pregnancy and the first five years of life' sets out the good practice framework for prevention and early interventions services for this period. It consists of a mixed approach of preventative programmes for all children and families with targeted and additional support to meet identified needs. It has a major emphasis on supporting parents, the importance of attachment and positive parenting, greater focus on pregnancy and building a progressive universal programme that responds to different risk factors of child's future chances as well as ensuring healthy development.

Pre-conception care has been defined as a set of interventions to identify and modify a woman's health or pregnancy outcome through prevention and management. Because a significant proportion of pregnancies are unintended (about half), the negative consequences of many behaviours, illnesses, and medications can affect fetal development early in pregnancy before a woman even realises that she is pregnant.

Thus, healthcare encounters during a woman's reproductive years should include counselling on medical care and healthy behaviours to optimise pregnancy outcome if it were to occur. For example, healthy women should begin folic acid supplementation ideally at least three months before conception and continue until 12 weeks' gestation.

Antenatal care is the care received from healthcare professionals during pregnancy. Children's health development begins in pregnancy and it is the responsibility of midwives to assess the health and social care needs of mothers ideally by the twelfth week of pregnancy. The midwife will co-ordinate the support of other professionals as needed to support the mother and family as required. It includes:

- a series of antenatal appointments to check on maternal and baby health (home and clinics)
- ultrasound scans
- screening checks for conditions that may affect the baby[1]•
    - Fetal Anomaly Screening Programme: first trimester Down's syndrome; 20 week ultrasound scan checking for physical abnormalities

[1] Screening is a way of finding people at risk of a health problem before they get symptoms. This means they can get earlier, and potentially more effective, treatment or make informed decisions about their health. Within the Healthy Child Programme, there are both antenatal and newborn screening programmes:

    - Infectious Diseases in Pregnancy Screening Programme: first trimester hepatitis B, HIV, syphilis and rubella susceptibility testing at booking
    - Sickle Cell and Thalassaemia Screening Programme
- immunisations
- antenatal classes (Great Expectations)
- referral on for additional support
- Healthy Start scheme if eligible[2]

Pregnancy care is carried out by a range of professional groups depending on maternal and fetal needs. It would include midwives, ultrasonographers, health visitors, GPs, Children Centre staff and if additional needs are identified may also include obstetricians, paediatricians, smoking cessation advisors, dieticians, anaesthetists, physiotherapists to name but a few.

Key measures of outcome of healthy pregnancy are mortality (maternal and baby). Actions/interventions that could reduce the inequalities in infant mortality are reducing teenage pregnancy, smoking and obesity, reducing poverty, poor housing/ overcrowding and improving infant nutrition and ensuring access and take up of healthcare services and targeted interventions aimed at reducing sudden unexpected deaths in infancy.

Low birth weight is a well-known contributor to poor outcomes in infancy and is particularly associated with prematurity and other risk factors such as smoking in pregnancy. Smoking is the major modifiable risk factor contributing to low birth weight; babies born to women who smoke weigh on average 200g less than babies born to non-smokers. The incidence of low birth weight is twice as high among smokers as non-smokers (Messecar, 2001).

Giving up smoking is one of the key steps that pregnant women and their partners can take to reduce the risks to themselves and their baby during pregnancy. Smoking in pregnancy can cause a range of serious health problems including miscarriage, premature birth, low birth weight (<2500g), sudden unexpected death in infancy.

[2] Healthy Start provides a nutritional safety net and encouragement for breastfeeding and healthy eating to around 600,000 women and children in over 450,000 very low income and disadvantaged families across the UK. Healthy Start vouchers can be put towards the cost of milk, fresh or plain frozen fruit and vegetables in 30,000 retail outlets (small shops as well as major supermarkets). The scheme also provides coupons that can be exchanged via the NHS locally for free Healthy Start vitamin supplements for children, pregnant women and new mothers.

Appointment	What should happen
First contact with your midwife or doctor	Your midwife or doctor should give you information about: • folic acid supplements • food hygiene, including how to reduce the risk of a food-acquired infection • lifestyle, including smoking cessation and the risks of recreational drug use and alcohol consumption • antenatal screening tests.
Booking appointment	Your midwife or doctor should give you information about: • how the baby develops during pregnancy • nutrition and diet, including vitamin D supplements • exercise, including pelvic floor exercises • antenatal screening tests • your pregnancy care pathway • where to have your baby • breastfeeding and workshops • antenatal classes • maternity benefits. Your midwife or doctor should: • see if you may need additional care or support • plan the care you will get throughout your pregnancy • ask about your job to identify any potential risks • measure your height and weight and calculate your body mass index • measure your blood pressure and test your urine for protein • find out whether you are at increased risk of gestational diabetes or pre-eclampsia • ask about mental illness and ask about any signs of depression • offer you screening tests and make sure you understand what is involved before you decide to have any of them • offer you an ultrasound scan to estimate when the baby is due • offer you an ultrasound scan at 18 to 20 weeks to check the physical development of the baby.
16 weeks	Your midwife or doctor should give you information about the ultrasound scan you will be offered at 18 to 20 weeks and help with any concerns or questions you have. Your midwife or doctor should: • review, discuss and record the results of any screening tests • measure your blood pressure and test your urine for protein • consider an iron supplement if you are anaemic.
18 to 20 weeks (anomaly scan)	*Ultrasound scan to check the physical development of the baby if you wish it.*

25 weeks*	Your midwife or doctor should: • check the size of your abdomen • measure your blood pressure and test your urine for protein.
28 weeks	Your midwife or doctor should: • check the size of your abdomen • measure your blood pressure and test your urine for protein • offer more blood screening tests • offer first anti-D treatment if you are rhesus D-negative.
31 weeks*	Your midwife or doctor should: • review, discuss and record the results of any screening tests from the last appointment • check the size of your abdomen • measure your blood pressure and test your urine for protein.
34 weeks	Your midwife or doctor should give you information about preparing for labour and birth, including how to recognise active labour, ways of coping with pain in labour and your birth plan. Your midwife or doctor should: • review, discuss and record the results of any screening tests from the last appointment • check the size of your abdomen • measure your blood pressure and test your urine for protein • offer second anti-D treatment if you are rhesus D-negative.
36 weeks	Your midwife or doctor should give you information about: • breastfeeding, including hints and tips for success • caring for your newborn baby • vitamin K and screening tests for your newborn baby • your own health after the baby is born • being aware of the 'baby blues' and postnatal depression. Your midwife or doctor should: • check the size of your abdomen • check the position of the baby and discuss options to turn the baby if he or she is bottom first (breech position) • measure your blood pressure and test your urine for protein.
38 weeks	Your midwife or doctor should give you information about what happens if your pregnancy lasts longer than 41 weeks. Your midwife or doctor should: • check the size of your abdomen

	• measure your blood pressure and test your urine for protein.
40 weeks*	Your midwife or doctor should give you more information about what happens if your pregnancy lasts longer than 41 weeks. Your midwife or doctor should: check the size of your abdomen measure your blood pressure and test your urine for protein.
41 weeks	Your midwife or doctor should: • check the size of your abdomen • measure your blood pressure and test your urine for protein • offer a membrane sweep • offer induction of labour.

2.2 First year of life

From birth, newborns undergo dramatic physical and mental changes. Babies are born with 25% of their brains developed and then there is a rapid period of development so that by three years of age their brains are 80% developed. In these first few years, the impact of neglect, poor parenting and other adverse experiences such as maternal depression can have a profound effect on how children are emotionally 'wired'. Research shows that although the brain continues to develop, these early experiences strongly influence a child's social and emotional development and their ability to reach their full potential. For example children of mothers who have postnatal depression are less likely to show secure attachment at 36 months and are more likely to have social, emotional and cognitive problems at five years and are more likely to experience depression at 16 years.

Prevention and intervention to address adverse experiences is therefore key in a child's early life and therefore requires the identification of emerging problems as early as possible through assessment and then a response to the identified needs. Intervention with effective programmes to reduce risk factors and increase protective factors can de-escalate the problem and prevent individuals and families needing more intensive and costly support and treatment, leading to better outcomes.

In particular, early intervention to promote social and emotional development can significantly improve mental and physical health, educational attainment and employment opportunities. Research also shows that there are significant economic benefits of early intervention with consistently good returns on investment.

The 'Healthy Child Programme pregnancy and the first five years of life' sets out the good practice framework for prevention and early interventions services for this period. It has a major emphasis on supporting parents, the importance of attachment and positive parenting and building a progressive universal programme that responds to different risk factors of child's future chances as well as ensuring healthy

development. Health visitors deliver the programme (once care has been handed over from the midwife), which is available to all families.

The government is currently introducing a new model for health visiting services which will strengthen the provision of the healthy child programme across England. The model will bring improved access and time with families, providing services where it best suits the family – at home, in health settings including GP surgeries, in Sure Start Children's Centre as well as other non-traditional settings.

Within this programme there is a universal component which is available for all children, parents and carers. Families needing different levels of service and may need different services at different times. This is reflected in the new service model for health visiting.

2.2.1 Universal Provision

- **Checks:** New born examination ; 6-8 weeks; 1 year
- **Infant nutrition:**
  - Vitamins and Healthy Start
  - Initial feeding: breastfeeding and safe, good practice for formula feeding
  - Weaning
  - Dental health
- **Health promotion and Injury prevention**
  - Maintaining infant health: anticipatory, practical guidance on reality of early days with an infant, healthy sleep practices and bath, book, bed routine to increase parent–infant interaction
  - Reduction of risk of sudden unexplained deaths in infancy
  - Dental health
- **Promoting sensitive parenting and attachment:**
  - Introduce parents to the 'social baby', by providing them with information about the sensory and perceptual capabilities of their baby using a range of media
  - Promote closeness and sensitive, attuned parenting, by encouraging skin-to-skin care and the use of soft baby carriers.
- **Screening**
  - Newborn hearing screening
  - Newborn and Infant Physical Examination (NIPE) Programme: a head to toe physical examination and specific examination of eyes, heart, hips and testes in boys, within 72 hours of birth (maternity service or GP) and again at 6 to 8 weeks of age (GP)
  - Newborn Blood Spot Screening Programme: a test at age five days for phenylketonuria (PKU), congenital hypothyroidism (CHT), sickle cell disease (SCD), cystic fibrosis (CF) and medium-chain acyl-CoA dehydrogenase deficiency (MCADD)
- **Immunisations** (see diagram below)

Routine childhood immunisations from June 2013

When to immunise	Diseases protected against	Vaccine given	Immunisation site**
Two months old	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib (Pediacel)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus (from July)	Rotavirus (Rotarix)	By mouth
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel)	Thigh
	Meningococcal group C disease (MenC)	Men C (NeisVac-C or Menjugate)	Thigh
	Rotavirus (from July)	Rotavirus (Rotarix)	By mouth
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR (Priorix or MMR VaxPRO)	Upper arm/thigh
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	dTaP/IPV (Repevax) or DTaP/IPV (Infanrix-IPV)	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given)	Upper arm
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (Gardasil)	Upper arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	MenC†	MenC (Meningitec, Menjugate or NeisVac-C)††	Upper arm

** Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book.
† This vaccination will be introduced during the 2013/14 academic year.
†† The vaccine supplied will depend on the brands available at the time of ordering.

Immunisations for at-risk children

At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intradermal)

- **Promotion of development and developmental checks**
- **Assessing maternal mental health**

2.2.2 Progressive services based on identification of need

- **Additional support**
  - Parenting, infant feeding, maternal depression, parental relations, babies with health or developmental problems, young mothers
- **High intensity home visiting**
  - Family Nurse Partnership; Universal Plus Health Visiting
- **Referral to specialist**
  - e.g. smoking cessation, speech and language therapist, paediatric care
- **Partnership response** as part of Child In Need or Safeguarding or complex need care package

2.3 Early years (1-4/5 years)

This is a key time for speech and language, social, emotional and cognitive development. It is also a time when parents need support as children gain independence and begin to enter into early years education settings.

2.3.1 Universal Provision

- **Immunisations:** as per programme

- **Checks:** The two to two and a half year review is led by a health visitor, who will review the child's developmental progress (social, emotional, behavioural and neurodevelopmental) and health status and, with the parents, plan any future support and services to meet the needs of the child and family. The review is an important opportunity to ensure that all immunisations are up-to-date.

- **Health promotion & Injury prevention**
  - Safety advice as child becomes more mobile
  - Dental health
  - Healthy eating
  - Active play
  - Promoting child health and lifestyles

- **Monitoring of development**

- **Supporting parenting**

- **Support to early years services for key health promoting messages**
  - Promoting child health and healthy lifestyles
  - Nutrition
  - Active play
  - Accident prevention
  - Dental health

- **Transfer to school: Health questionnaire**

2.3.2 Progressive services based on identification of need

- **Additional support**
  - Parenting, children at risk of obesity / feeding problems, maternal depressions, parental relations, babies with health or developmental problems / abnormalities
- **High intensity home visiting**
  - Family Nurse Partnership; Universal Plus Health Visiting
- **Referral to specialist**
  - e.g. smoking cessation, speech and language therapist, paediatric care
- **Partnership response** as part of Child In need or Safeguarding or complex need care package

Policy Objective (B): Enable all children, young people and adults to maximise their capabilities and have control over their lives

Achieving the best possible health sets a key foundation for a child or young person to flourish, achieve and stay safe as they grow up. Health is crucially linked to education, so that a child with poor educational outcomes may experience not just educational problems in their future but also poor health outcomes, but also conversely good health and emotional wellbeing are associated with improved attendance and attainment at school. Children who thrive at school are also better placed to act on health information.

Lifestyles established through childhood and adolescence influence a person's health throughout their life. For example;

- 8 in 10 obese teenagers go on to be obese adults;
- half of life time mental illness starts at age 14
- more than 8 out of 10 adult smokers started before 19
- adolescents who binge drink are 50% more likely to be dependent on alcohol or misusing other substances by age 30

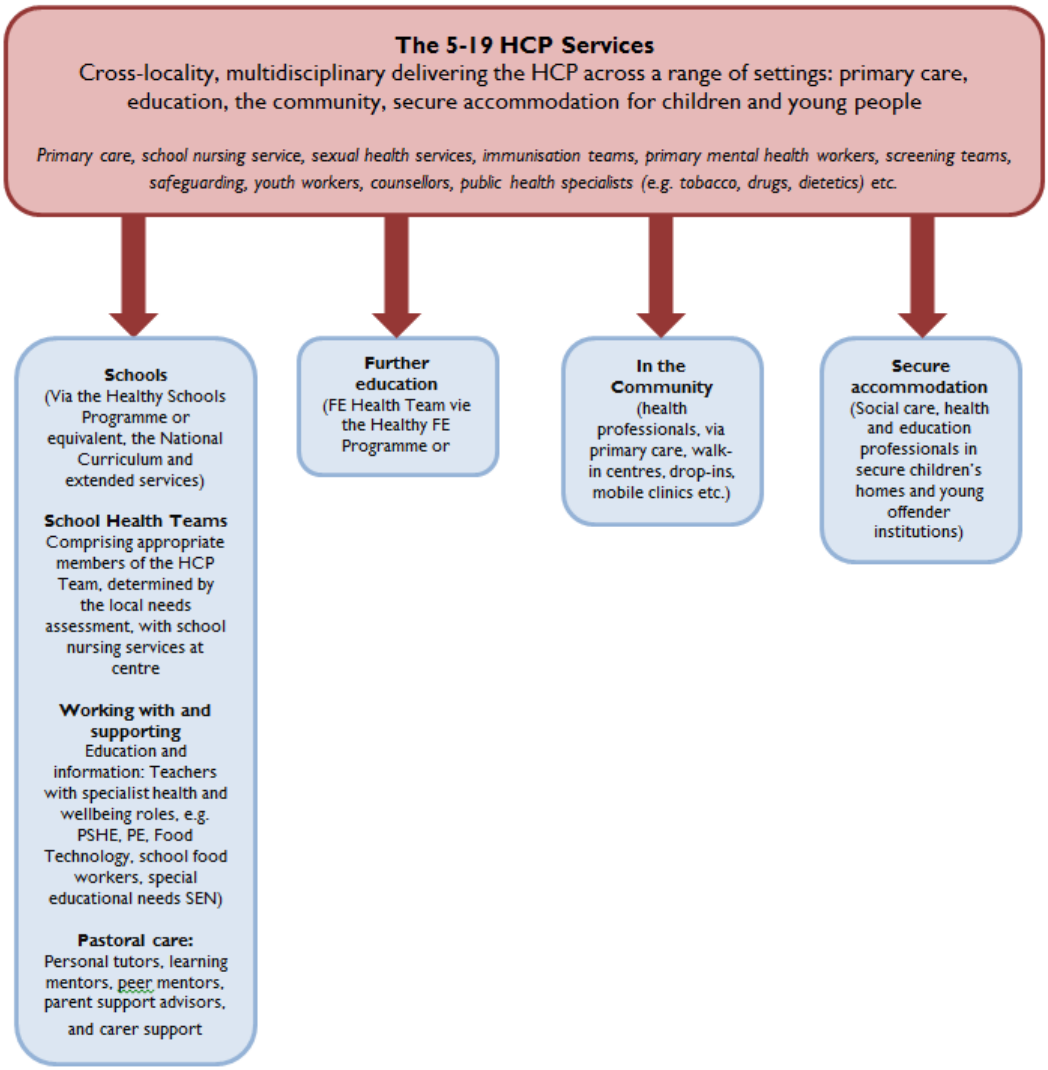
The Healthy Child Programme 5-19 sets out the good practice framework for prevention and early interventions services for children and young people age 5-19 and recommends how health, education and other partners working together across a range of settings can significantly enhance and child or young person's life chances. It focuses on providing healthy environments, building resilience, working in partnership with educational and other settings.

The Healthy Child Programme 5-19 is delivered by a wide range of agencies and disciplines across a locality in a range of settings, which can also facilitate access to more specialist services.

Key priority areas for this programme focus more on the health protecting and promoting behaviours that support children, young people and adults to maximise their capabilities and have control over their lives through:

- Emotional health, psychological wellbeing and mental health
- Promoting health weight
- Supporting children and young people with long term conditions or disability
- Teenage pregnancy and sexual health
- Drugs, alcohol and tobacco

Schools have an important role to play in the promoting of healthy lifestyles underpinned by their statutory duty to promote the wellbeing of their pupils, to provide healthy school food and provision of health promoting aspects of the curriculum e.g. Personal Social, Health and Economic Education (PHSE) and Relationship and Sex Education (RSE).



2.4 Primary School age (4/5-11)

2.4.1 Universal Provision

- **School Entry Health questionnaire:** opportunity to review immunisations, hearing screening question, parental concerns
- **Orthoptics screen for visual impairment**
- **National Child Measurement Programme:** Reception and Year 6
- **Health promotion**
  - Support for appropriate social and emotional development
  - Prevention and tackling of bullying
  - Physical activity- PE curriculum and active travel
  - Healthy Nutrition

2.4.2 Progressive services based on identification of need

- **Identification of additional needs**
  - Referral to specialist (child based or parent based) e.g. smoking cessation, speech and language therapist, paediatric care

  - Support to for children, parents and school for children with complex health problems, special educational needs or complex welfare concerns

  - Partnership response as part of Child In need or Safeguarding or complex need care package

- **Support for parents and carers**
  Support to for children, parents and school for parents / carers with problems (young carers, parents with alcohol, substance misuse, mental health problems, learning difficulties or domestic violence)

2.5 Secondary school/college age (11-19)

Emerging evidence on adolescent brain development shows that in pre puberty and puberty there is a rapid and dramatic re-organisation of the brain. These changes affect behaviour and attitudes at a time when health and wellbeing choices can be challenging. Social capabilities are being developed and there is a heightened sensitivity to reward. The combination of these can lead to greater risk taking behaviours

Risk taking behaviour is considered a normal and positive part of growing up and supports the development of resilient, positive young people. However, harmful risk taking behaviours, such as smoking, drug and alcohol misuse or unprotected sex, can reduce life chances and opportunities and impact on health and well-being.

There is a close link between harmful risk taking behaviours and the most vulnerable children and young people, and similarly there are the ubiquitous links to deprivation and inequality. Risky behaviours overlap and cluster and have areas of similarity and co-dependency.

