Public Document Pack

#healthyplym

Democratic Support
Plymouth City Council
Civic Centre
Plymouth PL1 2AA

Please ask for Amelia Boulter
T 01752 304570
E amelia.boulter@plymouth.gov.uk
www.plymouth.gov.uk/democracy
Published 05 February 2014

HEALTH AND WELLBEING BOARD

Thursday 13 February 2014
10 am
Warspite Room, Council House

Members:
Councillor Sue McDonald (Chair)
Councillors Nicky Williams and Dr John Mahony

Statutory Co-opted Members: Director for People, NEW Devon Clinical Commissioning Group representative, Director for Public Health, Healthwatch representative, NHS England, Devon, Cornwall and Isles of Scilly representative.

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

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

This meeting will be broadcast live to the internet and will be capable of subsequent repeated viewing. By entering the Warspite Room and during the course of the meeting, members are consenting to being filmed and to the use of those recordings for webcasting.

Although the public seating areas are not filmed, by entering the meeting room and using the public seating area, the public are consenting to being filmed and to the use of those recordings for webcasting.

The Council is a data controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with authority's published policy.

Tracey Lee
Chief Executive

HEALTH AND WELLBEING BOARD

1. APOLOGIES

To receive apologies for non-attendance by Health and Wellbeing Board Members.

2. DECLARATIONS OF INTEREST

The Board 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 meeting held on 16 January 2014.

5. COMMUNITY AND VOLUNTARY SECTOR MEMBERSHIP

The board to have a discussion on community and voluntary sector membership on the Health and Wellbeing Board.

6. BETTER CARE FUND (Pages 7 - 38)

The Board to consider the draft of the Better Care Fund template and metrics.

7. WORK PROGRAMME (Pages 39 - 42)

To review the Health and Wellbeing Board work programme.

8. 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 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

Health and Wellbeing Board

Thursday 16 January 2014

PRESENT:

Councillor McDoanld, in the Chair.
Dr Richard Stephenson, Vice Chair.

David Bearman, Andy Boulting, Carole Burgoyne, Jerry Clough, Peter Edwards, Amanda Fisk, Tony Hogg, Stephen Horsley, Councillor Dr Mahony, Debbie Roche, Clive Turner, Steve Waite and Councillor Nicky Williams.

Apologies for absence: Sue Kelley and Ann James.

Also in attendance: Dame Suzi Leather, Ross Jago – Policy and Performance Officer and Amelia Boulter – Democratic Support Officer.

The meeting started at 2.00 pm and finished at 4.00 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.

20. APPOINTMENT OF VICE-CHAIR

The Board agreed the appointment of Richard Stephenson as Vice Chair.

21. DECLARATIONS OF INTEREST

There were no declarations of interest.

22. CHAIR'S URGENT BUSINESS

The Chair welcomed Debbie Roche to the board. Debbie has been nominated to represent the community and voluntary sector on the board.

The Chair informed the panel that an extraordinary meeting of the board would take place on 13 February 2014 to consider the Better Care Fund.

Carole Burgoyne, Strategic Director for People announced that following a recruitment process, she was pleased to announce the appointment of Kelechi Nnoaham as the Director for Public Health (DPH) from 1 April 2014. Stephen Horsley would continue to act as interim DPH until the end of March 2014.

23. MINUTES

Agreed that the minutes held on 5 September 2013 be confirmed.

24. HEALTH AND WELLBEING STRATEGY

Richard Stephenson introduced the final draft of the Plymouth and Health and Wellbeing Strategic Framework for approval. It was reported that the production of the framework involved all members of the board over the last 12 months and to thanks to Kevin Elliston, Rob Nelder, David Bearman and Ross Jago for their contributions.

There was a collective understanding on the Health and Wellbeing Board to move the focus away from just health and to draw attention to the strategic approach, make best use of resources and focus the work on the promotion of health and wellbeing.

The Chair suggested an additional recommendation that at the next board a work programme of future items and Solution Shops to be agreed by the board.

It was raised whether the framework was reflected in the Children and Young People's Partnership, Community Safety Partnership, Growth Board or in any partnership plans? Carole Burgoyne and Ross Jago to produce a paragraph for inclusion in the strategy on links to the strategic partnerships.