Levels of autonomy in the family, sense of belonging in schools and feeling safe in the local community can promote resilience. The fact of their youth means there is time to prevent damaging behaviours and attitude developing and time to help them establish good patterns of managing their health

2.5.1 Universal Provision

Immunisations: as per programme

Transfer to secondary school: School Entry Health questionnaire: opportunity to review immunisations, parental and young person concerns, pass on ongoing needs, follow upon NCMP results

Health promotion

- Support for appropriate social and emotional development
- Prevention and tackling of bullying
- Physical activity- PE curriculum and active travel
- Healthy Nutrition
- Sexual health

2.5.2 Progressive services based on identification of need

- **Identification of additional needs**
  - Referral to specialist (child based or parent based) e.g. smoking cessation, drugs and alcohol misuse services, smoking cessation, paediatric care, CAMHS

  - Support to for children, parents and school for children with complex health problems, special educational needs or complex welfare concerns

  - Partnership response as part of Child In need or Safeguarding or complex need care package

- **Support for parents and carers**
  Support to children, parents and school for parents/carers with problems (young carers, parents with alcohol, substance misuse, mental health problems, learning difficulties or domestic violence)

3. Commissioning

With effect from April 2013, health and children's health commissioning architecture was changed. This is explained in below:

Key LA Public Health commissioning responsibilities
Healthy Child Programme for school-age children, including school nursing
Contraception (over and above what GPs provide) Testing and treatment of sexually transmitted infections, sexual health advice, prevention and promotion
Mental health promotion, mental illness prevention and suicide prevention
Local programmes to address physical inactivity and promote physical activity
Local programmes to prevent and address obesity, including **National Child Measurement Programme** and weight management services
Drug misuse services, prevention and treatment
Alcohol misuse services, prevention and treatment
Local smoking related activity, including stop smoking services and prevention activity
Locally-led initiatives on nutrition
Population level interventions to reduce and prevent birth defects (with PHE)
Dental – oral health promotion

Key CCG commissioning responsibilities
Children's healthcare services
Maternity Services (and routine newborn services)
CAMHS
Adult mental health services
Community health services, including speech and language, continence, wheelchair services and home oxygen services (except for public health services such as health visiting and family nursing)
Elective hospital care
Urgent and emergency care, including A&E and ambulance services (for anyone present in their geographic area), out-of-hours primary medical services except where retained by practices
Services for people with learning disabilities
NHS Continuing healthcare
Infertility services

Key NHS CB commissioning responsibilities: public health
Public health services for children from pregnancy to age 5 (Healthy Child Programme 0-5), including health visiting and family nurse partnership and responsibility for Child Health Information Systems (responsibility for children's public health 0-5 due to transfer to LAs in 2015)
Immunisation programmes
National Screening programmes
Public health services for those in prison or places of detention
Sexual assault referral services

Key NHS CB commissioning responsibilities: healthcare
Primary medical services commissioned under the GP contract, out of hours where retained by practices
Pharmaceutical services provided by community pharmacy services, dispensing doctors and appliance contractors
NHS sight tests and optical vouchers
Dental services
All health services for children, young people and adults in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children's homes, secure training centres, immigration removal centres, police custody suites)
Health services for families of members of the armed forces (where they are registered with Defence Medical Services) (Primary care for members of the armed forces will be commissioned by the Ministry of Defence)
Specialised and highly specialised services

Based on NHS Commissioning Board Commissioning Factsheet for CCGs (July 2012) www.commissioningboard.nhs.uk

4. Major needs assessments

4.1 The National child measurement programme (NCMP)

- The NCMP involves the annual measurement of the height and weight of children in reception year and Year 6, and the return of the data to the Health and Social Care Information Centre (HSCIC).

- The purpose of the programme is to provide robust public health surveillance data on child weight status, to understand obesity prevalence and trends at local and national levels, to inform obesity planning and commissioning and underpin the Public Health Outcomes Framework indicator on excess weight in 4-5 and 10-11 year olds.

- The NCMP provides parents with feedback on their child's weight status: to help them understand their child's health status, support and encourage behaviour change and provide a mechanism for direct engagement with families with overweight, underweight and obese children.

- Local authorities took on a duty for local delivery of the NCMP from 1st April 2013. As a mandated public health programme, provision to resource the delivery of the NCMP is made through the ring-fenced public health grant for local authorities. Nationally the programme is overseen by Public Health England.

- Being overweight or obese does not only endanger children's health. It can affect their attendance at school, their learning and their academic achievement. It may also call for extra staff training to ensure that children with health conditions can be appropriately supported during the school day.

- All of the 67 Infant, Junior, and Primary Schools in Plymouth agreed to take part in the 2012/13 NCMP and 5,021 children were weighed and measured.

- The overall participation rate (92.5%) remains well above the 85% target set by the Department of Health.

- The prevalence of obese children in 2012/13 was above the national average for Year R (9.9% compared to 9.3%) and below the national average for Year 6 (17.5% compared to 18.9%).

4.2 Survey of Health Visitor caseloads

- Health visiting teams deliver the Healthy Child Programme to all children under the age of five years registered with a Plymouth General Practice (GP). The teams are based in localities and are affiliated to the GP practices and Children's Centres within those localities. Alternatively, when a family with one or more children aged less than five years moves into the area (and prior to them registering with a GP practice) the child is allocated a health visiting team on a geographic basis.

- Surveying of health visitor caseloads was first undertaken in the Bristol and Weston area in the early 1990s. Local managers were concerned with the workload of their health visitors and therefore established a list of 26 family-related health needs indicators. Each health visitor went through their caseload and assessed each family against the 26 factors. Individual families were found to have considerable differences in need with individual family scores ranging from zero factors present to 19 factors present. The data collected in this first survey of health visitor caseloads was validated against other health-related data to confirm its robustness.

- A similar survey was first carried out in the former South & West Devon Health Authority area in 1999. The original data collection forms used in the Bristol and Weston survey were amended to include (1) the GP practice code, (2) the family postcode and (3) the number of children in specific age groups in the family. Good (reliable) information is available for Plymouth every two years from 2002 to 2012. The information collected since 2002 has been used extensively by NHS Plymouth and its partners. Most importantly perhaps, the information is used to ensure that the distribution of health visiting 'resources' across the city is equitable.

- The survey results are regarded as indicative of the health circumstances of the entire population of families with children under the age of five years usually resident in the city of Plymouth, acknowledging however that a few families may not have been included in the health visitor caseloads at the time of the survey (for instance, first-born babies to newly established families).

- Based upon their professional judgement, health visitors assess each family against a set of factors using standardised definitions and a common survey form. These factors cover observations of the health, social and lifestyle situation of the family together with details of illnesses and disabilities in the family. The association of a family with a particular health factor is therefore dependent upon the judgement of the heath visitor based upon their observations of the family in question. One survey form is completed by a health visitor for each family on their caseload, a total of 13,635 records (families) in 2012.

- As the survey is based on what the health visitor knows about the family (as opposed to being based on a more traditional face-to-face survey) the information collected is subjective and there is also the risk that information about particular aspects of family life can remain 'hidden' from the health

visitor. Having said that, the information collected is more timely than traditional health indicators and is based on a large number of families (>13,000) across the whole city. The focus of the survey is on 'health' not 'healthcare' and 'need' not 'service delivery.' Most importantly perhaps, information on the wider determinants of health is collected.

Figure 1: The family health needs profile form 2013

Family Health Needs Profile 2013

Number of children in the family:	
Less than 3 years	
3-4 years (inclusive)	
5-15 years (inclusive)	

Family postcode: | | | | | | | |

Ethnic group: |

1. One parent family	(0=no, 1=yes)	
2. Violence within the family	(0=no, 1=yes)	
3. Difficulties with spoken English	(0=no, 1=yes)	
4. Separation and/or divorce in last year	(0=no, 1=yes)	
5. Parent(s) have learning difficulties	(1 point per parent)	
6. Parent(s) have literacy problems	(1 point per parent)	
7. Parent(s) are under 18 now	(1 point per parent)	
8. Parent(s) 'in care' or abused as a child	(1 point per parent)	
9. Children at risk of significant harm (including those on the child protection register)	(1 point per child)	
10. Three or more children within the household aged under five years	(0=no, 1=yes)	
11. In receipt of social work, probation, NSPCC or other professional support	(0=no, 1=yes)	
12. A bereavement which is significant to the family	(0=no, 1=yes)	
13. Major wage earner is unemployed	(0=no, 1=yes)	
14. Low income, dependant on benefits	(0=no, 1=yes)	
15. Poor housing having detrimental effect	(0=no, 1=yes)	
16. In temporary accommodation	(0=no, 1=yes)	
17. Three or more changes of address in last year	(0=no, 1=yes)	
18. Parent(s) abuse alcohol	(1 point per parent)	
19. Parent(s) smoke	(1 point per parent)	
20. Parent(s) abuse drugs	(1 point per parent)	
21. Disabled or chronically sick adult within the household or close family	(1 point per adult)	
22. Depressed or mentally ill parents	(1 point per adult)	
23. Low birthweight (only children born in the last year)	(0=no, 1=yes)	
24. Previous sudden infant death (S.I.D.) in the family	(0=no, 1=yes)	
25. Centiles indicate the need for extra monitoring	(1 point per child)	
26. Children with special educational or medical needs	(1 point per child)	
27. Developmental delay	(1 point per child)	
28. Behavioural problems	(1 point per child)	
29. Family affected by social isolation	(0=no, 1=yes)	
30. Parenting problems	(0=no, 1=yes)	
31. Failed to follow up professional recommendation to seek medical opinion	(0=no, 1=yes)	

4.3 Health and wellbeing survey in Plymouth schools

- Six of the inner-city secondary schools are currently carrying out a health and wellbeing survey.

- The survey is being completed (online) by pupils in years 8 (12-13 year olds) and 10 (14-15 year olds)

- The survey process co-ordinated by Stoke Damerel Community College. Significant advice and guidance has been provided by the Council's Public Health team.

- The Public Health Team has also provided funding to allow the survey to be expanded to cover the remaining secondary schools in the city.

- The Schools Health Education Unit (University of Exeter) has designed the survey and will be analysing the results.

- Pupils at the remaining secondary schools will complete the survey in the Summer term.

- The questionnaire covers the following issues, diet, smoking, alcohol consumption, substance misuse, stress and support, physical activity, sex and relationships, staying safe, bullying, enjoying and achieving, leisure and money, carer responsibilities.

- As the survey is being completed online the results should be available in the early Autumn.

- The information is being collected in a way that will allow the results to be made available by neighbourhood, electoral ward and locality.

- It is hoped that a modified version of the survey will be rolled out to Primary Schools although the detail of this is still to be confirmed.

5. Child health 'performance' in Plymouth

5.1 The PHE child health profile 2014

Public Health England

Child Health Profile
March 2014

Plymouth

This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	South West	England
Live births in 2012			
	3,418	61,131	694,241
Children (age 0 to 4 years), 2012			
	15,700 (6.1%)	303,400 (5.7%)	3,393,400 (6.3%)
Children (age 0 to 19 years), 2012			
	60,000 (23.3%)	1,197,800 (22.4%)	12,771,100 (23.9%)
Children (age 0 to 19 years) in 2020 (projected)			
	63,200 (23.3%)	1,273,400 (22.3%)	13,575,900 (23.7%)
School children from minority ethnic groups, 2013			
	2,802 (8.6%)	66,110 (10.6%)	1,740,820 (26.7%)
Children living in poverty (age under 16 years), 2011			
	22.4%	16.2%	20.6%
Life expectancy at birth, 2010-2012			
Boys	78.3	80.0	79.2
Girls	82.1	83.9	83.0

Children living in poverty

Map of the South West, with Plymouth outlined, showing the relative levels of children living in poverty.

Contains Ordnance Survey data

Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2011-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 23.3% of the population of Plymouth. 8.6% of school children are from a minority ethnic group.

The health and wellbeing of children in Plymouth is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 22.4% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average.

Children in Plymouth have average levels of obesity: 10.0% of children aged 4-5 years and 17.6% of children aged 10-11 years are classified as obese.

The teenage pregnancy rate is worse than the England average. In 2012/13, 56 teenage girls gave birth. This represents 1.7% of women giving birth which is worse than the England average.

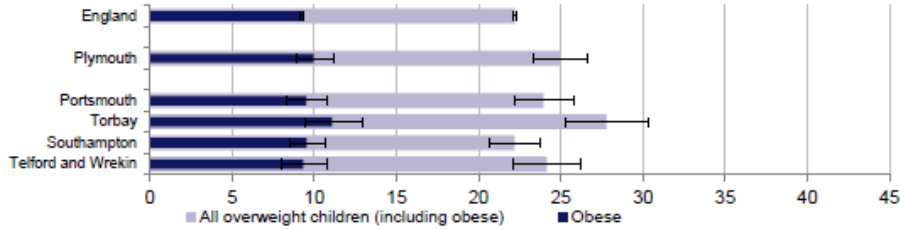
A higher than average proportion of children are judged to have achieved a good level of development at the end of the foundation stage, with 57.3% achieving this milestone. The foundation stage assessment is completed in the final term of the academic year in which a child reaches the age of five.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

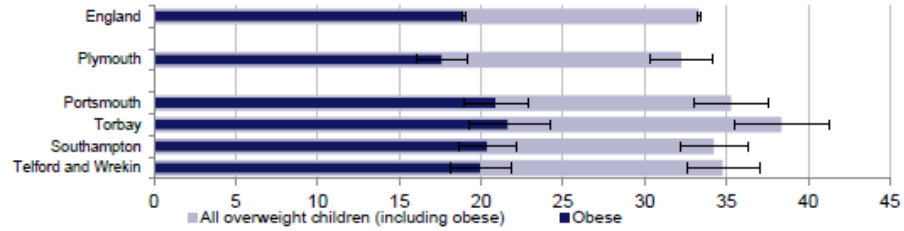
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a worse percentage in Reception and a similar percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2012/13 (percentage)



Children aged 10-11 years classified as obese or overweight, 2012/13 (percentage)

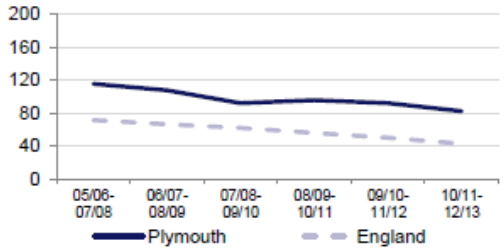


Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval. Data source: National Child Measurement Programme (NCMP), Health and Social Care Information Centre

Young people and alcohol

In comparison with the 2005/06-2007/08 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher than the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

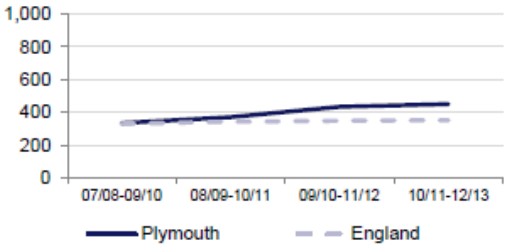


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is higher in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)



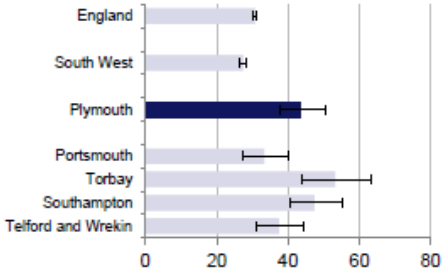
*Information about admissions in the single year 2012/13 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

Plymouth Child Health Profile — March 2014

These charts compare Plymouth with its statistical neighbours, the England and regional average and, where available, the European average.

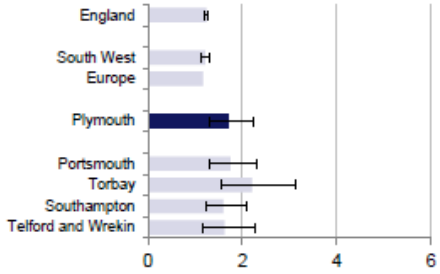
Teenage conceptions in girls aged under 18 years, 2011 (rate per 1,000 female population aged 15-17 years)



In 2011, approximately 44 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is higher than the regional average. The area has a higher teenage conception rate compared with the England average.

Data source: ONS

Teenage mothers aged under 18 years, 2012/13 (percentage of all deliveries)

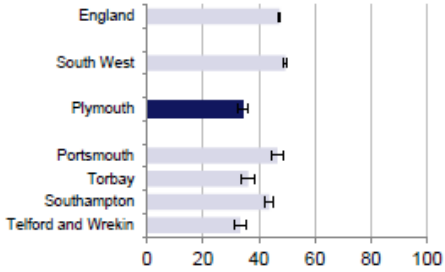


In 2012/13, 1.7% of women giving birth in this area were aged under 18 years. This is higher than the regional average. This area has a higher percentage of births to teenage girls compared with the England average and a higher percentage compared with the European average of 1.2%*.

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

* European Union 27 average, 2009. Source: Eurostat

Breastfeeding at 6 to 8 weeks, 2012/13 (percentage of infants due 6 to 8 week checks)

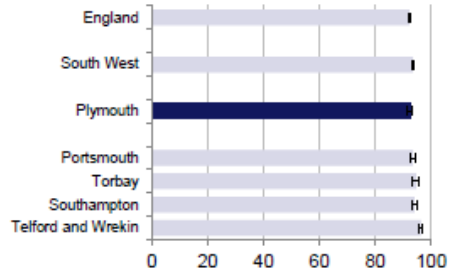


In this area, 34.2% of mothers are still breastfeeding at 6 to 8 weeks. This is lower than the England average. 69.1% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Data source: PHE

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2012/13 (percentage of children age 2 years)



Compared with the England average, a similar percentage of children (92.6%) have received their first dose of immunisation by the age of two in this area. By the age of five, 86.0% of children have received their second dose of MMR immunisation. This is lower than the England average. In the South West, there were 80 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data sources: Health and Social Care Information Centre, PHE

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

Plymouth Child Health Profile — March 2014

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	15	4.4	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	6	11.6	12.5	21.7	4.0
Health protection	3 MMR vaccination for one dose (2 years)	3,042	92.6	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	3,224	98.1	96.3	81.9	99.4
	5 Children in care immunisations	235	83.9	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	1,416	33.1	34.4	89.1	14.1
Wider determinants of ill health	7 Children achieving a good level of development at the end of reception	1,715	57.3	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	1,727	60.8	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	5	16.7	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	690	7.8	5.8	10.5	2.0
	11 First time entrants to the youth justice system	150	669.8	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	10,140	22.4	20.6	43.6	6.9
	13 Family homelessness	188	1.6	1.7	9.5	0.1
	14 Children in care	370	73	60	166	20
	15 Children killed or seriously injured in road traffic accidents	8	17.8	20.7	45.6	6.3
Health improvement	16 Low birthweight of all babies	256	7.4	7.3	10.2	4.2
	17 Obese children (4-5 years)	274	10.0	9.3	14.8	5.7
	18 Obese children (10-11 years)	389	17.6	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	24.9	27.9	53.2	12.5
	20 Under 18 conceptions	186	43.6	30.7	58.1	9.4
	21 Teenage mothers	56	1.7	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	42	82.0	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	30	72.6	75.2	218.4	25.4
Prevention of ill health	24 Smoking status at time of delivery	564	16.7	12.7	30.8	2.3
	25 Breastfeeding initiation	2,327	69.1	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,180	34.2	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	5,111	332.4	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	647	153.3	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	543	127.1	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	81	148.8	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	36	70.7	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	242	425.5	346.3	1,152.4	82.4

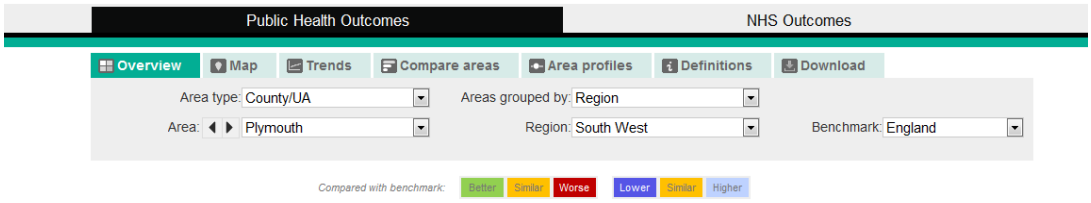
Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012
2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13
5 % children in care with up-to-date immunisations, 2013
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012
17 % school children in Reception year classified as obese, 2012/13
18 % school children in Year 6 classified as obese, 2012/13
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2011
21 % of delivery episodes where the mother is aged less than 18 years, 2012/13
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13
24 % of mothers smoking at time of delivery, 2012/13
25 % of mothers initiating breastfeeding, 2012/13
26 % of mothers breastfeeding at 6-8 weeks, 2012/13
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13

The spine chart shows that of the 32 indicators, there are four greens, 16 ambers and 12 reds. The 12 reds are:

(10) 16-18 year olds NEET
(11) First time entrants to the youth justice system
(12) Children in poverty (under 16s)
(14) Children in care
(20) Under 18 conceptions
(21) Teenage mothers
(22) Hospital admissions due to alcohol specific conditions
(24) Smoking status at time of delivery
(25) Breastfeeding initiation
(26) Breastfeeding at 6-8 weeks
(28) Hospital admissions caused by injuries (0-14 years)
(32) Hospital admissions self-harm (10-24 years)

5.2 Children and Young People's Health Benchmarking Tool



Indicator	Period	England	South West	Bath and North East Som...	Bournemouth	Bristol, City of	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
Healthy life expectancy at birth (Male)	2009 - 11	63.2	65.1	65.7	63.0	63.1	62.6	66.2	66.9	65.2	*	66.2	60.9	66.0	65.1	67.3	64.9	63.5	66.5
Healthy life expectancy at birth (Female)	2009 - 11	64.2	66.3	68.2	63.9	63.2	64.6	66.6	66.8	69.1	*	64.2	60.7	67.5	66.3	70.5	64.3	64.4	68.0
Life Expectancy at birth (Male)	2010 - 12	79.2	80.0	80.6	78.6	78.3	79.5	80.4	81.2	80.0	*	79.6	78.3	80.2	80.4	81.0	79.3	79.1	80.4
Life Expectancy at birth (Female)	2010 - 12	83.0	83.9	84.4	83.1	83.0	83.5	84.1	85.3	84.1	*	83.5	82.1	84.1	84.1	84.6	82.7	82.4	83.9
Children in poverty (all dependent children under 20)	2011	20.1	15.6	12.5	19.4	24.9	17.6	13.2	12.7	14.1	2.9	14.4	21.6	15.9	14.3	11.3	16.6	23.0	11.4
Children in poverty (under 16s)	2011	20.6	16.2	13.1	19.7	25.3	18.1	13.6	13.2	14.7	2.8	14.9	22.4	16.5	14.9	11.9	17.3	23.8	11.9
School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	51.7	55.6	50.7	57.5	49.5	49.4	63.8	60.9	52.0	*	63.7	57.3	48.0	53.3	67.0	55.1	*	51.9
School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	36.2	36.8	28.7	42.2	33.7	33.0	47.8	40.0	33.8	*	39.3	42.4	29.7	31.1	47.1	37.3	*	29.2