Agreed that –

1. the board approves the Plymouth Health and Wellbeing Strategic Framework.

2. at the next board a work programme of future items and Solution Shops to be agreed by the board.

25. FAIRNESS COMMISSION

Dame Suzi Leather, Chair, Plymouth Fairness Commission provided the board with a position statement on the Fairness Commission report. It was reported that two members of the Health and Wellbeing Board, Andy Boulting and Richard Stephenson were fairness commissioners and Dame Suzi thanked them for their work. The recommendations would be published in March. The Fairness Commission talked to more than 1,000 individuals and groups, listened to their areas of concern and included in our position statement our interim findings. Areas of concern -

- Community power and influence - there was a profound sense of un-control in the city and people felt they were being done to by public services. There was also a clear lack of engagement with political processes, we can't simply withdraw public services and need to increase social density and build on resilience.

- Individual and family wellbeing - highest levels of self-harm in the country and high rates of domestic abuse. Plymouth in many respects has poor mental health and heard repeatedly the concern on the quality and quantity of services provided to children. The shortcomings on the mental service was an intolerable burden on the police service.

- Young people and young adults - there was concern that many young people were not being given the opportunity to reach their full potential. How young people learn to express themselves and get work ready.

- Discrimination and social exclusion - this behaviour had no place in a modern city, it was suggested that racism and abuse was prevalent and under-reported. Those with disabilities felt isolated because of difficulties accessing certain services and public places.

- Implications for an ageing population - Plymouth was the first to become a Dementia Friendly City. We listened to older people and people supporting people with dementia there was an uneven provision and the need for better signposting and diagnosis by GPs.

- Cost of living crisis - financial issues were a common area of concern. Need to explore affordable credit and financial services and money management in schools.

- Housing - third of private housing stock in the city not decent. Look at different approaches to improve standards and better access to independent housing advice.

- Strengthening the local economy - Low rate of start-ups but this had changed over last 12 months.

Dame Suzi further reported that they were going to set out early wins which meant the medium and long term goals could not be forgotten about. The medium and long term goals would make the most difference and shouldn't be surprised by that. This was the last chance of taking this seriously, city leaders need to know how people feel, the economic crisis we cannot simply continue as we are and the city will be markedly difference so we have do things in different ways and looking at a smaller state.

The board felt that the report had some hard hitting facts and how the board commission money against some of the issues that the Fairness Commission had raised. How do we make sure for next year's commissioning intentions that could start to make a difference on the concerns raised.

The Board <u>agreed</u> –

1. to thank Dame Suzi Leather and members of the Fairness Commission for the work undertaken so far.

2. to invite Dame Suzi Leather to return when the final report is complete so the Board can develop an early response to the recommendations.

3. that in developing the work programme for the Solution Shops, the Board will work with Fairness Commission to make early progress on shared issues.

26. **NEW DEVON CCG COMMISSIONING FRAMEWORK / NEW DEVON COMMISSIONING INTENTIONS**

Jerry Clough, Managing Director, Western Locality provided the board with the commissioning and framework and intentions for NEW Devon CCG. The CCG were required to produce a 2 year and 5 year plan to be signed off by the Health and Wellbeing Board. It was also reported that -

a) NEW Devon CCG over 900,000 people and work consistently carried out across this patch. Our job is about the people that we service and place them at the centre of our work, about the individual and how they receive care;

b) the Better Care Fund is about integration and how we will deliver better services and will comeback with a clear statement on the Better Care Fund that we all sign up to;

c) we can work independently and we want to work collaboratively with all our providers to come up with the best solutions. Funding was extremely tight and cannot afford to waste money and make this very clear this is the desired way for working for us;

d) the final framework document set out the high level finance plan and describes the levels of improvement and transformation to deliver a balance plan next year.