Indicator	Period	England	South West	Bath and North East Som...	Bournemouth	Bristol, City of	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	36.2	36.8	28.7	42.2	33.7	33.0	47.8	40.0	33.8	*	39.3	42.4	29.7	31.1	47.1	37.3	*	29.2
School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	69.1	70.4	71.3	70.0	69.7	67.0	73.0	69.8	71.7	*	77.0	70.5	70.3	72.4	70.6	65.9	*	67.4
School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	55.8	55.2	55.3	57.9	58.5	53.8	56.6	53.2	52.2	*	56.7	60.3	47.8	55.5	55.3	53.0	*	48.2
Pupil absence	2011/12	5.11	5.21	5.03	5.46	5.69	5.20	5.06	5.41	5.08	4.96	5.11	5.47	4.92	5.22	5.05	5.00	5.66	5.12
First time entrants to the youth justice system	2012	537	561	705	371	936	537	483	266	466	-	807	670	357	689	774	581	728	378
16-18 year olds not in education employment or training	2012	5.8	5.5	4.8	5.4	7.9	5.1	5.3	4.9	5.2	-	3.2	7.8	6.4	4.5	4.7	6.3	5.2	6.2
Low birth weight of term babies	2011	2.8	2.5	2.6	2.6	2.3	2.4*	2.3	2.6	2.4	*	1.8	2.9	2.4	2.8	2.4	3.0	3.2	2.0
Breastfeeding - Breastfeeding initiation	2012/13	73.9	77.9	83.9	76.9	80.7	79.8	77.8	78.0	74.3	*	81.4	69.1	76.9	79.1	77.3	76.8	71.1	81.0
Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2012/13	47.2	49.3	59.7	52.3	*	46.7	50.6	52.0	50.6	*	50.7	34.2	52.3	51.4	46.3	47.6	36.0	47.6
Smoking status at time of delivery	2012/13	12.7	13.3	9.4	13.2	12.3	13.8	9.9	16.7	13.5	*	11.3	16.7	13.2	17.4	9.7	13.0	17.5	13.3
Under 18 conceptions	2011	30.7	27.3	16.2	31.7	33.2	30.3*	26.0	22.5	21.5	*	25.6	43.6	31.3	27.8	20.5	30.8	53.1	22.9
Under 18 conceptions: conceptions in those aged under 16	2011	6.1	5.1	4.1	5.1	5.4	5.4*	4.4	5.0	5.1	*	3.2	7.7	3.6	6.0	3.9	5.1	7.3	5.3
Child development at 2-2.5 years	2010	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	22.2	22.9	23.2	21.4	21.9	24.1	24.9	19.9	24.6	*	24.3	24.8	23.2	23.3	16.7	23.2	28.0	21.3
Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	33.3	30.9	26.4	31.5	33.9	31.0	29.7	29.2	32.9	*	31.2	32.1	28.3	29.4	30.3	32.8	38.5	29.4
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	103.8	103.9	120.0	116.6	104.2	105.5	103.8	116.3	80.4	*	80.6	153.3	131.3	114.2	91.8	96.8	81.2	94.0
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	130.7	144.2	133.0	169.8	137.3	166.2	132.5	162.2	126.0	*	106.1	127.1	210.0	156.4	111.7	145.2	151.1	162.5
Emotional well-being of looked after children	2011/12	13.8	15.0	15.4	13.8	14.8	14.5	16.6	14.2	14.9	-	14.6	17.3	12.5	15.5	13.8	13.2	15.4	14.1

Indicator	Period	England	South West	Bath and North East Som...	Bournemouth	Bristol, City of	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2011	2125	2031	1475	2044	2074	1881	1934	1612	1917	-	3614	2319	1535	1786	2024	2331	3057	1861
Chlamydia diagnoses (15-24 year olds) - CTAD (Male)	2012	1368	-	545	1765	1851	1446	1480	1082	1291	*	1073	1295	998	1054	383	1553	2507	1150
Chlamydia diagnoses (15-24 year olds) - CTAD (Female)	2012	2568	-	1207	2816	4413	2966	2850	1835	2237	*	2680	2117	1942	2271	1048	3271	4852	2460
Chlamydia diagnoses (15-24 year olds) - CTAD (Persons)	2012	1979	-	874	2290	3142	2194	2141	1432	1759	-	1866	1688	1458	1646	703	2413	3644	1766
Population vaccination coverage - Hepatitis B (1 year old)	2012/13	*	-	*	*	*	*	*	*	85.7*	*	*	100*	*	*	*	100*	*	100*
Population vaccination coverage - Hepatitis B (2 years old)	2012/13	*	-	100*	*	*	*	*	*	71.4*	*	*	41.2*	*	*	*	100*	*	100*
Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2012/13	94.7*	96.1*	95.9*	94.9*	96.4*	94.9*	95.9*	97.2*	96.9*	*	97.3*	96.8*	94.9*	93.8*	97.9*	96.8*	97.3*	96.6*
Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2012/13	96.3*	97.3*	98.5*	96.6*	96.7*	96.7*	97.0*	98.1*	97.5*	*	98.1*	98.1*	96.6*	95.8*	98.7*	98.0*	98.6*	97.6*
Population vaccination coverage - MenC	2012/13	93.9*	95.5*	95.4*	93.9*	95.4*	94.4*	95.3*	96.8*	96.6*	*	97.1*	96.3*	93.9*	93.5*	96.6*	95.1*	96.8*	96.4*
Population vaccination coverage - PCV	2012/13	94.4*	96.0*	95.7*	94.4*	95.8*	94.9*	95.8*	97.2*	96.9*	*	97.4*	96.3*	94.4*	94.5*	97.5*	95.9*	97.0*	96.6*
Population vaccination coverage - Hib / MenC booster (2 years old)	2012/13	92.7*	93.0*	93.3*	92.0*	90.8*	93.1*	92.1*	94.6*	95.2*	*	94.2*	92.0*	92.0*	89.9*	95.7*	94.4*	94.6*	94.2*
Population vaccination coverage - Hib / Men C booster (5 years)	2012/13	91.5*	92.7*	93.4*	94.9*	90.5*	92.4*	92.4*	94.6*	90.9*	*	94.1*	93.2*	94.9*	90.7*	96.2*	93.7*	93.2*	92.9*
Population vaccination coverage - PCV booster	2012/13	92.5*	94.1*	95.2*	93.1*	91.9*	92.4*	92.8*	96.2*	96.5*	*	95.2*	93.2*	93.1*	93.4*	96.0*	95.4*	95.4*	95.2*
Population vaccination coverage - MMR for one dose (2 years old)	2012/13	92.3*	93.5*	93.9*	92.1*	90.7*	92.7*	92.8*	94.9*	96.1*	*	94.2*	92.6*	92.1*	92.8*	95.7*	94.9*	94.8*	94.2*
Population vaccination coverage - MMR for one dose (5 years old)	2012/13	93.9*	94.6*	94.9*	95.2*	93.1*	95.1*	93.8*	94.7*	93.8*	*	95.9*	95.4*	95.2*	94.4*	96.7*	95.9*	94.5*	94.9*
Population vaccination coverage - MMR for two doses (5 years old)	2012/13	87.7*	88.7*	88.5*	88.1*	83.1*	89.5*	87.8*	91.2*	91.4*	*	89.8*	86.0*	88.1*	88.8*	91.6*	90.2*	86.4*	89.5*
Population vaccination coverage - HPV	2012/13	86.1*	81.5*	81.8*	84.1*	68.2*	63.6*	75.7*	86.1*	86.8*	*	90.2*	79.9*	84.1*	91.3*	78.1*	96.2*	83.5*	89.6*
Infant mortality	2009 - 11	4.29	3.49	2.42	2.65	2.73	4.00	3.91	3.63	3.13	-	3.81	4.99	3.65	3.51	2.28	2.97	6.01	3.50
Tooth decay in children aged 5	2011/12	0.94	0.79	0.49	0.90	0.78	0.92	0.68	0.74	0.87	0.29	0.78	0.65	0.79	0.86	0.42	0.82	1.03	0.75

The areas where Plymouth is red (in this framework and also in the Public Health Outcomes framework (PHOF)) are:

- Healthy life expectancy at birth (male)
- Healthy life expectancy at birth (female)
- Life expectancy at birth (male)
- Life expectancy at birth (female)
- Children in poverty (all dependent children under 20)
- Children in poverty (under 16s)
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year old not in education, training or employment
- Breastfeeding initiation
- Breastfeeding at 6-8 weeks
- Smoking at time of delivery
- Under 18 conceptions
- Excess weight in 4-5 year olds
- Hospital admissions caused by unintentional and deliberate injuries in 0-14s
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage (MMR two doses, five year olds)
- Population vaccination coverage (HPV)

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TRANSFORMATION PROGRAMME
SUMMARY OF PROJECTS DELIVERING SAVINGS IN 2014/15

Integrated Health and Wellbeing

1. Programme Summary

The programme is aligned to the wider PCC transformation portfolio of programmes, which has been developed to deliver the Council's Blueprint for future service delivery. It will also play a key role in describing what an integrated suite of community health and social care services may look like in the future, which will then feed into the CCG's Transforming Community Services programme as part of its procurement timescales.

The programme will aim 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. The programme will consist of the following three projects:

- Integrated Commissioning
- Co-operative Children and Young People's Services
- Integrated Community Health and Social Care Provision

1.1 Strategic Case

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 programme will deliver effective integrated care to the population of Plymouth and in doing so will streamline cost.

1.2 Aim

The programme aims to engage with commissioning and delivery partners to establish a more collaborative, integrated and strategic approach to how PCC and the CCG commission and deliver services, with the aim of reducing costs, improving patient/service user experience and improving outcomes for residents in Plymouth.

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
- 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.
- Working cooperatively with partners, enhance the lives and outcomes for children and young people.
- 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 and integrated system of health and wellbeing, focusing on increasing the capacity and assets of people and place

2. Integrated Approach to Health and Wellbeing Project Summary

2.2 Background

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. This approach fits with PCC's ambition of being a co-operative council, 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".

2.3 Project Definition

The Integrated Commissioning Project aims to build upon co-location and existing joint commissioning arrangements, with the focus of establishing a single commissioning function, the development of integrated commissioning strategies and pooling of budgets.

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"

2.4 Project Objectives

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 and 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.

- Single team developing and implementing key commissioning strategies for Health, Care and other services.
- Cost savings achieved through better control, planning and utilisation of resources.
- An integrated budget for Health and Social Care
- Team collaborates through sharing knowledge and skills on each strategy
- Potential platform for further collaboration in the future

2.5 Project Scope

2.5.1 Integrating Commissioning

The integrated commissioning project aims to design and develop a whole new commissioning architecture across both the Western Locality of NEW Devon CCG and the People Directorate of Plymouth City Council. This element of the project will specifically look to develop

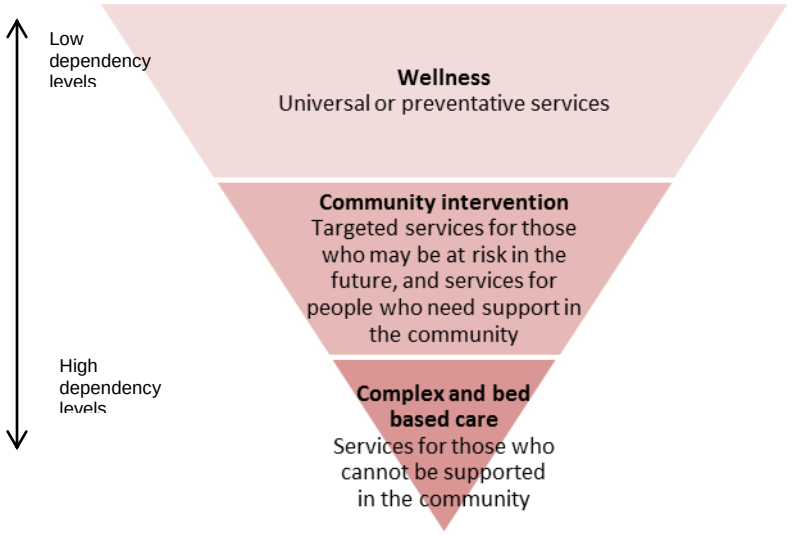
- Integrated Commissioning Function.
- Development of New Governance Architecture.
- Section 75 for pooled budget

The table below shows the different elements that are in scope-

PCC	CCG
All people directorate commissioning functions including but not limited to;	Western Locality; Partnerships
Cooperative Commissioning Team;	
Homes and Communities including Community Safety	
ODPH	
Certain Policy and Performance elements	

Integrating Provision through Commissioning

Integrated commissioning not an end in itself and the primary drivers of this project is to improve service delivery and provision with the aim of improving outcomes and value for money. This project will therefore develop three co-dependent commissioning strategies with the aim of commissioning an integrated system of health anf wellbeing.



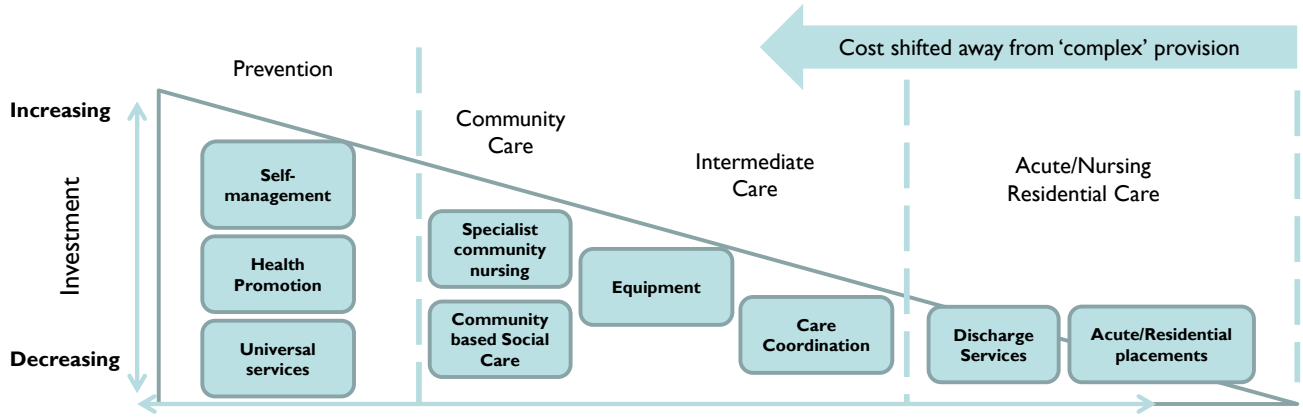
The three inter related dependent strategies are-

***Wellness*:** *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 aim of this integrated commissioning activity is to move the balance of spend away from Complex provision towards services in Community and Wellness, in order to manage the demand and avoid costs incurred:



The scope of the programme will therefore 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. 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.

The estimated directly addressable spend for the Integrated Commissioning Project is as follows:

Project	PCC	CCG
COMMISSIONING	2,803,219	3,068,022

Some simplifying assumptions have been made about certain aspects of addressable spend in scope. These are as follows:

All Plymouth Community Healthcare spend relates to individuals from Plymouth – this is because there is a separate Community Health services provider that covers the remainder of the Western Locality (which is within Devon County Council area)

60% of Plymouth Hospitals NHS Trust spend commissioned by the Western Locality of the CCG is attributable to individuals from Plymouth – this is because approximately 60% of the population of the Western Locality live in Plymouth, and Derriford Hospital is the only major acute care provider within the Western Locality

For certain areas of CCG Partnerships commissioned spend, we have assumed that 45% of the spend relates to the Western Locality (as approximately 45% of the population covered by NEW Devon CCG live in the Western Locality), and of this spend, we have assumed that 60% is attributable to individuals living in Plymouth (as 60% of the population of the Western Locality live in Plymouth)

The addressable commissioning spend shown in the table above does not currently include finance and/or business support/commissioning support functions from either PCC or CCG at present. Further development of the programme comes with a requirement to determine what areas of both organisations are within the scope of the programme. The CCG will need to determine which functions are predominantly serving the Plymouth territory and/or the wider CCG. There are also likely to be other sources of public sector funding (such as work and pensions) which will need to be considered as part of the next phase of work.

2.5.2 Exclusions from 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) within scope.

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. Other public sector commissioning organisations such as Police and Crime Commissioner, Probation, NHS Area Team 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.

The Integrated Commissioning Project will set down the Integrated Commissioning Strategies that will shape and change health and wellbeing provision towards a more preventative and community based focus. However the project won't cover the actual commissioning activity or the integrated provider redesign.

2.6 Interfaces

2.6.1 Dependencies

Area	Dependency
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.
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 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.
Project Delivery	The partnership agreement must be in compliance with Section 75 of The NHS Act 2006.
Project Delivery	Devon CCG has to re-commission its community healthcare services contract by March 2016. The current provider is Plymouth Community Healthcare (PCH), who also provides certain Public Health services in Plymouth. The commissioning timescale for this, and the associated 'Transforming Community Services' programme, will influence workstreams concerning other community services.

2.7 Costs

Results Summary for 2014/15 to 2016/17	
Total project cost savings/income £'000	1,060,000
Total project expenditures £'000	-340,000
Net project savings / income £'000	1,400,000
ROI (return on investment - after 3 years)	211.8%
Discounted ROI (return on investment - after 3 years)	339.2%
Average Annual Discounted ROI	113.1%
NPV (net present value) £' 000	652,367
at a discount rate of:	4.5%
IRR (internal rate of return)	619.7%
Payback year	Year 1

To achieve the cost savings anticipated for 2014/15, the project will focus on three areas:

- Review of People Directorate Commissioning Activity to restructure team before integration. It is anticipated that this will achieve £100k in 14/15.
- Cost reduction of 10% annually to both PCC through better commissioning. This is anticipated to provide a £200k saving to PCC in 14/15.

- Initial cost estimates are for Project Resources in 14/15 of £340K.

3. Integrated Community Health and Social Care Service Delivery Project Summary

3.1 Project Definition

3.1.1 Project Objectives

The Integrated Community Health and Social Care Service Delivery Project will focus on developing an integrated service delivery model function stretching across health and social care, providing the right care at the right time in the right place. 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. The project will also allow focus on developing joined up population based, public health, preventative and early intervention strategies.

Plymouth City Council, the Western Locality of the NEW Devon Clinical Commissioning Group 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.

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.

Plans for integration have been informed by the Transforming Community Services Process and responds to what the public have consistently said is needed. The following 'I' Statements are from the Western Locality TCS Process:

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 project aims to engage with delivery partners to establish a more collaborative, integrated and strategic approach to how PCC and the CCG deliver services, with the aim of reducing costs, improving patient/service user experience and improving outcomes for residents in Plymouth.

3.1.2 Project Scope

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. At present, these services have been included within the addressable spend analysis that is laid out below.

The following criteria have been devised to establish a baseline of services across PCC and NEW Devon CCG that are within the scope of the programme, and the changes we make will be based on our TCS engagement work and what we have heard from the public about how services should change.

Service spend is in scope if:

- Some or all service outcomes are shared
- Service requires input and decisions from two or more parties
- Requires single input from one party but service users significantly overlap

Service spend is out of scope if:

- Outcomes are aligned but not dependent on others
- Service operates effectively independently of others although activity and spend may be impacted by changes in other service areas.
- Limited overlap in service users

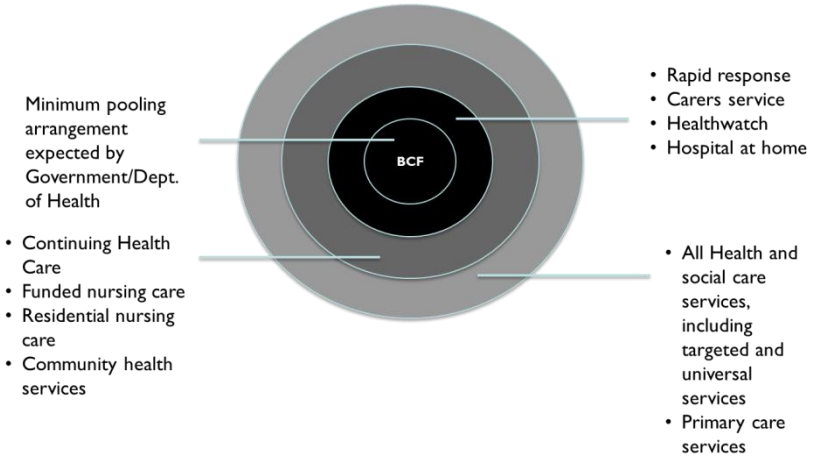
By assessing each service against these criteria, a baseline list of services that are in the scope of the programme has been devised. The detailed list of these services across PCC and NEW Devon CCG can be seen in the embedded spreadsheet in Appendix A. Note that this list is subject to agreement by the HWB Integration Programme Board and as such there may be changes.