In response to questions raised, it was reported that -

e) they were working across the 3 local authorities with joint strategies. This was an incredible achievement and critical to localise our intentions, what we do locally would be different and need to make sure we get the variation right in the right area;

f) checks and balances against the Joint Strategic Needs Assessment (JSNA) to cross relate into local areas. Information was being gathered from Public Health England to make sure everything was crossed checked;

g) there were radical ideas for targeted follow up care and lots of examples that follow up care kept people well. Look to put in systems to empower people, for lots of people if feel that you need a follow up here is a number and you can make that decision whether you want that appointment;

h) there was a need to get a clear definition on vulnerable groups and this should be made more explicit in the framework;

i) the final plan be aligned to the Health and Wellbeing Strategy and would come back to a future the board for a more detailed discussion;

j) the 5 year strategy would describe the landscape on the future commissioning on primary care and in the future will work to a different model of practice and solution to what we currently face;

k) the Better Care fund comes with a set of rules and regulations and fits well into discussions that we are having. There is a very clear scale of integration and was the Better Care Fund the way to deliver ambition?

The Board were happy with the development of the framework but following today's discussions wanted to see included explicit alignment of the framework with the Health and Wellbeing Strategy.

27. PROGRESS REPORT ON WINTERBOURNE VIEW

The Board noted the progress report on the Winterbourne View.

28. PROPOSED HEALTH PROTECTION COMMITTEE FOR THE HEALTH AND WELLBEING BOARDS AND HEALTH PROTECTION ASSURANCE ARRANGEMENTS

Stephen Horsley, Interim Director of Public Health provided an update on the proposed Health Protection Committee for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council. It was reported that –

a. all three local authorities were required to have the appropriate arrangement in place to protect their public's health;

b. it was proposed that a Health Protection Committee would report to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council;

c. Devon and Torbay Health and Wellbeing Boards had approved this arrangement.

The Plymouth Health and Wellbeing Board agreed the proposed Health Protection Committee for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council and Health Protection Assurance Arrangements.

29. EXEMPT BUSINESS

There were no items of exempt business.

This page is intentionally left blank

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Plymouth City Council**
Clinical Commissioning Groups	**Northern Eastern, Western Devon CCG**
Boundary Differences	**No significant boundary issues**
Date agreed at Health and Well-Being Board:	**13th February 2014**
Date submitted:	**14th February 2014 (draft)**
Minimum required value of ITF pooled budget: 2014/15	**£5,700,000**
2015/16	**£19,532,000**
Total agreed value of pooled budget: 2014/15	**£5,700,000**
2015/16	**£19,532,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Northern, Eastern, Western Devon CCG
By	Paul O'Sullivan
Position	Managing Director Partnerships
Date	3/2/14

Signed on behalf of the Council	Plymouth City Council
By	Carole Burgoyne
Position	Strategic Director for People
Date	3/2/14

Signed on behalf of the Health and Wellbeing Board	Plymouth Health and Wellbeing Board

By Chair of Health and Wellbeing Board	Cllr S McDonald
Date	

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

We recognise the importance of engaging with our local providers and collaborating to develop integrated plans. We already work with acute and community providers to deliver integrated care, and in the past year have engaged with our key health providers across a number of events to share plans for further integration.

Much of this interaction has taken place under the banner of the local 'Transforming Community Services' (TCS) initiative; both of the healthcare providers integral to this plan, Plymouth Community Healthcare Community Interest Company and Plymouth Hospitals NHS Trust, have attended events relating to TCS in the past year. We consider this to represent a sound basis for the development of this plan given that the key TCS themes of joined-up care, putting individuals at the heart of the care plan, and reducing inequalities, are equally recognised in the BCF. In addition, the development of the wider Devon CCG commissioning framework has included a recent provider event focused on a whole system approach.

Specifically a solution shop on integration and the BCF took place in December 2013 with Plymouth Health and Wellbeing Board, which has Chief Executive representation from both the acute and community based health care providers.

The views gathered at these events, and through other interactions with providers, have had a direct impact on the development of this plan. They have also been used to develop our business case for an Integrated approach to Health and Wellbeing.

Going forward we are developing a consultation and engagement plan around integration which will utilise existing forums around Residential and Nursing care, Domiciliary Care and Health Provider meetings.

Working towards the final submission of the BCF, we have arranged a provider engagement event for 5th March, where we will meet to discuss plans with all local NHS providers. It is anticipated that this will cover the BCF and wider strategic planning.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our plans are focused on delivering an integrated service to those who need it.