In addition to considering whether services are in or out of scope of the programme, services that will form part of the integrated provision project have been grouped into three categories, which correspond to differing levels of need and complexity, and allow a focus on the aim of 'investing to save'. These three categories are:

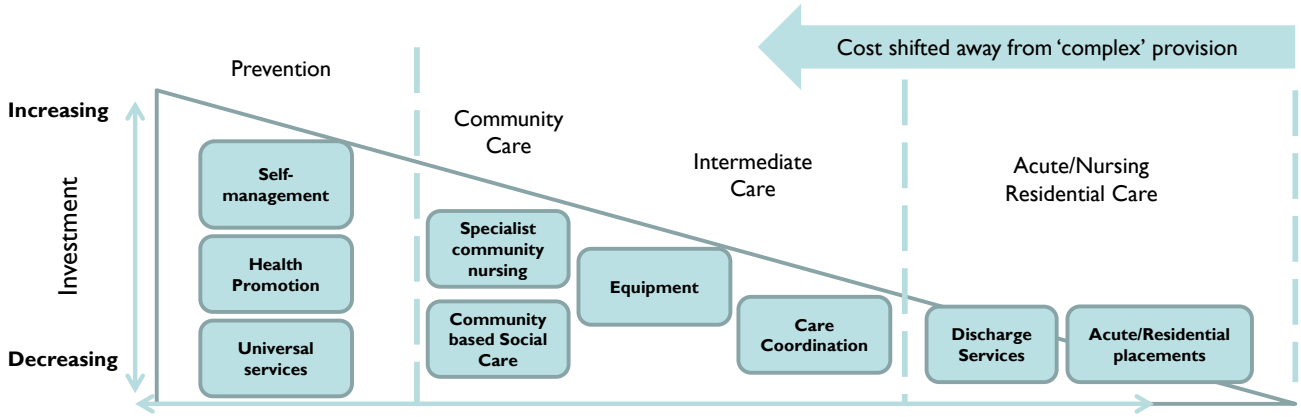
- Wellness - Universal or preventative services. This includes many Public Health services, such as smoking cessation and sexual health campaigns, and PCC services that do not require a FACS assessment. The category also includes early years prevention and early intervention services, and best start 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 project aims to eradicate duplications. Functions within scope include:

- Assessments of Needs
- Safeguarding of vulnerable adults
- Community based provision including equipment provision
- Service planning/Care Coordination
- Hospital admission prevention/rapid response
- Hospital Discharge planning



The intention is to move the balance of spend away from Complex provision towards services in Community and Wellness, in order to manage the demand and avoid costs incurred:



3.1.3 Exclusions from scope

The scope of the project 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) within scope.

The project 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 (from NHS England to CCGs) takes place within the timescale of this project.

3.2 Outline Project Deliverables and/or Desired Outcomes

Benefit	Baseline [2012/13]	Target [2014/15]	Target [2015/16]	Target [2016/17]
Health and Wellbeing Outcomes				
Delayed transfers of care (per 100,000 population)	13.1			Return to national average
Delayed transfer of care due to adult social care (per 100,000 population)	5.2			Return to average of comparator group
Reduction in long term admission to care homes and residential homes (65 and over) (per 100,000 population)	697			
Emergency admissions: not in need of admission				5% reduction in admissions
Use of bed-based care				5% reduction in emergency admissions 5% reduction in community hospital admissions
Reduction in length of stay for older people in acute (Plymouth Hospitals NHS Trust) hospital beds	8.31			5% reduction in average length of stay
Reduction in length of stay for older people in non-acute (Plymouth Community Healthcare) hospital beds	33.05			5% reduction in average length of stay
Readmissions to ED within 30 days				10% reduction in 30 day readmissions

Potential Years of Lost Life (PYLL) from causes amenable to healthcare for children and young people				Above average (measurements yet to be carried out nationally)
Effectiveness of reablement – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	89.30%			2% improvement
Community activity levels				Dependant on project intervention
Activity of elderly care services				National average ratio Community:RC&NC
Proportion of deaths in usual place of residence				2% increase
Number of care homes awarded the Dementia Quality Mark				
Social care related quality of life	19.4			5% improvement
Control over daily life	83.4			5% improvement
To halt the increase of excess weight in childhood (year 6) in Plymouth and then decrease it by 15.3% by 2021/22	32%			decrease it by 15.3% by 2021/22
To halt the increase of excess weight in childhood (reception) in Plymouth and then decrease it by 5.4% by 2021/22	25%			decrease it by 5.4% by 2021/22
Young people with complex mental health needs				5% reduction by 2017
Carer satisfaction	48%			5% improvement
Patient and service user experience				70% score on Plymouth I Statements

3.3 Financial Benefits

Benefit	Baseline [2012/13]	Target [2014/15]
Financial efficiencies to PCC • Review of ASC • Single management structure for community service delivery • Tapering contracts • Increased use of reablements • Service redesign	£41,900K	£500K
Financial efficiencies to CCG • Tapering contracts • Reducing bed days in Derriford • Service redesign		TBC

4. Co-operative Children and Young People's Services Project Summary

The intention to transform services will offer new opportunities at each age and stage of life and bring coordination to services currently organised and delivered through separate pathways. The partnership with schools and other settings is well-established and the ambition to create new models of working is being realised through innovative and cooperative system leadership.
Since 2010, funding for a number of support services has been transferred from the Local Authority to schools, enabling them to go to the market to select a provider(s) for these services
This places at risk those PCC services traditionally provided to schools, unless they can be provided in an alternative manner
CCYPS wishes to work in partnership, *in a cooperative manner*, with a wide range of partners, including schools, to effect this transformation. The drivers for this and other changes include:

- A focus on the health and well-being of children through, for example, an increase in the take up of school meals using fresh, healthy food
- A blended and complimentary approach to improvement using the best skills at the right time in the right place
- An extended offer to communities to support skills development and employment from early years to adult life
- An holistic, 'one path' approach to early intervention and meeting need.

4.1 Project Objectives

The aim of the project is to develop a cooperative response across the various partners and agencies to develop a coherent pathway and service delivery that supports children, young people and their family achieving their outcomes. Services for children and young people will be integrated with schools, health and other partners in a more cost effective way which would deliver services cooperatively.

A capability assessment approach has been taken to assess ELAFS capabilities against desired outcomes. This assessment also involved determining which capabilities belonged in the same for each cluster. The resulting proposed initial clusters within the scope of the Cooperative Children and Young People's Services are as follows:

1	Education Catering & Facilities Services
2	Community & Extended Learning
3	Targeted Services (SEN)
4	Enrichment and Aspiration
5	Knowledge and Intelligence

4.2 Project Scope

The table below shows the services in scope for each of the five clusters:

Cluster	Services that form the cluster
Education Catering and Facilities	Education Catering
Targeted Support and Early Help	Education Welfare and Monitoring Children's Centres Management Youths Services Management Child's Health and Wellbeing Education of Children at Risk and Excluded Early Help and CAF Settings Advisory Services SEND Moderation and Statutory Assessment SEN Child Assessment SEND Support Occupational Therapy Support Safeguarding Advice, Guidance and Support School Transport Planning and Scheduling Educational Psychology Early Years Statutory Duties Parents Partnership Management Transportation for SEN Sensory Support

	Effective Inclusion of Children and Young People Short Breaks, Respite
Community and Extended Learning	VCS Engagement Adult and Community Learning
Teaching and Aspiration	Governor's Training/Governance (Strategic Infuence) SACRE Music Education Outdoor Education Services for Schools Global and Cultural Education Newly Qualified Teachers Inductions Schools to School Support/Strategic Partnership Monitoring Challenge Standards Interaction Schools Sports Development
Knowledge and Intelligence	Quality Assurance School Organisation Management Data Management Employment Skills School's Admissions School's Forum Demand Forecast and Planning School Place Planning Capital Planning Performance Management
Not Clustered	Voice of the Parent Voice of the Child Links to and with DfE

Additional services

- Youths Services Management
- Family Group Conferencing
- Youth Offending Team
- Family Intervention
- Family Support

The estimated addressable spend for the project is as follows:

Project	Category	PCC
CO-OPERATIVE CHILDREN AND YOUNG PEOPLE	Wellness	11,011,687
	Community Intervention	11,405,628
	TOTAL	22,417,315

4.3 Exclusions from 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) within scope.

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 (from NHS England to CCGs) takes place within the timescale of this programme.

4.4 Outline Business Case

4.4.1 Benefits

Benefit	Baseline [Year]	Target [Year 1]	Target [Year 2]	Target [Year 3]
Maximise resources and achieve financial savings through: - Family Support Review - Review of SEND/ Targeted Services - Review of Teaching and Aspiration Cluster - Review Learning and Communities (Education Catering) - Ensuring Full cost recovery services		£450K		
Implementation of Cluster Model Saving	£22.417K	£450K	TBD	TBD

4.4.2 Costs

Initial cost estimates for 14/15 are £135K

Northern, Eastern and Western Devon
Clinical Commissioning Group

PLYMOUTH
CITY COUNCIL

Outline Business Case

Programme Name:	Integrated Approach to Health & Wellbeing		
Date:		**Version:**	2.0
Programme Projects:	**2. Integrated commissioning** **3. Co-operative children's and young people's services** **4. Integrated community health and social care provision**		
Author:			
Owner (SRO):	Jerry Clough, Carole Burgoyne		

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1. Executive Summary

Plymouth City Council and Northern, Eastern and Western Devon CCG are facing a combination of severe budget pressures, and rising demand for services. These challenges will require system-wide changes, and it is in this context that the two organisations have committed to create a vision for integrated commissioning, health and social care provision, and provision of services focused on children and young people. All of this will help to achieve the Health & Wellbeing Board's vision of "Healthy, happy, aspiring communities."

The programme is aligned to the wider PCC transformation portfolio of programmes, which has been developed to deliver the Council's Blueprint for future service delivery. It will also play a key role in describing what an integrated suite of community health and social care services may look like in the future, which will then feed into the CCG's Transforming Community Services programme as part of its procurement timescales.

The programme will aim 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. The programme will consist of the following three projects:

- Integrated Commissioning
- Co-operative Children and Young People's Services
- Integrated Community Health and Social Care Provision

Services that will form part of the integrated provision project have been grouped into three categories, which correspond to differing levels of need and complexity, and allow a focus on the aim of 'investing to save' as noted above. These three categories are:

- *Wellness* - Universal or preventative 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.
- *Complex and bed based care* - Services people with complex needs, who cannot be supported in the community.

Instead of restricting the programme to a single option, a combination approach is proposed which will enable momentum to be maintained while further detailed analysis and design work can take place to inform a further options appraisal of the preferred vehicle to deliver the operating model of integrated care.

The benefits shown in this business case (of approximately £11.1m per annum across both organisations) are highly indicative, and as part of full business case development, further analysis of preferred workstreams will be done, to provide a more robust financial case. This approach will require a detailed analysis of service provision, in order to develop a series of 'mini-business cases' which will enable an informed strategic view to be taken by the Programme Board. There are five themed workstreams that have been identified for each of the Co-operative Children and Young People's Services and Integrated Health and Social Care projects.

The programme approach is underpinned by a governance framework and terms of reference agreed by the board and detailed within this document.

2. Vision

The vision for the Health and Wellbeing programme is to establish a collaborative, integrated and strategic approach to how CCG and PCC with some partners commission and deliver services, with the aim of improving patient/service user experience and improving outcomes for residents in Plymouth from the resources available.

To achieve this vision the CCG and PCC will deliver better services that are co-designed with the individual person/patients. These transformed services will maximise the choice and control for the person/patient. Through working in a collaborative and integrated manner with key partners, the CCG and PCC will promote the independence for the person/patient.

Through integrating Health and Social Care, the transformed services will be focused on reducing health and social inequality for the children, families and adult residents of Plymouth. The programme will deliver three discrete elements:– integrated commissioning; an integrated adult provider and a redesigned, collaborative approach for services for children and their families.

The outcomes from the programme are the prioritisation of delivering an enhanced prevention and early intervention capability. Children, young people and adults will feel safe. They will be treated with dignity and respect. They will feel they have control over the services that meets their needs and personal outcomes.

3. 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.

3.1 Case for Change

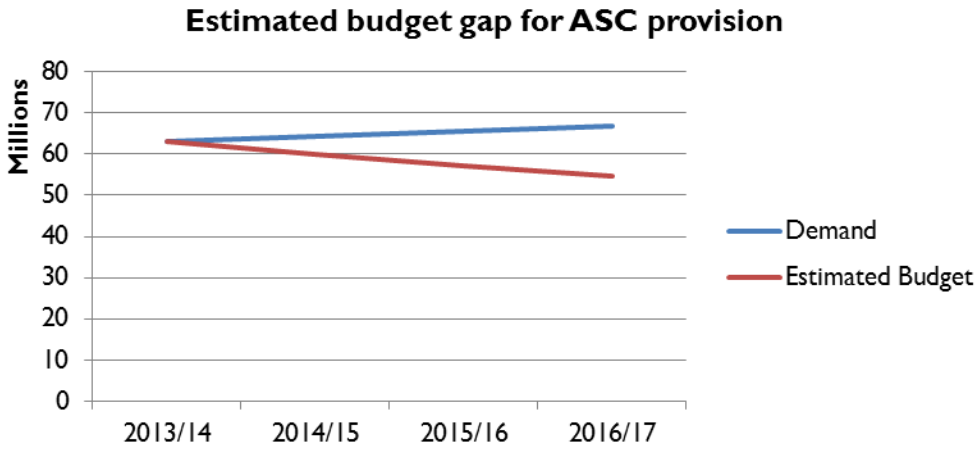
3.1.1 Local Strategic Drivers for Health & Social Care Integration

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. The graph below illustrates the projected increase in demand for adult social care services (increase of 2% per annum) against the projected budget reduction for these services over the next four years:



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, 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.

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.

The local case for change is also supported by the significant reductions in budgets within the Local Authority meaning that the status quo is no longer a financially sustainable option to deliver the Council's statutory requirements. ELAF services are currently funded by three main funding streams:

- Local Authority funding - for services undertaken to fulfil its statutory duties.
- Traded Income made up of a range of services and products that are sold to schools.
- Specific ring-fenced grant funding

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.

4. 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.

5. 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

6. 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

The Plymouth Children & Young People's Plan

The Plymouth Children & Young People's Plan 2011-2014 includes the following priorities:

7. Equipping young people with skills, knowledge and opportunities to make a successful transition to adulthood

8. Improving levels of achievement for all children and young people

9. Providing all children with the best possible start to life

10. Tackling risk taking behaviours through locality delivered services

Education, Learning and Family Support services play a critical role in supporting the successful delivery of the outcomes associated with these priorities. Although there has been some success in improving levels of achievement among children and young people, there are a number of wider health outcomes where further work is required. These include breastfeeding and teenage pregnancy rates.

A review of Children's Centres in the city was recommended by the Joint Commissioning Partnership in May 2013, in order to prepare for re-commissioning and probable funding reductions from PCC as a result of budget pressures. Against this backdrop, it will be important to consider how an integrated suite of services for children and young people, offered across public sector partners, may help in achieving outcomes within the Children & Young People's Plan and Health & Wellbeing Strategy, whilst also working within the reduced resource envelope available.

Children in need of protection

There has been a significant increase in the number of looked after children subject to a Child Protection Plan in Plymouth in 2013, and there is an urgent requirement to develop an enhanced prevention and early intervention strategy in order to manage demand resulting from vulnerable children and families.

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.

11. 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.

12. 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

13. 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.

14. Some social care services that Plymouth City Council delivers could be more cost effective if they were delivered in an alternative way.

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 CCG intends to issue an ITN to suppliers in March 2014, and this programme will therefore need to consider whether it is appropriate for TCS to procure an integrated suite of community health and social care services, and if so, how this process can be managed.

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 Bill

Published on the 10th May 2013 and based on the White Paper Caring for our Future, the Care Bill 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 Bill 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 Integration Transformation Fund

The Integration Transformation Fund (ITF) is a 'game changer': 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.

Public Health Outcomes Framework 2013-1016

The Public Health Outcomes Framework addresses two key outcomes:

15. Increased healthy life expectancy

16. 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. It describes a whole system approach, refocused around achieving positive health outcomes for the population and reducing inequalities in health, rather than focused on process targets. Much of the proposed new public health system that is described in the document depends on the provisions of the Care Bill, which has yet to be passed by Parliament.

Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework (ASCOF) was first launched by the Department of Health in March 2011 and was recently updated in March 2012. It is used to demonstrate the achievements and strengths of adult social care in delivering better outcomes through describing a set of outcome measures. The framework is useful from both a national and local context in terms of benchmarking, highlighting risks, reporting success, managing service improvement etc.

NHS Outcomes Framework 2014/15

The NHS Outcomes Framework (NHSOF) has recently been updated for 2014/15, and describes a set of outcome measures across five domains:

17. Preventing people from dying prematurely

18. Enhancing quality of life for those with long term conditions

19. Helping people to recover following episodes of ill health or injury

20. Ensuring people have a positive experience of care

21. Treating and caring for people in a safe environment and protecting them from avoidable harm

As with the Public Health Outcomes Framework and Adult Social Care Outcomes Framework, the NHSOF is a useful tool in terms of benchmarking, highlighting risks and reporting successes, and the three frameworks together provide an important narrative around the co-operation required between health and social care in order to achieve improvements on these metrics.

NHS Call to Action

NHS England has recently published "The NHS belongs to the people: a call to action", which sets out the challenge facing the NHS, and states that the NHS needs to change in order to meet these demands and make the most of new medicines and technology. The paper 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. In this context, an integrated

system of health and wellbeing services should have as one of its aims the promotion of independence and self-management of long term conditions, with appropriate targeted support.

Closing the NHS Funding Gap

This report, by the health service sector regulator Monitor, details ways that NHS commissioners and providers may close the anticipated funding gap in the NHS, which is anticipated to grow to up to £30bn a year by 2021. It focuses on potential productivity gains that can be split into the following four categories:

- Improving productivity of existing services
- Delivering the right care in the right setting
- Developing new ways of delivering care
- Allocating spending more rationally

All of the above categories will be key considerations for this programme, with delivering care in the right setting and improving the productivity of existing services being of particular importance.

Effective implementation of national education policy

The Coalition Government has set out a series of radical reforms which will change the educational landscape. These reforms impact on both the delivery of our services and on our statutory functions. The White Paper "The Importance of Teaching" sets out the principles for this changing landscape, which include:

22. A strong strategic role for local authorities as champions for parents, families and vulnerable pupils, taking action where there are concerns about the performance of any school in the area, and using their intervention powers to act early and effectively to secure improvement in maintained schools.

23. A more diverse approach to the provision of school improvement

24. Freedom for local authorities to define what role they will play in supporting school improvement for local schools.

25. Placing school-to-school support at the heart of very many local authority school improvement strategies.

26. Making it easier for schools to learn from one another

27. Ensuring schools have access to best practice, high-quality materials and improvement services which they can choose to use.

28. Rewarding schools which effectively support weaker schools and demonstrably improve their performance.

29. Ensuring that schools below the floor standard receive support

This concept of greater involvement in school to school support draws from evidence of good practice. 'The Missing Link' recent research published by the Association of Directors of Children's Services reports on the characteristics of LAs who are successful in managing effective school improvement and highlights the importance of a collaborative partnership working between schools and the local authority.

The Academies Act 2010

Local schools are seeking a new and responsive arrangement in service delivery where they have influence over the design of services. Schools and Academies consider that the present models were not utilising the skills of teachers in schools and are not always delivering what they want or need. We are also not using effectively the skills of schools in the delivery of our statutory duties. The national policy direction has altered the face of the educational landscape. The role of the LA is changing rapidly - especially in its relationships with schools. The Academy and Free School initiatives mean that the LA must have a different role; in essence it retains its statutory functions and strategic responsibilities but has less power to influence and intervene.

Meanwhile schools are free to make a wide range of decisions and their ability to trade and purchase services from a variety of sources is increased. Schools are coming together to share their views and make their voice heard in relation to the type and quality of service they wish to access. The LA needs to respond swiftly and positively as schools make budget and expenditure decisions for future years.

The Children and Families Bill 2013

The Children and Families Bill takes forward the Coalition Government's commitments to improve services for vulnerable children and support strong families. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background. The Bill reforms the systems for adoption, looked after children, family justice and special educational needs. It will encourage growth in the childcare sector, introduce a new system of shared parental leave and ensure children in England have a strong advocate for their rights.

As part of this Bill the Government is transforming the system for children and young people with special educational needs (SEN), including those who are disabled, so that services consistently support the best outcomes for them. The Bill extends the SEN system from birth to 25, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met, by replacing old statements with a new birth- to-25 education, health and care plan; offering families personal budgets; and improving cooperation between all the services that support children and their families, particularly requiring local authorities and health authorities to work together.