At the heart of our work on community services there has been substantial patient, service user and public engagement including a specific focus on issues of relevance to integrated working. Engagement has included:

- Health summits which have already taken place in many communities to gauge the initial views of local people- these summits so far have reached more than 1,000 people.
- Voluntary sector events/other discussions
- Council events/attendance at meetings
- Local Healthwatch led survey of carers and housebound people

- Set up of community groups/reference groups for testing direction

Health scrutiny committee's and Healthwatch have also been actively involved in the stakeholder events for Transforming Community Services (these events are already discussed in the provider section of this document). In addition, for people who can face barriers to engagement, HealthWatch events have been scheduled for January 2014 to discuss out of hospital services.

Meetings with Plymouth Healthwatch specifically about the BCF have now taken place and there is a commitment to contribute to the development and monitoring of the Integration agenda going forward.

There has also been elected member engagement as the BCF was considered by Caring Plymouth (Overview and Scrutiny Panel) on the 30th January 2014.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Integrated approach to health and wellbeing- outline business case	Programme covers integrated commissioning, co-operative children and young people's services, and integrated community health and social care provision. The overall aim is to establish a more collaborative, integrated and strategic approach to how organisations commission and deliver services, with the aim of reducing costs, improving patient/service user experience and improving outcomes for the residents of Plymouth. The business case considers a number of options regarding the vehicle to deliver an operating model of integrated care, and plans to develop these options. **[Add as attachment to plan]**
Joint Strategic Needs Assessment (JSNA)	The JSNA looks at the current and future healthcare needs of the local population to inform and guide the planning and commissioning of health, wellbeing and social care services. **[Add link]**
Joint Health and Wellbeing strategy	Sets out the purpose and strategic approach of Plymouth's Health and Wellbeing Board, approach to health and wellbeing and guiding principles, approach to public engagement, use of evidence and data, and the initial priority areas that have been identified for action. **[Add link]**
NEW Devon CCG Commissioning Framework	This sets out the five year strategic direction for the CCG and specifically the plans that support delivery of the CCG vision for 2014/16. It is a modular document with new modules and information being added as work progresses. **[link to be added]**

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The vision set down by the Plymouth Health and Wellbeing Board is to create an integrated system of person centred care which fulfils the ambitions of National Voices, with the outcome for individuals that-

"I can plan my care with people who work together to understand me and my carers, allowing me control and bringing together services to achieve the outcomes important to me"

To achieve this it is recognised that a whole system and whole person approach is needed, which means not only working across the whole of the local health, public health and social systems but also working with other local authority services, other statutory partners, key stakeholders, people and communities.

Within this context the Health and Wellbeing programme is to establish a collaborative, integrated and strategic approach to how the CCG and PCC with some partners (e.g. Police and Probation) commission and deliver services, with the aim of improving patient/service user experience and improving outcomes for residents in Plymouth from the resources available.

Strategic Aims and Principles

- Building on co-location of the western locality of NEW Devon CCG and Plymouth City Council, 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
- 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.

Core Workstreams

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

Key outcomes-

Integrated commissioning

- 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 collaboration through sharing knowledge and skills on each strategy
- Potential platform for further collaboration in future.

Integrated health and social care provision

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

For Individuals

- Greater choice and control over the care and support they receive
- Timely support in a crisis and support to recover
- Care provided closer to home and in communities
- Reduced health inequalities
- Receive high quality services and are safe from abuse
- Individuals will receive the right care, in the right place at the right time

b) Aims and objectives

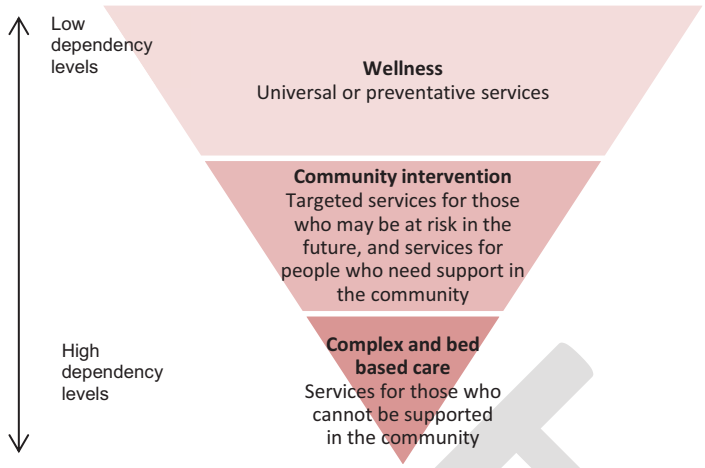
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The overall aims are to engage with commissioning and delivery partners to establish a more collaborative, integrated and strategic approach to how Plymouth City Council and NEW Devon CCG commission and deliver services, with the aim of improving patient/service user experience, improving outcomes for residents, and reduce costs.