Working Together to Safeguard Children (2013)

This guidance governs how organisations and individuals should work together to safeguard and promote the welfare of children. It requires Local agencies to have in place effective ways of identifying emerging problems and potential unmet needs for individual children and families. This includes assessment of the need for early help and the provision of early help services which are coordinated and not delivered in a piecemeal way. Services included within the early help offer are high quality support in universal services, family and parenting programmes, assistance with health issues and help for problems relating to drugs, alcohol and domestic violence. Services may also focus on improving family functioning and building the family's own capability to solve problems; this should be done within a structured, evidence-based framework involving regular review to ensure that real progress is being made.

Welfare Reform Act 2012

The Coalition Government has enacted a series of reforms to the welfare system, which are intended to make the system fairer, and support more people into work. The reforms include a simplification of the benefit structure, with the creation of the Universal Credit. In terms of housing benefits, a cap has been introduced as well as the 'spare room subsidy' for houses deemed to be under-occupied.

Research by the National Housing Federation has shown that nearly 2,000 households in Plymouth have been affected by the changes to housing benefits in particular, with an average loss of income of £711. This is likely to place additional strain on certain housing services provided by PCC, and this programme will need to consider the impact of reducing budgets on rising demand for these services.

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, by leveraging on the existing capability within Public Health, and the local knowledge and transformational capability that exists within PCC.

Integration of Health and Social Care – A Strategic Response

In response to these 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.

3.2 Aim

The programme aims to engage with commissioning and delivery partners to establish a more collaborative, integrated and strategic approach to how PCC and the CCG commission and deliver services, with the aim of reducing costs, improving patient/service user experience and improving outcomes for residents in Plymouth.

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

4. 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

5. 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.

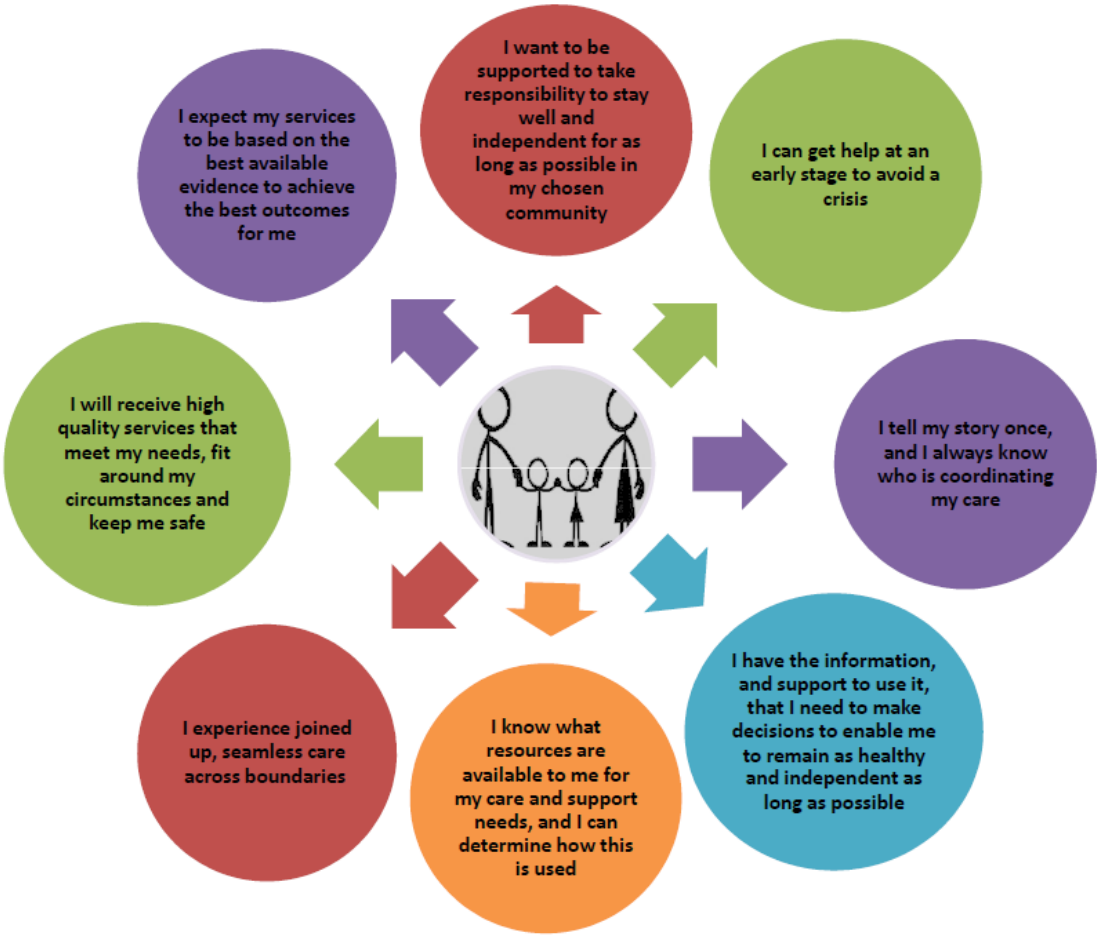
6. An emphasis on those who would benefit most from person-centred care such as intensive users of services and those who cross organisational boundaries

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

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

3.3 Outcomes

The following "I statements", have been developed nationally and approved by the Plymouth Health & Wellbeing Board, describe the desired outcomes, which people who use integrated health and wellbeing services will experience. It is recognised that further work on these will be undertaken to put into a local context and also to develop "I statements" for children and to make accessible for those with Learning Disabilities:



The diagram over the page illustrates outcomes for other key stakeholders:

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

There are three overall outcomes of the programme:

i. **Integrated Commissioning:** a single, integrated and co-ordinated approach to commissioning across the social care and health system

ii. **Co-operative Children's and Young People's Services:** alternative delivery models for a variety of children's and young people's services, including many of those currently provided by the Education, Learning and Family Support Assistant Directorate within PCC, in conjunction with partners. The exact shape, size, form and number of these will be dependent on business case development

iii. **Integrated Health & Social Care Provision:** an alternative delivery models for health and social care services, and to facilitate the development of an integrated health and social care economy within Plymouth

3.4 Scope

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. At present, these services have been included within the addressable spend analysis that is laid out below.

The following criteria have been devised to establish a baseline of services across PCC and NEW Devon CCG that are within the scope of the programme.

Service spend is in scope if:

- Some or all service outcomes are shared
- Service requires input and decisions from two or more parties
- Requires single input from one party but service users significantly overlap

Service spend is out of scope if:

- Outcomes are aligned but not dependent on others
- Service operates effectively independently of others although activity and spend may be impacted by changes in other service areas.
- Limited overlap in service users

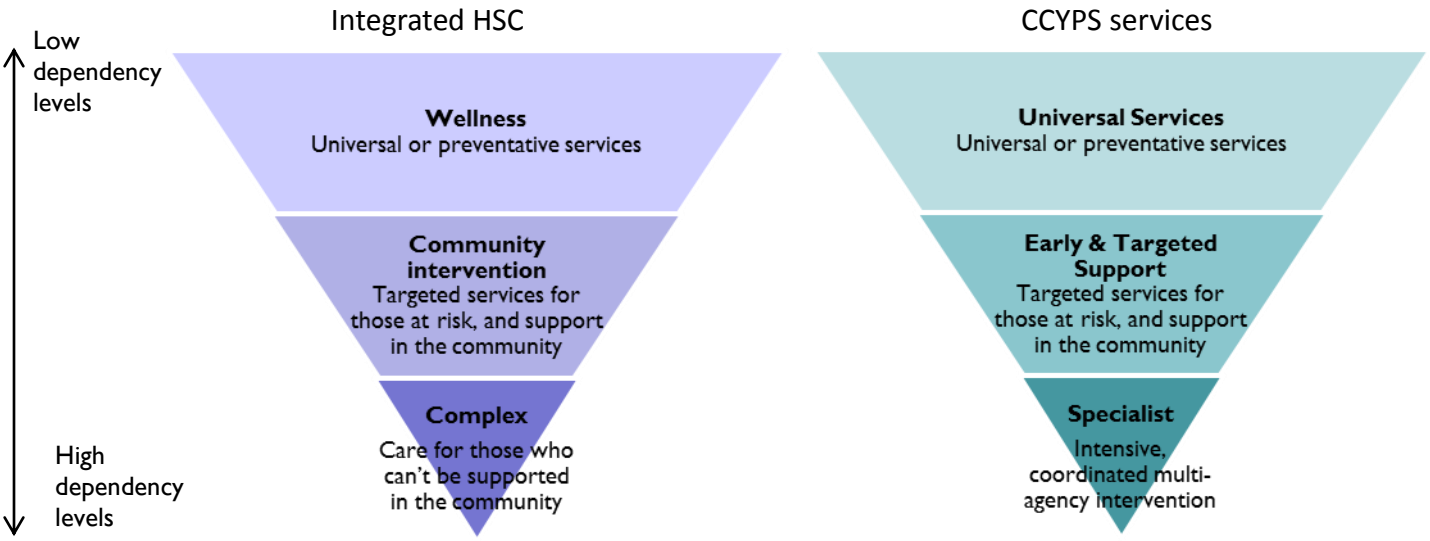
By assessing each service against these criteria, a baseline list of services that are in the scope of the programme has been devised. The detailed list of these services across PCC and NEW Devon CCG can be seen in the embedded spreadsheet in Appendix H. Note that this list is subject to agreement by the HWB Integration Programme Board and as such there may be changes.

In addition to considering whether services are in or out of scope of the programme, services that will form part of the integrated provision project have been grouped into three categories, which correspond to differing levels of need and complexity. These three categories are:

- *Wellness* - 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 diagram below shows how PCC and CCG services may be conceptualised as part of an integrated economy. 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:

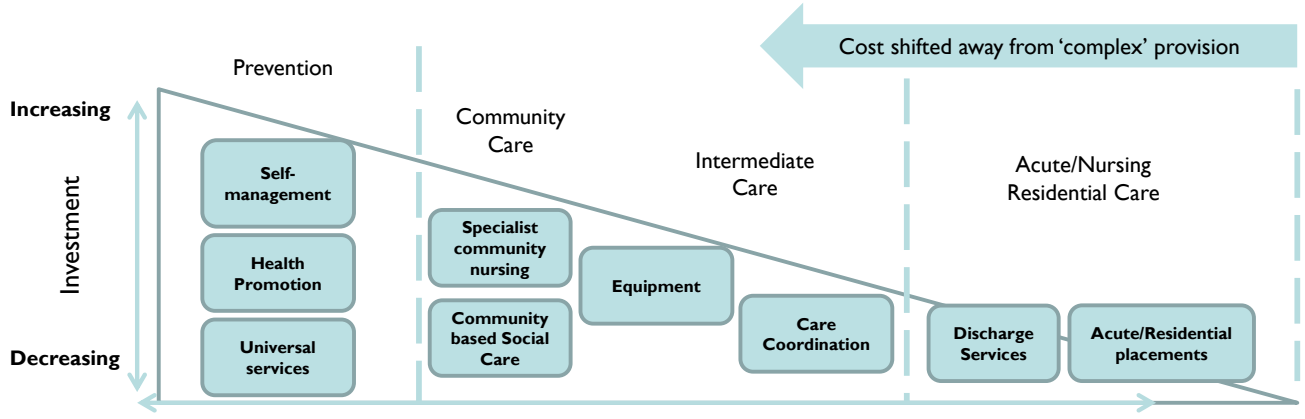


The two triangles are provided in order to reflect the different language which is recognised by partners across the scope of services, with commissioners and providers of services in the scope of CCYP services understanding the terms "Universal, Targeted and Specialist" services, in line with the current PCC Early Intervention and Prevention Strategy. However, the boundaries between levels of support and intervention described across both triangles are intended to be consistent and for ease, the terms used for Integrated HSC services (Wellness, Community and Complex) are used throughout this document.

The table below provides some examples of the types of services which have been categorised under each level of care:

Project	Category	PCC examples	CCG examples
INTEGRATED HEALTH AND SOCIAL CARE PROVISION	Wellness	Stop smoking; Contraception and sexual health; Drug and alcohol services	Counselling
	Community Intervention	Community equipment; Reablement; Domiciliary care	Community nursing; RITA; Podiatry
	Acute and bed based care	Nursing care; residential care	A&E; Elective/non-elective inpatient
CO-OPERATIVE CHILDREN AND YOUNG PEOPLE	Wellness	Outdoor education; Early years service; Youth services	-
	Community Intervention	Youth Offending Team	-
INTEGRATED COMMISSIONING		Joint Commissioning team; Community Safety; Housing renewals; ODPH	Western Locality; Partnerships

The intention is to move the balance of spend away from Complex provision towards services in Community and Wellness, in order to manage the demand and avoid costs incurred:



The estimated addressable spend for each of the projects that comprise the Integrated Health & Wellbeing Programme is as follows:

Project	Category	PCC	CCG
HEALTH AND SOCIAL CARE PROVISION	Wellness	18,977,621	38,203
	Community Intervention	58,259,377	47,269,301
	Complex and bed based care	33,178,472	155,330,275
CO-OPERATIVE CHILDREN AND YOUNG PEOPLE	Wellness	11,011,687	-
	Community Intervention	11,405,628	-
COMMISSIONING		2,949,258	1,143,510
	TOTAL	135,782,042	203,781,289

Some simplifying assumptions have been made about certain aspects of addressable spend in scope. These are as follows:

- All Plymouth Community Healthcare spend relates to individuals from Plymouth – this is because there is a separate Community Health services provider that covers the remainder of the Western Locality (which is within Devon County Council area)
- 60% of Plymouth Hospitals NHS Trust spend commissioned by the Western Locality of the CCG is attributable to individuals from Plymouth – this is because approximately 60% of the population of the Western Locality live in Plymouth, and Derriford Hospital is the only major acute care provider within the Western Locality
- For certain areas of CCG Partnerships commissioned spend, we have assumed that 45% of the spend relates to the Western Locality (as approximately 45% of the population covered by NEW Devon CCG live in the Western Locality), and of this spend, we have assumed that 60% is attributable to individuals living in Plymouth (as 60% of the population of the Western Locality live in Plymouth)

The addressable commissioning spend shown in the table above does not currently include finance and/or business support from either PCC or CCG at present. Further development of the programme comes with a requirement to determine whether these areas of the organisations are in scope, and if so from a CCG perspective, which parts of the organisation are serving Plymouth territory. There are also likely to be other sources of public sector funding (such as work and pensions) which will need to be considered as part of the next phase of work.

Within the Integrated Health and Social Care provision project, it will be necessary to draw up a list of

services where a redesign and reconfiguration of services is desired, and it will be this process redesign that informs the new integrated operating model.

3.5 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) within scope.

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 (from NHS England to CCGs) takes place within the timescale of this programme.

3.6 Assumptions

It is assumed that all services within the Council are to be considered for their potential to be delivered using an alternative model. The development of the Blueprint will inform services on which this programme should focus, while the Outline Business Cases will provide the type of alternative model which is considered to be the preferred option for each service area.

ICT, TUPE and other governance arrangements relating to alternative delivery models are to be determined.

4. Options Appraisal

To deliver this programme, commissioners jointly agreed a framework for assessing the chosen solutions for each project area. This ensured both organisations have confidence that the locally developed model will meet a set of core design priorities. The choice of type of operating model or delivery vehicle can be informed by a number of criteria, of which some will be more important than others. This set of criteria has been agreed and used to shape in the service assessment for PCC's Blueprint development and can be used to appraise the options for new delivery models in health and wellbeing:

Criteria	What is most important?
Cost	**Delivery at the best possible cost** *Does the model deliver within the available resources and is the financial governance and management robust?*
Quality	**Delivery at the highest possible quality, which are responsive to customer needs and focused on outcomes** *Does the model improve quality of provision? Does the model lead to improved patient/public outcomes? Does the model ensure dignity is a key element of delivery?*
Manage Risk	**Ability to control, mitigate and manage risk of failure (including financial, reputational, delivery, operational)** *Does the model ensure user safety is paramount? Does the model put at risk clinical governance standards and accountability? Does the model put at risk safeguarding standards and accountability?*
Flexibility	**Ability to flex service offering to demand** *How easily can resources be redirected to different areas of demand, either geographic, need or both?*
Collaboration	**Ability to work with another organisation to deliver the service** *To what extent does the option allow for collaboration?*
Generate Income	**Ability to generate revenue** *Are services which can generate income able to exploit this possibility?*

4.1 Integrated approach to commissioning and integrated health and social care services

Outlined below are options for redesigning the way that the local authority and health organisations in Plymouth commission and deliver services with a view to achieving a range of financial and non-financial benefits. These have been appraised through a workshop with the Programme Board and a preferred option selected which provides the future direction of travel for Plymouth:

Table of Options for Integrating Health and Social Care

	Commissioning	Provision	Health and Wellbeing
1. Minimum	Commissioners come together with shared line management but commissioning budgets remain separate	Providers chose to collaborate around particular pathways or services	Organisations respond individually to Health and Wellbeing Board strategy and priorities
2.	Commissioners come together with shared line management and pooled commissioning budgets (for services in scope of integration) but employer remains the existing organisation	Providers come together in a lead provider model on a pathway or service model basis	Organisations agree a planned programme of initiatives for collaboration around the health and wellbeing strategy and priorities
3.	Commissioners and pooled budgets transfer into one existing organisation (via TUPE), thereby changing employer for some staff	Provision is merged in to a single provider entity on a horizontal, vertical or pathway basis	Organisations create new entities or partnerships for particular aspects or initiatives within the health and wellbeing strategy
4. Maximum	Commissioners and pooled budgets come together to create a new commissioning entity with potential to grow in terms of geography, scope and partners	Provision is merged in to a single provider, integrated across all aspects of health and social care for the city	Organisations form a new entity or formal partnership to take forward a city wide, comprehensive health and wellbeing programme

4.2 Conclusions

Instead of restricting the programme to a single option, a combination approach is proposed which will enable momentum to be maintained while further detailed analysis and design work can take place to inform a further options appraisal of the preferred vehicle to deliver the operating model of integrated care.

At this stage, an initial appraisal of options for delivery vehicles for both integrated commissioning and provision has enabled certain options to be ruled out, so that the focus of work can be narrowed to further explore those options which are preferred. The outcome of this initial appraisal is detailed below:

Integrated commissioning

The ambition for intergrating commissioning is to achieve level 4, i.e. creating a new commissioning entity with potential to grow in terms of geography, scope and partners. The following options were considered to define the preferred model to be used to deliver integrated commissioning:

	Description	Benefits	Risks
1	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 • Can develop consistent approach	• 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
2	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

3	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
4	Commissioners and pooled budgets come together to create a new commissioning entity	• 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 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	• 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' the commissioning function is politically unsavoury

The options which were identified as the preferred options to explore further were 3 & 4. This is due to the potential of these options to broaden the scope and scale of the commissioning function in future.

Co-operative children's and young people's services

In relation to those services, which fall within the scope of Cooperative Children and Young People's Services, it has been agreed that Level 4 (*Integration via a new (unspecified) delivery vehicle*) above, describes the preferred future delivery arrangements for these services. This means that the service delivery options for the Cooperative Children and Young People's Services will seek to have single vehicle responsible for the delivery of integrated services, outcomes and statutory duties.

The services within the scope of the Cooperative Children and Young People's Services have been organised into 5 theme clusters:

1	Education Catering Services
2	Service for Adult Education (PACLS)
3	Targeted Services (SEN)
4	Enrichment and Aspiration
5	Knowledge and Intelligence

To arrive at the service delivery clusters, a capability assessment approach was taken, where ELAFs current capabilities were assessed against its value streams or in simple terms, its desired outcomes.

Through this assessment an understanding of the performance and value (i.e.. performance against outcomes) of these capabilities were determined. This assessment also involved determining which capabilities belonged in the same value stream clusters (outcome cluster), which of these capabilities would deliver outcomes better or perform better if they remained in house and which were best delivered via a different vehicle, requiring an integrated delivery option and identifying the best suited delivery model for each cluster.

Each of these clusters will complete an options appraisal of viable alternatives to establish which is the most appropriate for that cluster and consider the range of partners, which could be involved in a new entity that would be responsible for the delivery of integrated services and work towards the council's cooperative objectives. The first stage of the options appraisal will be to validate the scope of the cluster, to ensure that links between the functions in-scope and those in the Integrated Health and Social Care Provision project are explored e.g. SEN provision, Child and Adolescent Mental Health services.

In developing level 4 integration, the following assessment was done to define the preferred model for the Cooperative Children's and Young People's services;

	Description	Benefits	Risks
1	Council and Partners come together with shared line management but service delivery budgets remain separate. Examples of this already exist within the Children's and Young People's services, however, does not proffer the cost cutting benefits that are sought from this transformation programme. (e.g. PTSA)	• Budget reduction through reduced management function • Ability to retain control of own organisation spend • Ability to manage total spend • Can develop consistent service delivery approach	• No oversight of complete budget so unable to manage integrated spend strategically • Potential risk of destabilisation as organisations can still act independently • Customers have to deal with more than one organisation to discuss contracts • Potential of retaining the 'silo' mentality • Low ability to extend to include further organisations
2	Council and Partners come together with shared line management and pooled Service Delivery budgets (for services in scope of integration) but employer remains the existing organisation. Examples of this already exist within the Children's and Young People's services, however,	• 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

	does not proffer the cost cutting benefits that are sought from this transformation programme. (e.g. Neighbourhood and Informal Learning)		
3	Council and Partners budgets transfer into existing organisations (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 service delivery – simpler for providers • Greater opportunities for career specialisation and progression for staff • Could be divested into separate entities 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
4	Council and Partners come together to create a new service delivery entity in form of a Mutual or Cooperative Enterprise	• Potential to sell services to other organisations/broaden remit of service delivery function • Potential to broaden membership to other organisations • Perception of independence makes partners equal • Strategic and operational oversight of complete integrated budget so can plan effectively • Single organisation is responsible for all service delivery – simpler for stakeholders • Greater opportunities for career progression for staff	• Cost of creating a new entity • Cost of overheads of operating a new entity • Potential increased procurement costs • Potential challenge under terms of 'state aid'
5	Council and Partners come together to create new service delivery entities, which would be a 'Honey-Comb' of Cooperatives and operate through a Joint venture approach	• Potential to sell services to other organisations/broaden remit of service delivery function • Potential to broaden membership to other organisations • Strategic and operational oversight of complete integrated budget so can plan effectively	• Cost of creating new entities • Cost of overheads of operating new entities • Potential challenge under terms of 'state aid'

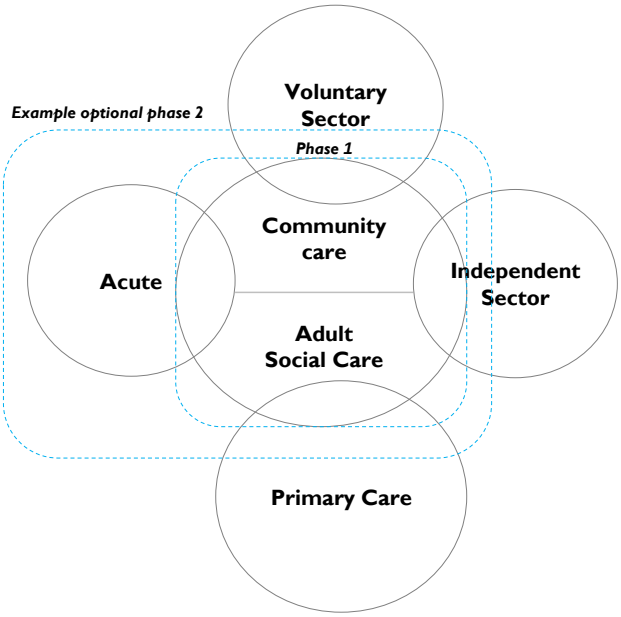
The options identified as the preferred options to explore further were 3 & 4 from the above table. This is because these options are best suited to deliver the outlined goals for the Co-operative Children's and Young People's services and also have the potential to broaden the scope and scale of the Co-operative Children's and Young People's services delivery function in future.

An evaluation of the best-suited entity for each service cluster will have to be done on a case-by-case basis, through engagement with Service Delivery Partners. Assessment of each case will consider the following design criteria.

- **Quality** – Does the entity improve the quality of services?
- **Cost** - Does the entity allow lower costs or improved value for money for the Council?
- **Co-operative Council** – Does the entity achieve the Council's aim of being a Co-Operative Council?
- **Risk** – Does forming the entity pose as a high risk to the Council?
- **Income Generation** – Does the entity explore the opportunities for income generation?

Integrated provision

With regard to integrated provision, Level 4 Integration above received the greatest level of support. This will establish a single integrated provider of community health and social care through a structural integration. The option includes an option for the single provider to act as a 'lead provider' and sub-contract areas of service to other providers. The first phase of integration will be to focus on *horizontal* integration, with the option to extend to include elements of *vertical* integration at a later date:



To define Level 4 integration, the following options were considered to define the preferred model to be used to deliver a single integrated provider:

	Description	Benefits	Risks
1	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.
2	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
3	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	• 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

	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

Further assessment and due diligence will be required to understand the potential benefits of structural versus operational integration. The current programme describes benefits which are not exclusive to structural integration and more analysis will need to be undertaken to understand whether full structural integration of either commissioning or service provision will deliver additional benefits over those which can be obtained through operational integration, based on formal or informal partnerships, as it is the transformational change which is planned to deliver the largest gains.

There are a variety of options for delivery vehicles and contracting mechanisms that could be used to ensure that assessment of structural integration is meaningful and manageable. Consideration must be given to whether there is an organisation which is best placed to provide this integrated service and the preferred procurement process to determine the future provider.

Following this outline business case and through the next stage of the programme, a detailed target operating model covering governance, staffing, finance, activity, funding and contracting will need to be developed in partnership with the proposed provider(s), if level 4 integration remains the preferred option following further assessment and legal advice on procurement and competition rules. It is clear that further discussion needs to take place before a formal options appraisal to decide on the future delivery vehicle for integrated health and social care.

It is recommended that a staged approach to integration should be adopted, commencing with the detailed design for operational integration, in order not to lose current levels of momentum and benefits which can be derived in the short term while further analysis of the benefits of structural integration are undertaken.

5 Management Case

5.1 Programme approach

The proposed approach is to develop more detailed analysis of the costs and benefits which will be derived from integration, to develop a robust evidence base on which to conduct a full options appraisal of the possible delivery vehicles for integrated health and social care and a Full Business Case for the chosen option. This will also allow the process of obtaining legal advice regarding the procurement process to determine the future provider to happen concurrently.

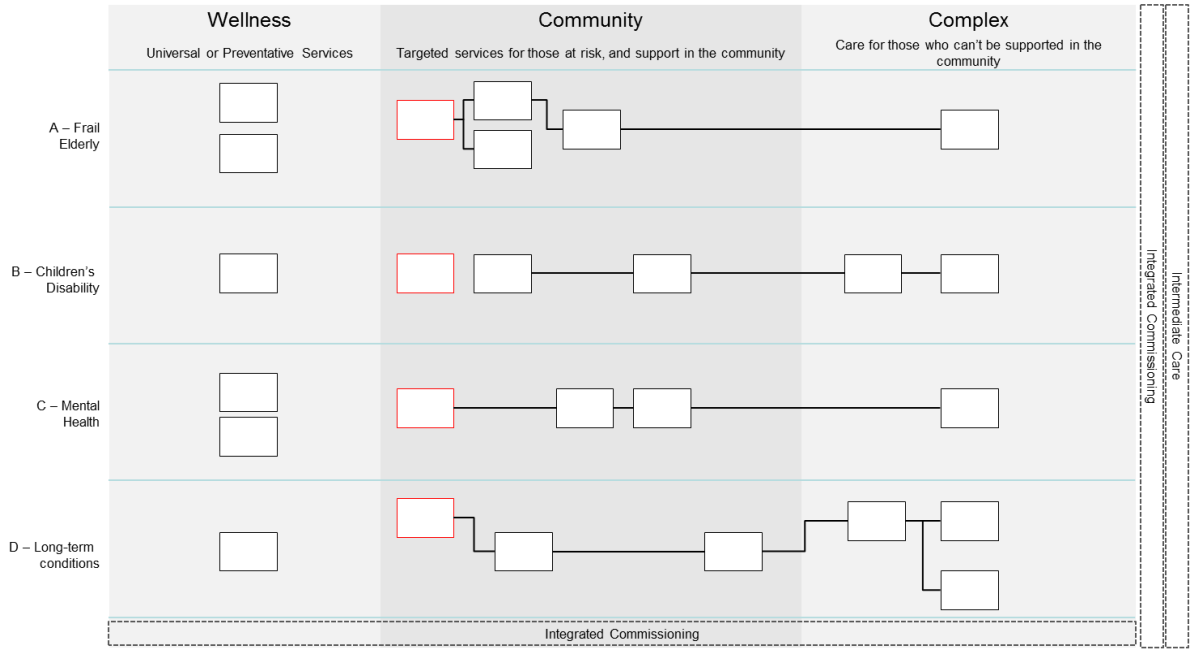
This approach will require a detailed analysis of specific areas of service provision in order to develop a series of 'mini-business cases' which will enable an informed strategic view to be taken by the Programme Board. In addition, this work will inform the detailed design of the future operating model, regardless of the vehicle chosen to deliver this.

Therefore, the initial project workstreams have been divided as follows:

Integrated Health & Social Care Services	Co-operative Children's & Young People's Services
Workstream A Frail Elderly Care	Workstream A Education Catering Services
Workstream B Children's Disability	Workstream B Service for Adult Education (PACLS)
Workstream C Mental Health	Workstream C Targeted Services
Workstream D Long Term Conditions	Workstream D Enrichment and Inspiration Services
Workstream E Integrated Commissioning	Workstream E Knowledge and Intelligence Service

The programme outcomes are primarily about improving health and wellbeing – so the workstreams reflect this by focusing on service users and care pathways, with an integrated delivery structure designed from the outcomes of these workstreams. These have been chosen because as the largest cohorts of service users, they represent the largest proportions of the addressable spend. It addition, people within these cohorts who use both health and social care services will be most affected by an integrated approach to health and wellbeing and therefore it addressing these first will provide a framework on which to build more discreet parts of the system. The aim of the workstreams will be to map the care pathways across the stages of need, with all associated activities, service providers, time and costs documented.

An illustrative example is shown below:



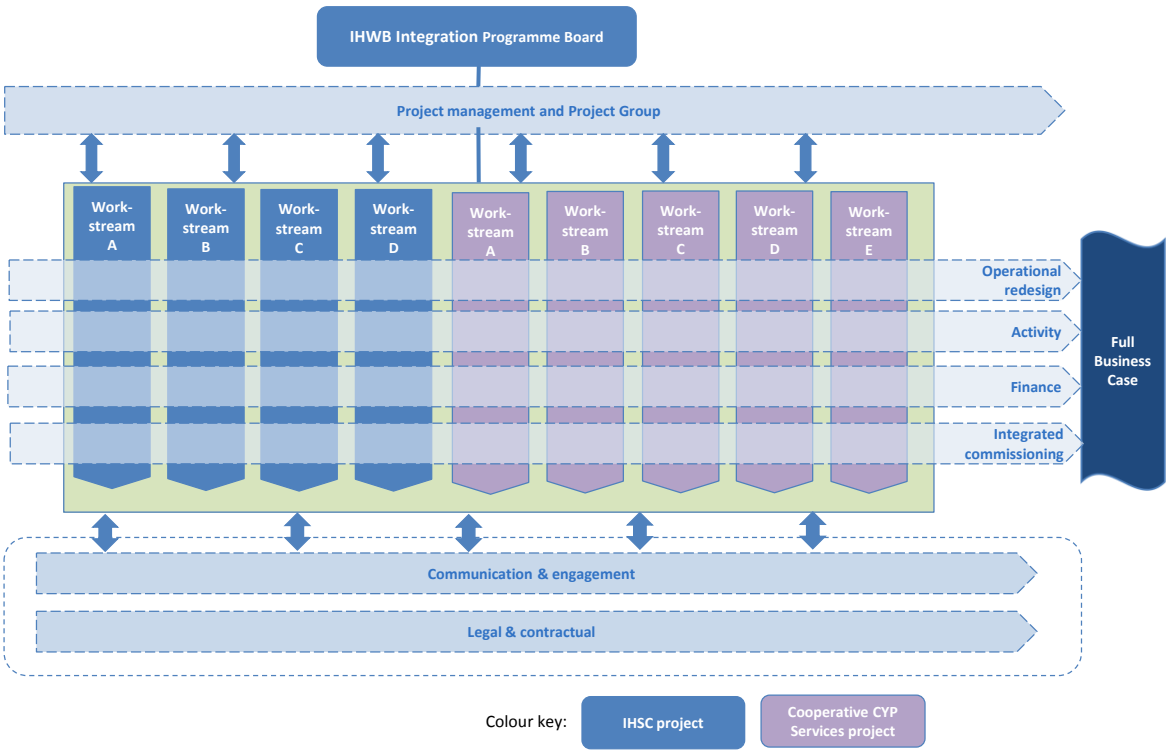
In the diagram above, red boxes represent the first point of contact for a service user or patient, while other boxes represent interactions that a service user or patient has with services.

Once conclusions are consolidated from all the relevant workstreams, potential integration options can be appraised as part of the full business case, which will give a more detailed picture of the expected benefits of the future provision and commissioning structure.

The integrated commissioning workstream will address how integrated commissioning could be applied across the whole system and will inform the decision on how the commissioning function will operate in future.

5.2 Programme structure

The proposed programme structure to deliver the Full Business Case is as follows:



Activity will be managed through a project management office and underpinned by two enabler workstreams of Legal and Contractual and Communications and engagement.

The key activities for each workstream are listed in the following tables:

Delivery workstream: 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 scope assumptions underpinning the OBC and identify gaps	Updated, consistent and tested assumptions underpinning operational redesign and information gaps added to workstream plan
<u>For IHSC project:</u> Working with Activity workstreams, analyse the existing pathway and design the 'to be'	Completed 'to be' service specifications based on a modernised, optimised safe and sustainable integrated

service for each division, based on a demand and capacity model	
<u>For Coop CYPS project:</u> Analyse functions and establish clusters, and undertake an options appraisal for the future delivery of each cluster	Preferred option
Develop the cost benefit analysis of implementing the new operational model for each division/cluster	Detailed cost and benefit analysis
Contribute to development of FBC document	Relevant technical input to the following sections: Strategic Context Option Appraisal Preferred Option

Delivery workstream: 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 parameters and assumptions to be used in Activity modelling	Agreed parameters used to determine capacity requirements are clearly set out (e.g. occupancy rates, daycase rates etc)
Develop or modify Activity modelling tools to deliver the required information within the agreed parameters	Demand and capacity model to establish future service requirements
Assess impact of national policy initiatives (demand management, shifts to primary care, choice, personalisation etc.)	Activity projections linked to decisions about primary and community care services and how acute provision is being delivered
Contribute to development of FBC document and appendices	Relevant technical input where required

Delivery workstream: Finance	
Purpose: To work with service areas to inform the service reconfiguration and develop the Financial business case	
Key activities	**Key outputs**
Detailed financial 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 Benefits realisation plan
Identify resources required to deliver the implementation	Workstream implementation plan including transitional costs and benefits
Contribute to development of FBC document and appendices	Relevant technical input to the following sections: Financial Analysis Cost benefit (VFM) analysis

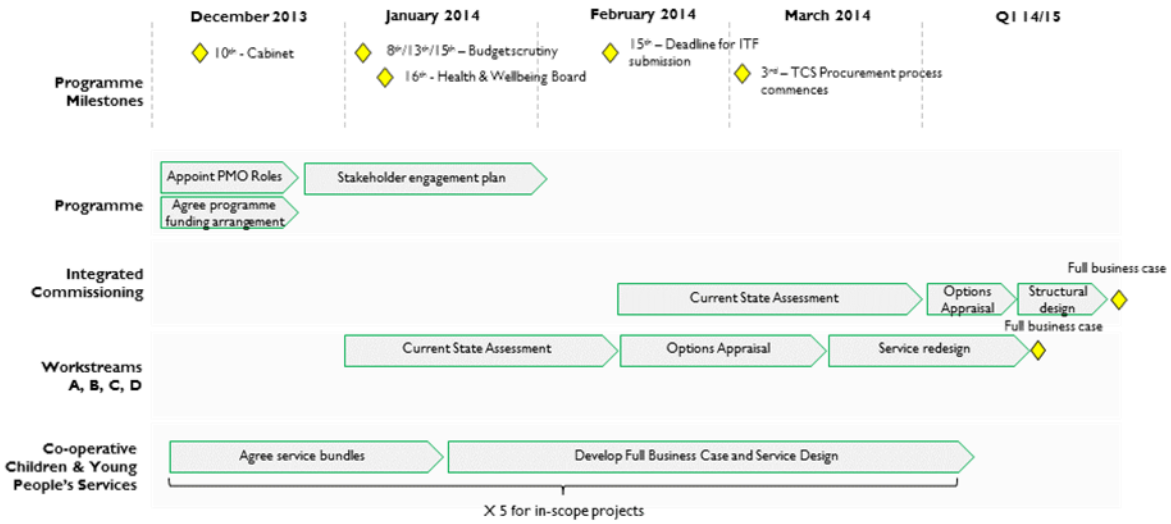
Enabling workstream: Legal and contractual	
Purpose: To deliver the activity required to provide the appropriate legal and technical support	
Key activities	**Key outputs**
Work with leads from each Workstream to identify legal and contractual issues	Milestone plan for legal and contractual engagement
Identify the procurement process to be followed in accordance with EU regulations and undertake the work needed to complete the necessary procurement documents	Compliant procurement process
Ensure the programme is linked in to TCS procurement process	Procurement specification alignment
Ensure employment issues e.g. (TUPE, Redundancy) are planned for correctly	Legal compliance with employment law requirements
Contribute to development of FBC document and appendices	Relevant technical input where required

Enabling workstream: 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

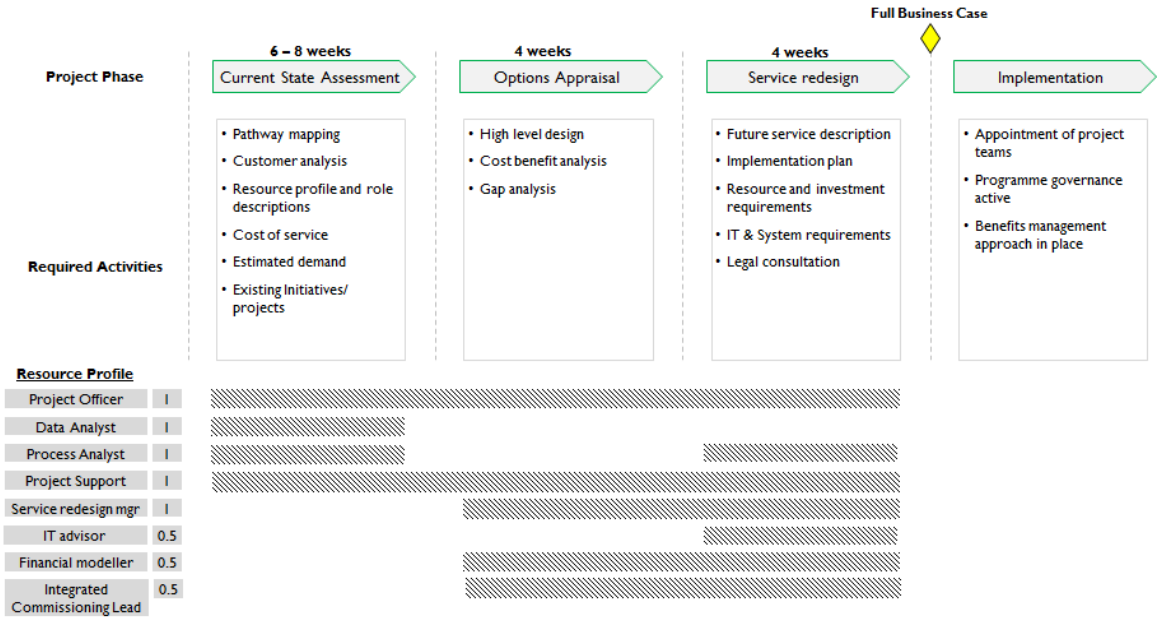
Manage stakeholders and develop appropriate communication and engagement toolkit	Communication and engagement toolkit
Liaise with PCC Transformation Portfolio Communications and Engagement Team	Coordinated communication and engagement activity
Working with HR where appropriate, support and enable communication and engagement with internal stakeholders (e.g. staff) using the toolkit	Newsletters, intranet, email bulletins, workshops, roadshows, documented meetings

5.3 Programme Plan

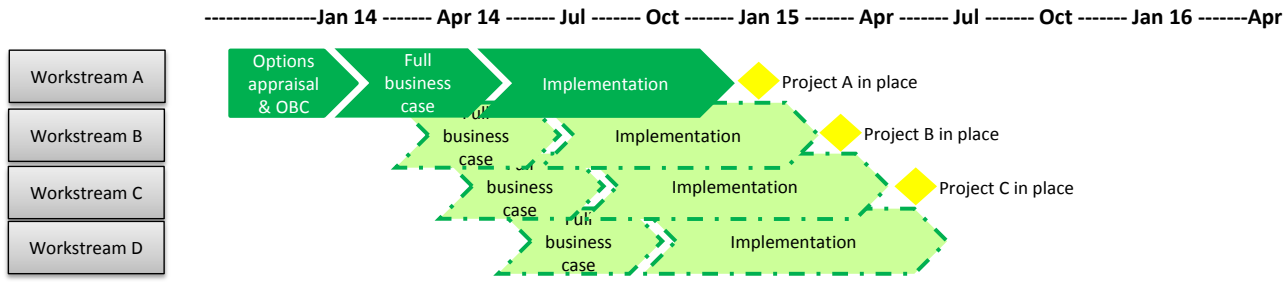
The programme plan shown below is a high level indication of the different projects within the programme.



Below is an indicative high-level project plan for the development of a mini-business case for the integration of a chosen HSC pathway or alternative delivery model for a Cooperative CYPS cluster. This will inform decisions on the required model of delivery at the programme level.