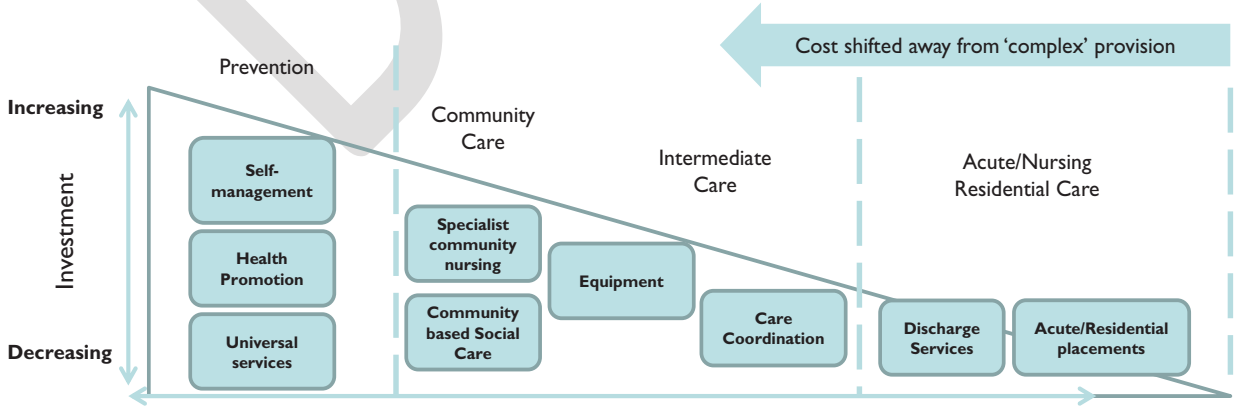
Services underpinning provision

Services that will form part of the integrated provision programme have been grouped into three categories, which correspond to differing levels of need and complexity. The diagram below highlight the integrated system that we are seeking to achieve-



- ***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 chart below shows the services we will target to achieve our aims:



c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Plymouth City Council and NEW Devon (Western Locality) have developed and agreed an Outline Business Case planning to achieve integrated commissioning and provision by 2016. Detailed Business Cases for both Integrated Commissioning and Integrated Provision are in development and aim to be completed by March 2014.

A detailed programme plan is in development with key milestones likely to be-

Integrated Commissioning

- Development of New Governance Architecture
- Development of Commissioning Strategies (Bed Based/Community Support/Wellness)
- Integrated Commissioning Function.

Integrated Provision

- Section 75 for pooled budget
- Process and Pathway Redesign activity
- Integrated provider function established.

Specifically in relation to schemes covered by the Better Care Fund the following planned changes are scheduled:

2014/15

- **Crisis Support-** In order to support winter planning, provide timely support in a crisis and facilitate timely discharges 15 step up and step down beds will be commissioned. Planned changes to the Reablement offer will see the service grow from delivering 1500 hours per week to 2000 hours per week. In addition Rapid Response Dom Care providing a 2 hour response will be available to expedite discharges 7 days per week.
- **Supporting Hospital Discharges-** Investment will be provided to a third sector provider to support effective hospital discharges with the aim of reducing delayed discharges. The service will grow to offering a seven day service.
- **Promoting Independent Living-** Additional investment is to be provided to the Community Equipment Service over and above core funding levels. This will allow the service to meet increased levels of demand, facilitate hospital discharges and allow people to remain living in their own homes. The service will be re-commissioned during the year to provide an enhanced service the following year in line with the National Conditions
- **Protecting Social Care**- Plymouth's eligibility criteria will be maintained at critical and substantial. In addition an enhanced universal offer focusing on information, advice and advocacy for all and a targeted early intervention and prevention offer based around floating support, befriending and handyperson person provision will be delivered.
- **Sustained Focus on Safeguarding and Quality Improvement-** The Quality Assurance Improvement Team will complete quality reviews of 50 Care homes, 15

Care Homes will pilot the Leadership Programme, 28 Care Homes will achieve the Dementia Quality Mark and quarterly Dignity in Care Forums will be held for Domiciliary and Care Home Providers.