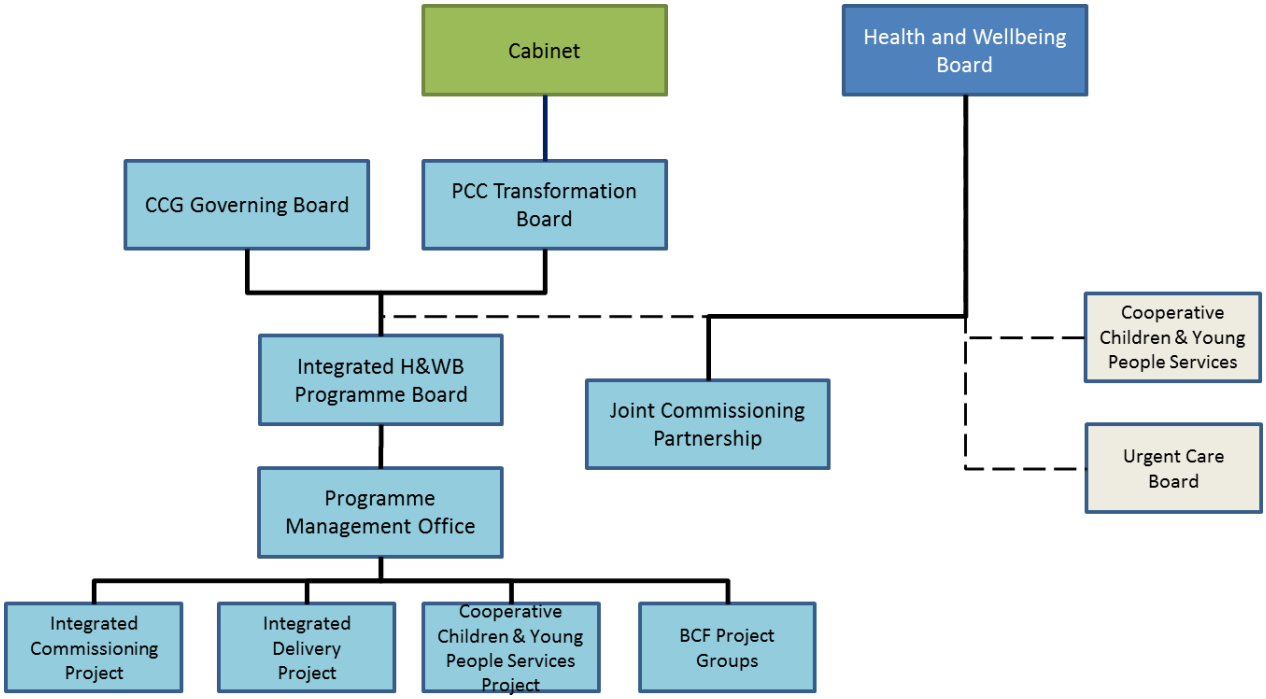
The resource profile set out above is what will be required **per pathway or service cluster**. This means that it is the minimum resource required to deliver one mini-business case at a time. If work is to be completed more quickly, with a number of pathways or clusters being assessed in parallel, the level of resource will need to be increased accordingly:



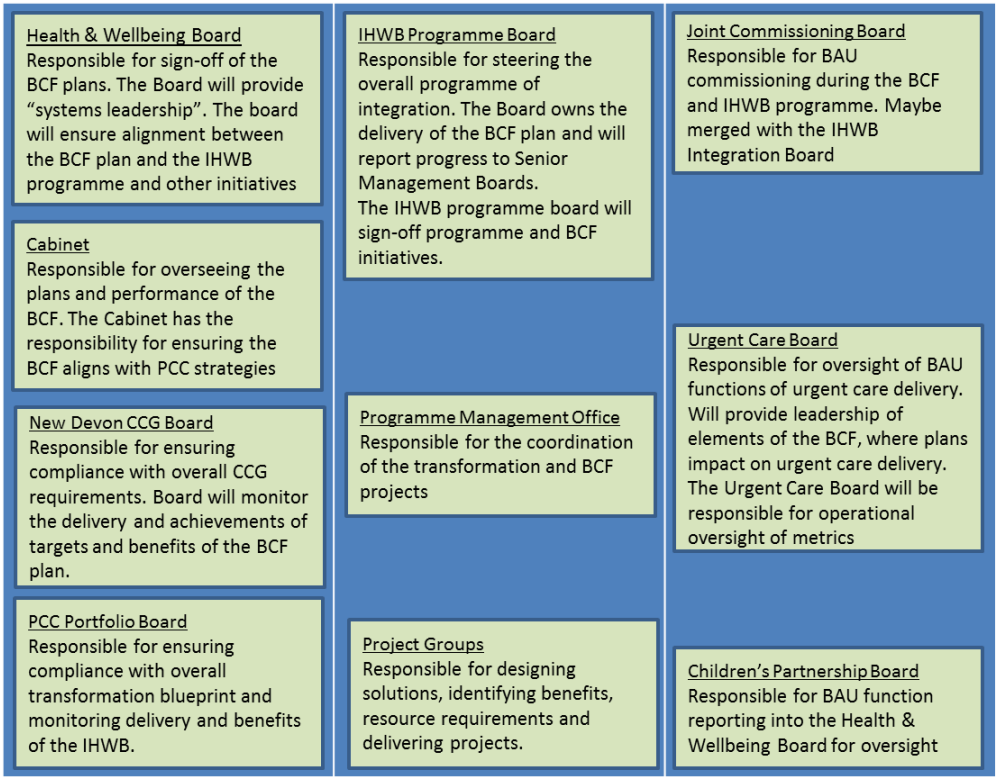
Refer to Appendix E for a detailed project plan.

5.4 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:



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					✓	

Terms of Reference to govern the HWB Integration Programme Board have been developed and are included in Appendix D

6 Financial Case

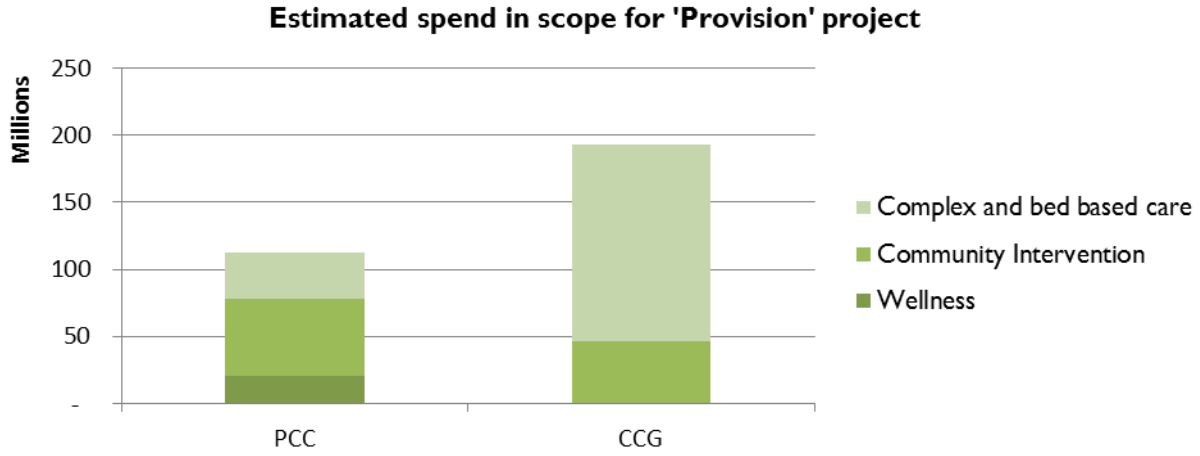
6.1 Addressable Spend

Plymouth City Council and NEW Devon CCG's budgets have been divided into three categories relating to degree of need for the end-user:

- **Wellness**: Universal/preventative services that enable self-management
- **Community intervention:** Services tailored to at-risk individuals supporting adults in the community including intermediate and community bed-based care
- **Complex and bed based care:** Acute, residential and nursing care

Making this distinction allows us to identify the value drivers in the healthcare system, which derive from reducing unnecessary uptake in specialist service. This can be achieved through projects aimed at improving integration within community services (for example).

The graph shows PCC and CCG spend across the three areas of the framework, and is based on the scoping within section 2.3:



At a high level, this early analysis indicates that the majority of PCC resources are directed towards higher cost, Specialist and Help at Home services such as nursing care and supported living. Specialist services such as acute care are dominant within the CCG spend analysed to date.

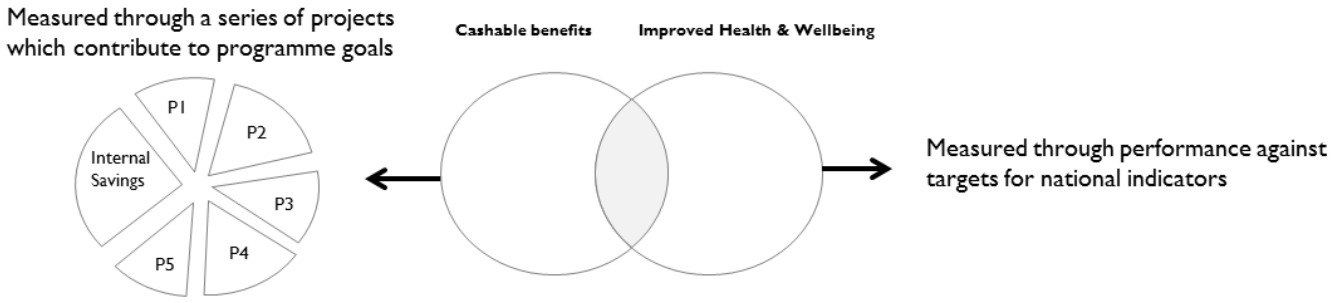
6.2 Approach to Benefits

The benefits of the programme can be divided between financial benefits (see 5.3) and health & wellbeing outcomes.

The agreed health & wellbeing outcomes can be divided into the levels of need categories of Complex, Community and Wellness.

Category	Performance measure	**3 year benefits target**
Complex/ Community	Delayed transfers of care	Return to national average
Complex	Delayed transfer of care due to adult social care	Return to average of comparator group
Complex	Emergency admissions: not in need of admission	5% reduction in category 1&2 admissions
Complex	Use of bed-based care	5% reduction in emergency admissions 5% reduction in community hospital admissions
Complex	Length of Stay	5% reduction in average length of stay
Complex	Readmissions to ED within 30 days	10% reduction in 30 day readmissions
Community	Potential Years of Life Lost (PYLL) from causes amenable to healthcare for children and young people	Above average (measurements yet to be carried out nationally)
Community	Effectiveness of reablement	2% improvement
Community	Community activity levels	*Dependent on project intervention*
Community	Activity of Elderly Care Services	National average ratio Community:RC&NC
Community	Proportion of deaths in usual place of residence	2% increase
Wellness	Social care related quality of life	5% improvement
Wellness	Control over daily life	5% improvement
Wellness	Childhood obesity	10% reduction by 2025
Wellness	Young people with complex mental health needs	5% reduction by 2017
User experience	Carer satisfaction	5% improvement
User experience	Patient and service-user experience	70% score on Plymouth I Statements

The majority of the cost savings will be delivered through targeted integration projects, where relevant services can be jointly commissioned based on commonalities or as part of an integrated care pathway. Only once the current spend on these pathways has been mapped can we understand the benefits opportunities fully. The remainder will be internal efficiency savings and revenue generated by the Cooperative Children and Young People's Services which will be quantified once the relevant projects have been defined.



In addition, the Cooperative Children and Young People's Services project has the potential to generate income. However, this figure is unquantifiable at this OBC stage, as the delivery vehicle(s) for these services have not yet been decided.

6.3 Cost and Benefits Analysis

This table provides the breakdown of potential financial benefits. The targeted integration benefits are highly contingent on which model of integration is adopted and on the current interventions in place in this area. This will be developed further in the full business case. Therefore, the benefits below are an illustration of potential opportunities which require further analysis.

		Annual Benefits					
Benefit Description	Category	Lower Range of Financial Benefit	Upper Range of Financial Benefit	Average Financial Benefit	PCC share	CCG share	level of Confidence
Integrated Commissioning	Cost Reduction	£204,638	£613,915	£409,277	£294,926	£114,351	Medium
Integrated Provision	Cost Reduction	£2,927,539	£5,018,638	£3,973,088	£1,463,269	£2,509,819	Low
Co-operative Children & Young People's services				£0			
Targeted integration example 1 - Self Management	Cost Reduction	£4,220,991	£8,024,087	£6,122,539	£1,115,262	£5,007,277	Low
Targeted integration example 2 - Community support and falls prevention	Cost Reduction	£2,086,904	£4,373,492	£3,230,198	£1,586,811	£1,643,387	Low
				£0			
				£0			
Projected Total Cost Reduction Benefits (£k)		£9,440,072	£18,030,132	£13,735,102			
Projected Total Income Generation Benefits (£k)		£0	£0	£0			
Projected Total Cost Avoidance Benefits (£k)		£0	£0	£0			
Percentage reduction for double counting		10%	10%	10%			
Optimism bias adjustment		10%	10%	10%			
			Total	£11,125,433			

Indicative Phasing of Average Financial Benefits

Now	2014/15	2015/16	2016/17	2017/18	2018/19	Total
	£1,112,543	£6,675,260	£11,125,433	£11,125,433	£11,125,433	£41,164,101

The nature of the financial benefits vary between projects. For example, the benefits of integrated commissioning are pure cost savings derived from reduced spend on resources to deliver commissioning services. The integrated provision benefits have been identified from the reduction in contract spend through employing mixed-speciality teams, tapering existing cotracts and strategic decomissioning.

The benefits of the targeted integration are realised through reducing demand for secondary care services. This is where the greatest potential benefit could be realised, but will require a higher level of analysis to identify and manage direct benefits (this is why they have been attributed a confidence level of 'low' at this stage.

Financial benefits for the Co-operative Children's and Young People's Services project have not been determined in full yet. A financial business case for the the Education Catering service has been developed, which identifies that by operating in a new delivery model in partnership with schools, the service will no longer require the current £600k level of subsidy it receives annually from PCC. The new model is predicated on the following assumptions:

- An annual reduction in service delivery costs
- A reduced management cost
- Reduced overhead charges through procuring support services competively
- Extended supply of meals to existing customers
- Any surplus made by the new delivery vehicle will be reinvested in the service, therefore removing the requirement for PCC to commit resources to grow the service

In addition, further additional income may be achieved through

- Expansion of customer base to additional schools
- Expansion of customer base to provide community meals and non-clinical meals for the hospital
- Extension of existing service offering to include breakfast and after-school provision

These three areas are not currently quantified and are less certain, so will need further work to develop as the service settles into the new delivery model.

There is a key risk to PCC in the proposal to procure support services competitively, as this will require PCC to be able to provide these services at prices similar to the external market. If PCC is unable to achieve this price, it will lose incomce from services such as Education Catering which, with a zero-based budget, will direct spend elsewhere away from the Council in order to achieve value for money. Therefore, the positive cost reduction to PCC derived from the new delivery model may be counteracted by a loss of income. The Blueprint work will need to consider the cost of support services, how best to deliver these comptetively as more services are moved outside of in-house delivery and the principles which underpin these proposed externalisations. This will be need to be done as an early activity within the Blueprint programme.

Further work to determine the cost benefit analysis for other areas of Co-operative Children's and Young People's Services will be continued as the programme progresses.

Refer to Appendix A for detailed cost benefit analysis.

6.4 Expected Costs

The programme has been designed to develop a full business case for a future integrated operating model.

The programme will be delivered through a programme management office. The cost of which has been estimated below:

Role	Programme Cost (annual)
Senior Project Manager	44,000

Senior HR Advisor	18,500
Business Change Advisor	8,250
Communications Officer	8,250
ICT programme manager	40,000
Finance Lead	9,250
	128,250

The cost of each workstream has been estimated below:

Role	Programme Cost	Business Case Cost
Project Officer	26,000	8,667
Data Analyst	10,000	833
Process Analyst	13,000	1,667
Project Support	20,000	6,667
Service redesign manager	38,000	6,333
IT advisor	7,500	625
Financial modeller	7,500	2,500
Integrated Commissioning Lead	6,500	2,167
Total	128,500	29,458

The costs above are resource time only, and assume PCC will invest internal resources in the programme. The total cost of developing the full business case is estimated below:

Total Costs (£)	
Programme Management Office	32,063
Workstream Business Case (x9)	265,125
Legal advice	20,000
Total	317,188

The latter phases of the programme are highly dependent upon the service redesign; therefore there is no value in attributing costs to this activity at present. The costs above are resource time only, and assume PCC will invest internal resources in the programme. Additional work to further develop programme costings will need to be performed as part of the next phase of work, and this may cause an increase in the estimated programme costs given above, as these have been developed without the full level of detail required. It is likely that the costs shown above would increase if external support was used.

Refer to Appendix A for detailed cost-benefit analysis.

7 Risks and compliance

7.1 Risk Analysis

Refer to Appendix C for detailed risk log.

7.2 Interdependencies

Within PCC, there are key interdependencies 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 made in the outline business case are compliant with this document. The other programmes within the PCC Transformation Portfolio will provide support around engaging with staff, developing new ways of working, and redesigning customer services.

NEW Devon CCG have 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.

The CCG also has to re-commission its community healthcare services contract by March 2016. The current provider is Plymouth Community Healthcare (PCH), who also provide certain Public Health services in Plymouth. The commissioning timescale for this, and the associated 'Transforming Community Services' programme, will influence workstreams concerning other community services.

Another key interdependency is with the Integration Transformation Fund (ITF) 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).

7.3 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 the Western Locality board may not be able to sign off on plans on its own, and approval from the CCG board may be required.

A key procurement constraint is that neither PCC nor the CCG will be able to decommission services currently provided by Plymouth Community Healthcare until expiry of the contract in 2016. This may affect the shape of future delivery vehicles, and the scope of services to be included within these.

7.4 Stakeholders

The table below provides a very high level indication of the key stakeholders in this programme of work. An in-depth stakeholder mapping exercise will need to be completed with a detailed engagement plan.

Stakeholder Type	Stakeholder	Responsible	Accountable	Consulted	Informed
Staff				X	X
Partners	NEW Devon CCG	X	X	X	X
	The Police and Crime Commissioner			X	X
	Plymouth Community Healthcare team			X	X
	Plymouth Hospitals NHS Trust		X	X	X
	Plymouth Community Homes			X	
	Schools	X	X		
	DELT			X	
Communities					
Members			X	X	X

8 Programme Organisation

The P&OD programme will be governed by a Programme Board using the standard Terms of Reference as set out by the Portfolio Office.

The purpose of a Programme Board is to ensure there is a continued and focused effort on driving the programme forward to ensure delivery of transformation outcomes, aligned with the Values of the Co-operative Council approach in accordance with the approved Programme Business Case. The Senior Responsible Owner, accountable for the successful delivery of the Programme, is appointed by the Transformation Portfolio Board acting as Sponsoring Group for the Programme.

8.1 Benefits Management

As part of benefits management, initial activity within the Workstreams will be to confirm, validate or update the baseline measures from this OBC.

Benefits management focuses on establishing clear mechanisms for monitoring the programme's achievement of its stated outcomes. The approach is described below:

- Refine the benefits identified in the OBC
- Validate the level of ambition for each benefit consistent with the recommendations
- Confirming the measure(s) for each benefit
- Developing monitoring arrangements:
    - using existing monitoring mechanisms where possible
    - by enhancing these to improve completeness or quality of measurement where considered critical
    - by integrating monitoring of these in to systematic project management reporting arrangements

A benefits scorecard will be developed during the Full Business Case activity to monitor proposals against project objectives. This scorecard will be in line with the PCC Transformation Portfolio Programme framework in order that the benefits of this programme can be incorporated into the wider programme. Benefits management will be integrated into project reporting processes.

8.2 Guiding Principles and Methodologies

The programme will use the Portfolio lifecycle, strategies, standards and methods put in place by the Transformation Portfolio Office (TPO).

8.3 Quality Management

Quality Management Strategy and Plan – Portfolio Office

8.4 Portfolio level Benefits Management

Portfolio Level Benefits Management Strategy will be used

8.5 Risk Management Strategy

Corporate Risk Management Strategy

8.6 Methodologies

The programme will follow the management guidance and standards defined by the TPO for processes, tools, methodologies, document management, templates and assurance.

Management of Portfolio, Managing Successful Programmes (MSP) and PRINCE2 methodologies will be used as tailored specifically for Plymouth City Council Transformation Portfolio.

8.7 Equality Impact Assessment

The Transformation Portfolio Office has written an Equality Impact Assessment on behalf of the Transformation Portfolio.

8.8 Any other tools / methodologies / processes / standards / assurance

Plymouth City Council Transformation Portfolio Lifecycle has been developed to assure the safe delivery of the projects and programmes in the Transformation Portfolio.

Governance is applied across the Projects and Programmes in accordance with the Transformation Start-up Pack and subsequent documentation from the Portfolio Office.

8.9 Programme documents

All documents pertaining to the standards, processes, tools, methodologies and assurance to be applied to all Programmes and Projects in the Transformation Portfolio will be found in the Portfolio Office Folder as shown above.
All files for specific Programmes and Projects will be filed by Programme and Project.

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All files for specific Programmes and Projects will be filed by Programme and Project.

9 Appendices

Appendix A – Capability Assessment

- Include relevant capability assessment for the programme (below example for Cooperative Centre of Operations)

Process	Key Activities	Capability			Identified Improvements *(Process not Key Activities level)*
		Current	Target	Gap	
Develop Vision and Strategy	Define Vision and Strategy	3	4	1	Standardised methodologies for benefit tracking, project and risk management to support strategic initiatives
	Develop Strategy	3	5	2	Revised governance structure/ process for the prioritisation and management of strategic initiatives
	Manage Strategic Initiatives	2	4	2	Future vision and strategies are based on true customer, market insight and are developed on the views of key internal and external stakeholders
Develop Services	Understand Markets, Customers and Capabilities	2	4	2	An in-house analytics capability develops the customer/ market insight required by all council services
	Manage Service Portfolio	3	5	2	There are clear policies/ guidelines on potential delivery models, approaches to market testing and legal/ financial parameters
	Develop Services and Define Delivery Models	2	5	3	Improved cross-directorate knowledge of the dependencies and links between separate services
Deliver Services	Deliver Service and Manage Demand	2	5	3	Refreshed performance management measures for service delivery and contract management
Manage External Partnerships	Manage Partner Relationships	3	5	2	Governance and legal frameworks have been re-defined to support increased partnerships with external organisations
Manage Knowledge, Improvement and Change	Manage Improvement	2	5	3	Standardised project management, change management and benefits tracking methodologies for PCC

Appendix B – Risk Log

No.	Risk	Likelihood	Impact	RAG Status	Mitigating Actions
IHWB_RSK_1	Savings delivered from the integration are not sufficient to meet the funding gap	3	4		• Scrutiny and validation of the business case, and the projected benefits in further phases • Account for optimism bias in financial model when developed
IHWB_RSK_2	Disruption to service delivery with an impact on service quality and reputation	2	4		• As part of business case phase contingency planning undertaken as part of implementation planning • Key scenarios identified and mitigation plans developed
IHWB_RSK_3	Negative impact on service users and threat to continuity of care	2	4		• Early engagement of key service user representative groups • Pathway re-design workstreams led by clinicians and social care professionals
IHWB_RSK_4	Staff/union resistance to the proposed changes and service redesign	3	3		• Early consultation with Unions • Union representation at key workshops.
IHWB_RSK_5	Difficulty in securing agreement across the partners to service redesign causes delay in delivery leading to savings targets being leaked, and delaying benefits realisation	3	3		• Areas of potential disagreement highlighted and discussed early in the process • Identification of key decision makers and a dispute resolution process • Formal agreements and protocols in place to enable teams to work

					together
IHWB_RSK_6	Multiple parties involved leading to partial support for business case, which delays implementation	2	3		• Key stakeholders identified at the start of the project and engaged regularly • Communications plan in place and key stakeholders provided with regular updates
IHWB_RSK_7	Baseline data is not robust and the business case is undermined	3	4		• Validation of the baseline data finance • Validation and ownership of the financial model by finance and service areas • Validation of the savings opportunities by service professionals
IHWB_RSK_8	Statutory or regulatory differences between Health and Social care lead to tensions	2	4		• Potential areas of conflict identified early and formal protocols or agreements put in place
IHWB_RSK_9	New legislation introduced which impacts on plans (e.g. Care Bill and Dilnot)	2	4		• Remain well-informed of policy and legislative developments and build in necessary changes early and challenge solution development
IHWB_RSK_10	Negative impact of procurement or tax requirements on new delivery mechanism, for example VAT regulations	3	3		• Consider likely impact of during the Options Appraisal process if new delivery vehicles/alternative structures are considered
IHWB_RSK_11	Legal challenge regarding competition and contracting	3	4		• Ensure notice periods to providers are duly followed and all consultation is documented
IHWB_R	Resources	3	3		• Develop programme

SK_12	required to deliver integration are not available/ funding does not exist to commission external resources				delivery plan and get cross party sign up to this. • Cross- party investment planning meeting to agree resource commitment.
IHWB_RSK_13	Footprint of NEW Devon CCG covering both Devon CC and Plymouth CC will delay approval of business case and implementation	3	3		•
IHWB_RSK_14	Transforming Community Services programme does not procure an integrated suite of community services	3	4		• Prioritise certain aspects of full business case development that provide a view on what services should be procured along with those provided by PCH
IHWB_RSK_15	Failing to reach agreed terms that are compliant with Teckal criteria, due to differing legal opinions	4	4		• 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) • Regular compliance checks and discussions

APPENDIX A

The Blueprint has been guided by the Strategic principles that were developed co-operatively with Members, senior Officers and staff

PLYMOUTH CITY COUNCIL

Our approach to developing the Strategic Principles has been value-led and they are woven throughout the principles – we have been **Democratic** by engaging a cross section of staff and Members, we have been **Fair** by being transparent in the exercise we are performing, we have been **Responsible** by being proactive in changing the way we would do things to meet financial challenges and we will be using **Partners** to deliver or commission services

Blueprint Component	Strategic Principles – By 2017 / 18 we will…
Vision & Purpose	…be a co-operative council delivering our values
	…work with our customers, communities and partners as one joined up team to serve our city
Customer & Channels	…know our customers' needs and preferences and proactively manage their expectations
	…make it easier and faster for customers to interact with the council
	…ensure customers and communities are informed and able to influence the council's decision making
	…have a consistent and accurate view of the customer demand on our services
Commissioning and Service Delivery	…use customers, communities and partners to deliver or commission services
	…prioritise, stop, change and grow services so that they fit within our financial budget
	…support partners to develop capability to help us commission from them
People, Organisation & Culture	…be a leaner, more flexible organisation employing a creative, empowered and resilient workforce
	…have the right organisation structure, capacity, skills and knowledge to deliver our priorities
	…deliver change effectively and have a positive culture of collaboration, commerciality and improvement
Process & Transactions	…have removed all unnecessary processes
	…have become outcome and cost focussed through simplified, standardised and clearly communicated processes
Technology and Information	…understand what technology and information we need to deliver against our business needs
	…treat information as an asset and protect it
	…have more integrated information (e.g. customer, management) with partners, facilitating better co-operative working
Accommodation	…have the right buildings in the right places to deliver our outcomes and support collaboration with partners
	…align assets and buildings with our priorities, maximising their value for the city
Planning and Performance	…jointly plan how we use our people, money and assets with our partners and communities
	…drive organisation and personal accountability and performance using a data led mentality, measuring the right things

powerpoint

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APPENDIX B (page 1 of 3)

BRIEFING GOVERNANCE ARRANGEMENTS

- TRANSFORMATION

David Trussler

In local government, decisions can be taken by the Council, the Cabinet, individual portfolio-holders, Committees and officers. There is a specific legal power to delegate ward-based decisions to ward members, but this has not been implemented at Plymouth City Council. Which decisions are implemented by whom, is determined by the general law, the Council's constitution and the Leader's scheme of executive delegations.

In complex areas of operation, the individual decision makers often find it useful to take the views of others in making decisions and to ensure a coordinated approach across the authority. One such complex area of operation will be the Transformation Project which is referred to in outline in the budget which was recently approved by Council.

The bodies which will support decision makers (but which can have no decision making powers of their own) will include:

- Members Transformation Board
    - Purpose: Executive ownership and accountability for Transformation Portfolio
    - Chaired by Executive Member for Transformation
    - Individual Executive members aligned to Programmes
    - Joined by Portfolio Board members as needed but will likely include Chair (CX), SROs and Portfolio Manager (Transformation Director)
    - Receive Portfolio Highlight Report from Transformation Portfolio Board
    - Pre-Cabinet approval of Programme Business Cases
    - Monthly Frequency
- Transformation Advisory Group
    - Purpose: Build cross-party dialogue, understanding and consensus on Transformation
    - Executive Member for Transformation (Chair), Shadow equivalent, Chair of Co-operative Scrutiny Board. Additional Labour member (flexible)
    - Supported by Transformation Director
    - Receive Portfolio Highlight Report

    - Monthly frequency
- Scrutiny Committees
    - Portfolio level scrutiny: CCSB
    - Programmes: Aligned to Scrutiny Boards with joint meetings where necessary

There is top level officer consideration of transformation through the Transformation Portfolio Board

- Transformation Portfolio Board
    - Purpose:
        - Coordinate the delivery of a Blueprint for the future of the organisation
        - Recommend prioritisation decisions between and within Programmes, reflecting council objectives
        - Ensure engagement strands (political, community/customer, staff and partners) are fully supporting and driving the Transformation Portfolio and Programmes
        - Ensure (financial and human) resources are available to deliver Portfolio
        - Ensure Portfolio benefits are delivered
        - Recommend Programme Business Cases and Exceptions
        - Escalation path for Programmes
        - Performance management (by exception) of Programmes
    - Membership of the Transformation Portfolio Board comprises
        - Chair: Chief Executive
        - Portfolio Manager: Transformation Director
        - SROs for each Programme
        - Four Engagement leads
            - Political:
            - Staff:
            - Community/Customers:
            - Partners:
        - S151 Officer
        - HR Director
        - Head of Portfolio Office

Programmes will be led by a Senior Responsible Owner of the Council who is accountable for successful delivery, achieving desired outcomes and realising expected benefits.

Their role in leading the Programme includes:

- Personal accountability for delivery of the programme outcomes and associated benefits
- Chairs the Programme Board and leads the Programme
- Owns the Programme Vision and provides strategic direction
- Manages the relationship with key stakeholders, ensuring strong and continued support for the programme
- Maintains alignment of the Programme to the overall Portfolio
- Secures the investment required to set up and run the programme and achieve the desired benefits
- Accountable for the running of programme governance arrangements in accordance with relevant Portfolio Office standards
- Owns the Programme Business Case
- Authorises the Programme Manager to carry out each stage of the Programme
- Appoints and authorises Project Executives to manage Projects within the Programme

Programmes comprise of Projects which are tasked to deliver new capabilities required and specified in the Programme/Project Business Case by the SRO. Projects are led by Project Executives.

The Project Executive

- Manages the relationship with key stakeholders
- Chairs the Project Board
- Owns the Project Vision and provides direction
- Is accountable to the Programme SRO for the overall success of the Project
- Authorises the Project Manager to carry out each stage of the project
- Is accountable for the project's governance arrangements in accordance with relevant standards
- Owns the project Business Case (where it is required)
- Ensures Risks and Issues are properly managed and resolved

The Transformation Portfolio Board is supported by the Portfolio Office.

- The Portfolio Office is an organisational capability, delivered through a Portfolio, Programme and Project Office (P3O) construct which provides:
    - Portfolio Alignment, Prioritisation and Planning
        - Blueprint aligned Portfolio of Programmes
        - Prioritisation of Programmes and Projects
        - Portfolio mapping & planning (outcomes, outputs, inputs, dependencies)
        - Portfolio financial strategy and planning
        - Portfolio resource strategy and planning
        - Portfolio level change control
        - Support for Engagement streams strategy & planning
    - Governance support: through education, training, & coaching.
    - Transparency: supporting high quality decision making through relevant and timely information provision and transmission.
    - Leadership roles: through ensuring leaders of change are in place who understand their roles and are given training and coaching support to deliver them
    - Delivery support: ensuring there is the right amount and type of specialist capability in place - including people in Programme and Project Management, Business & Technical Architecture, Business Analysis & Design, Change Management, Subject Matter Expert roles – with the right experience, knowledge, skills and behaviours.
    - Assurance: through constructive and consultative support of Programme and Project teams across the Portfolio, Programme and Project lifecycle.
    - Quality, Reusability and Traceability: ensuring that best practice models, products, processes, standards and tools are in place and being used consistently to maximise the chances of successful delivery.
    - Risk Management
    - Quality Management
    - Reports for the Transformation Portfolio Board

Risks to the delivery of Transformation objectives and benefits are managed using a Portfolio, Programme and Project Risk Management Methodology using *OGC* Management of Risk and aligned to PCC Corporate Risk Management. Risks and Issues are identified, articulated and assessed at the Project, Programme and Portfolio level against a scoring for Proximity, Likelihood and Consequence/Impact.

Risks are assessed by area such as Financial and Organisational and the mitigation for the risk is articulated with both a current RAG status and a residual RAG status assigned. Regular risk assessments are held led by the Portfolio Office to ensure that the Project, Programme and Portfolio responsible officers have identified all risks and their required actions and status, and that the identified actions to mitigate the risks are being effective. The Portfolio Office also monitors risks that need to be escalated from Project to Programme and Programme to Portfolio (as well as to the Corporate Risk Register as appropriate) are escalated and actioned.

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CARING PLYMOUTH

Tracking Resolutions and Recommendations
2013 - 2014

Date, agenda item and Minute number	Resolution	Target date, Officer responsible and Progress	
Minute 18 26 September 2013 Social Care Budget	Agreed that - 1. the Panel is provided with a breakdown of the £75 million to include staffing and administration costs, this to include a breakdown of the £4.5m social care 256 money. 2. the Panel is provided with a process paper on joint assessment, how it's undertaken and who has responsibility for continuous healthcare.	Date	14 November 2013
		Officer	Dave Simpkins, Assistant Director for Co-operative Commissioning
		Progress	Dave Simpkins to provide the panel with the information as requested. Amelia Boulter to chase and circulate by email. Information provided and circulated to panel members.
Minute 27 14 November 2013 Dementia Strategy	Agreed that a review of the Dementia Strategy takes place in the New Year to review the action plan.	Date	March 2014
		Officer	Craig McArdle, Head of Joint Commissioning
		Progress	Scoping meeting take place by March 2014.
Minute 28 14 November 2014 Public Health Outcomes	Agreed that the panel receive on a quarterly basis the Public Health Outcomes report to include trends and narrative on progress to address issues.	Date	March 2014
		Officer	Rob Nelder, Public Health Consultant
		Progress	The panel to receive the information as requested on a quarterly basis. This is an agenda item for 6 March 2014.
Minute 36 30 January 2014 Better Care Fund	The panel noted the Better Care Fund briefing and agreed that progress on the Better Care Fund provision be reviewed by the panel when more information is available.	Date	TBC
		Officer	Craig McArdle, Head of Joint Commissioning
		Progress	Draft submission went to the Health and Wellbeing Board on 13.02.14. Final submission to be signed off by Health and Wellbeing Board on 27.03.14.

Recommendations sent to the Cooperative Scrutiny Board.

Date, agenda item and minute number	Caring Plymouth Recommendation	Corporate Scrutiny Board Response	Date responded
6 March 2014 Minute 44	**Safeguarding Adults Board** Agreed that – 1. the Safeguarding Business Plan and Annual Report to be brought back to a future meeting for review. 2. the panel be provided with a clearer understanding and awareness around safeguarding interventions and responsibilities to include – • Engagement with Care Homes; • Risk around personalised budgets; • The range of issues that cause safeguarding alerts. 3. a review of places of safety and use of Section 136 to be brought back to the panel for consideration. 4. a report on the risk associated with integration and the delegation of responsibilities to ensure the council retains control over safeguarding.		

Date, agenda item and minute number	Caring Plymouth Recommendation	Corporate Scrutiny Board Response	Date responded
6 March 2014 Minute 45	**Public Health Outcomes Framework** Agreed that – 1. As part of the induction pack into Child's Health, preparation of briefs for the worst child health performance indicators including current resourcing, activities, barriers and opportunities – • Breastfeeding • Under 18 Conceptions • Excess weight • Unintentional injuries • Vaccinations (MMR and HPV) • Smoking in pregnancy 2. Quality of air to be brought back to a future meeting – - Prior to the Energy from Waste Plant commencing operation that Public Health via Plymouth City Council's Environmental Protection Team or the appropriate agency, commissions baseline air quality testing at various points in the city to monitor future effects on air quality.		
6 March 2014 Minute 46	**Continuing Healthcare** Agreed that links are placed on Plymouth Online Directory (POD) on Plymouth City Council's website to information links about personal budgets (e.g. Department of Health's leaflet and Age UK leaflet) and that the link should also provide advice on when and how to claim continuing healthcare.		

Date, agenda item and minute number	Caring Plymouth Recommendation	Corporate Scrutiny Board Response	Date responded
6 March 2014 Minute 47	**Recommendations from Budget Scrutiny** Agreed that an action plan addressing the revised approach to health inequalities across the city is brought to the Caring Scrutiny panel within six months by the incoming Director of Public Health.		
6 March 2014 Minute 48	**Tracking Resolutions** Agreed that – 1. The Better Care Fund plan to be brought back to a future meeting. Specific areas the panel would like to review in more detail, such as the 7 day working will be shared at a later date, once the plan has been published. 2. the Chair of the Caring Plymouth panel to send a letter in support of the Leader to the Secretary of State regarding Plymouth's Public Health Settlement and its subsequent impact on the BCF.		

Recommendation/Resolution status

Grey = Completed item.

Red = Urgent – item not considered at last meeting or requires an urgent response.

CARING PLYMOUTH

Work Programme 2013 - 2014

Please note that the work programme is a 'live' document and subject to change at short notice. The information in this work programme is intended to be of strategic relevance and is subject to approval at the Cooperative Scrutiny Board.

For general enquiries relating to the Council's Scrutiny function, including this committee's work programme, please contact Amelia Boulter, Democratic Support Officer, on 01752 304570.

Date of meeting	Agenda item	Purpose of the agenda item	Reason for consideration	Responsible Officer
04.07.13	Urgent Care - accident and emergency improvement plan - NHS111 commissioning	To look at the plans in place for dealing with emergencies	Public Interest	Jerry Clough (Director of Western Locality) (speak to Amanda Nash)
	Public Health	Plans for next 12 – 18 months	New Council Service	Debbie Stark – Interim Joint Director of Public Health Carole Burgoyne – Director for Place
	Healthwatch	What are their plans for the first 12 months of operation?	New Council contract	Vicky Shipway – Chief Executive for Colebrook Society Ltd Craig McArdle – Head of Strategic Commissioning, Adult Social Care
26.09.13	Social Care Budgets	To receive a report on the social care budgets to include delivery plans and update on personalisation.		Dave Simpkins – Interim AD for Joint Commissioning
	Health & Well Being Strategy	To receive a progress report on the development of the Health and Wellbeing Strategy.	To note	Ross Jago – Research and Policy Officer
	Disabled Parking at Derriford Hospital	To look at the plans for disabled parking at Derriford Hospital.	Part of the consultation process prior to plans being submitted to Planning for approval.	Andrew Davis

Date of meeting	Agenda item	Purpose of the agenda item	Reason for consideration	Responsible Officer
14.11.13	Carers Strategy	To be provided with an update on the strategy.	Strategy due for a refresh in 2013.	Debbie Butcher
	Dementia Strategy	To be provided with an update on the strategy.		Debbie Butcher
	Pledge 90 – Mental Health Review	To receive a further update on the progress on the mental Health Review.	Review of findings.	Craig McArdle
30.01.14	Integrated Transformation Fund	To review the plan prior to submission to the Department of Health on 15.02.14.	Review the plan.	Craig McArdle and Paul O'Sullivan
	Review of Car Parking Charges at Derriford Hospital	To have input into the consultation process on car parking charges at the hospital.		Andrew Davies – PlymouthHospital Trust
06.03.14	Recommendations from Budget Scrutiny	To review the recommendations made at budget scrutiny	To add any relevant recommendations for action onto the Caring Plymouth Tracking Resolutions	Candice Sainsbury
	Safeguarding Adults Board	To have an understanding on the role of the board	The board to have awareness of other partnerships	Debbie Butcher
	Continuing Health Care	Process/Costs to PCC		
03.04.14	Children's Health	To give the panel an understanding of children's health – - breastfeeding - under 18 conceptions - excess weight - unintentional injuries - vaccinations (MMR and HPV) - smoking in pregnancy	Children's Health previously addressed by the CYP OSP.	Dr Julie Frier
	Review of Car Parking Charges at Derriford Hospital	To have input into the consultation process on car parking charges at the hospital.		Andrew Davies – Plymouth Hospitals Trust
	Plymouth Hospitals NHS Trust Quality Accounts	To have an overview of the quality accounts		Jayne Glynn – Plymouth Hospital Trust
	Transformation	To be given an overview on the scrutiny of the transformation programme.	Overview	Craig Williams – Interim Programme Manager, Integrated Health and Wellbeing

Scrutiny Review Proposals	Description
Health Accountability Forum	The forum is an opportunity for Plymouth Hospitals NHS Trust (PHNT) to answer any questions on any concerns and issues raised by members of the public and members of the Caring Plymouth Panel. The forum may lead to more specific items to be explored further in a Co-operative Review.
Dementia Strategy Review	PID to be produced. Meeting taking place on 22.01.14
Carers Strategy Refresh	PID to be produced. Meeting taking place on 22.01.14

Scrutiny Review Proposals	Description
Pledge 90 – Mental Health Review	In May 2012, Plymouth City Council announced 100 pledges around the 10 priority areas identified in the Corporate Plan. Pledge 90 was to 'conduct a wide ranging review of the adequacy of mental health service and support in the city alongside mental health providers and charities'. Review took place on 16.12.13.
Maternity Services	

One-off sessions

To cover the relationship between the Health and Wellbeing Board, NEW Devon CCG and Local Area Team to look at roles and responsibilities.

Health Champion Training provided by Public Health.