- **Care Coordination to deliver person centred care**
  The team will continue to ensure timely support to prevent hospital admissions and expedite discharges. The offer will manage up to 80 referrals across the system per week via a single access point; it will focus on continuing to reduce care home admissions building on the current improved performance of 3% conversion to long term care.

2015/16

In addition to the above schemes the following developments are planned for 2015/16:

- **Community Equipment Service**- The Community Equipment Service will be extended to offer a seven day service
- **DFG's –** In order to meet demand and keep people in their homes and communities funding will be ringfenced for DFGs
- **Care Bill Changes-** Although precise details are not presently known provision in the Better Care Fund has been made to complete this and planning is underway based around the following workstreams:
  - Integration and health
  - Financial Processes
  - Customer Journey
  - Preparing the Care and Support Market
  - Safeguarding

Further planning of schemes for 2015/16 is presently underway and will finalised before the April submission

Alignment of other key plans

As part of the preparation of this plan, the existing forms of the JSNA, JHWS, the commissioning framework and intentions, and local authority plans have been considered.

We will ensure that this close coordination continues through the governance arrangements we have put in place.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The immediately identifiable implications of the plan on NHS services are as follows:

Plymouth Hospitals NHS Trust (acute trust) – admissions avoided, lengths of stay and delayed transfers of care reduced.

Plymouth Community Healthcare CIC (community services provider) - admissions avoided, lengths of stay and delayed transfers of care reduced.

The majority of savings will be made by providers as a result of reduced lengths of stay. It may be possible, but not yet quantified, that the bed stock in either or both provider could be reduced.

Our plan is aimed at reducing hospital admissions by commissioning greater support in the community, with services wrapped around individuals and their GPs. Hospital attendances may remain the same or increase as specialist advice and guidance is sought for individuals' diagnosis and initial treatment/intervention plans but with the majority of the care being provided by the primary or community health and social care team.

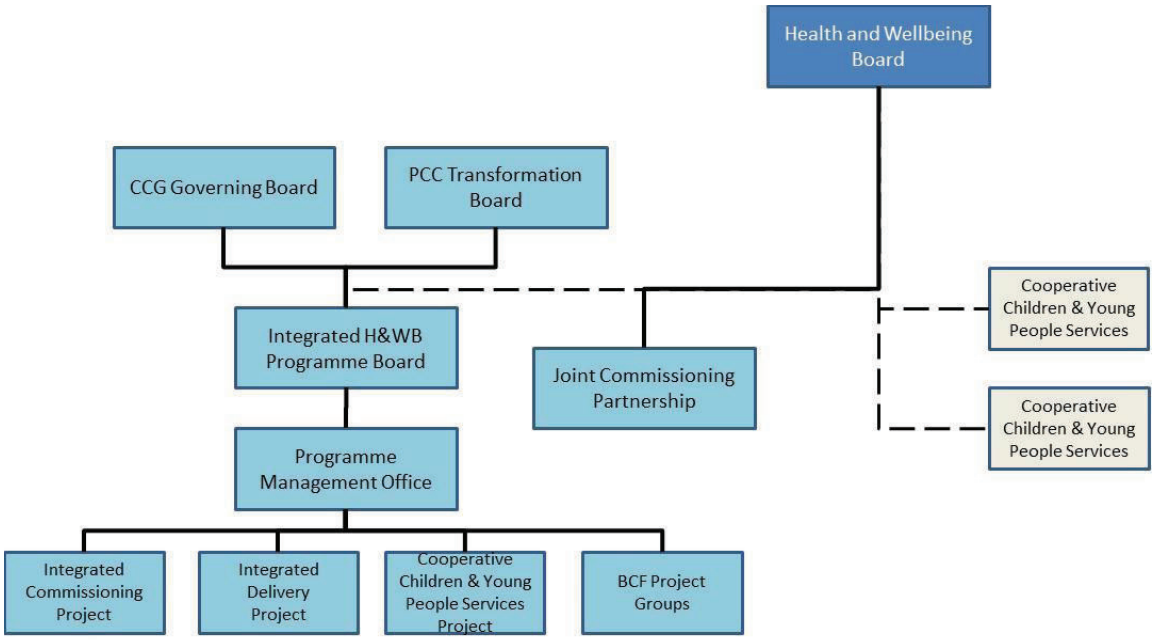
The CCG has identified the potential for c. £3m savings from acute providers during 2014/15, based on the better management and support of frail older people. We are still working through the absolute detail in terms of volume and value impact on individual providers at present. This will be provided in the next version of the BCF submission.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The governance of the Better Care Fund will be managed within the existing governance structure for the Integrated Health and Wellbeing programme. The programme is joint initiative between the Western Locality of New Devon CCG and Plymouth City Council.

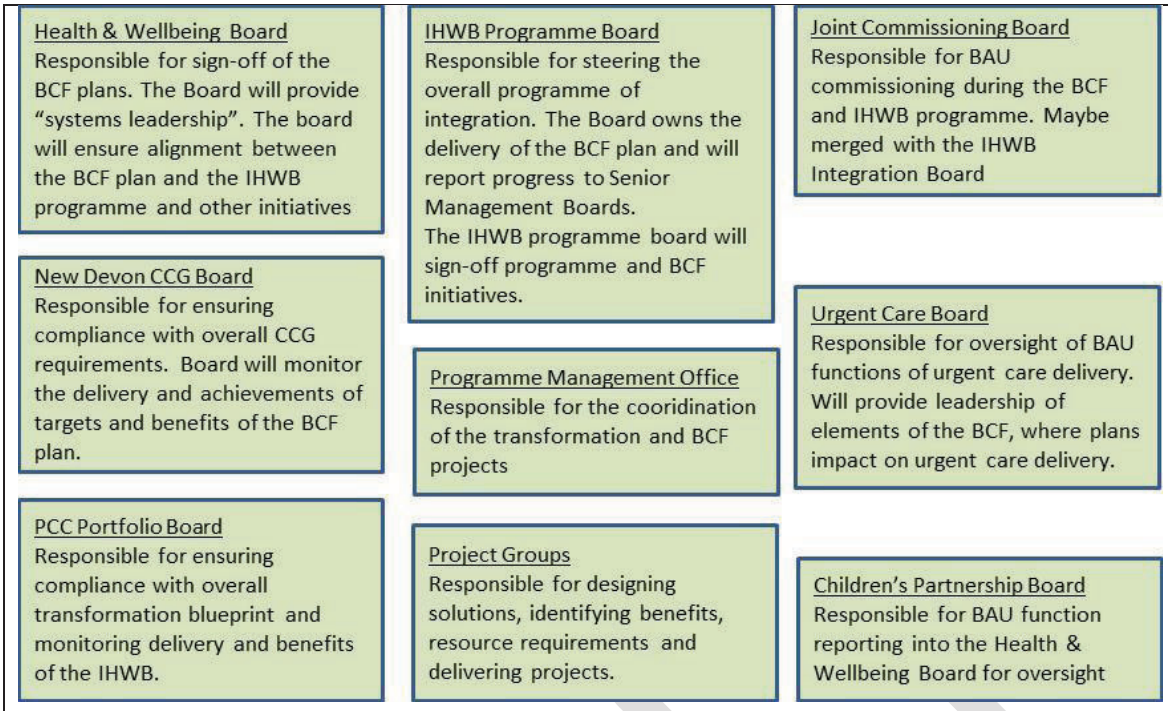
The governance structure is:



The role of the Health and Wellbeing Board is to ensure local partners are an integral part of the plans for BCF. The board will sign off the BCF plan and provide the leadership for the BCF plan. The board will expect the Integrated Health and Wellbeing programme (IHWB) board to report progress on delivery plans and performance.

The IHWB Board will undertake the responsibility for delivering the elements of the BCF plan. This will include monitoring the performance indicators and reviewing risks and issues.

There are a number of other boards that will play a role in overseeing the delivery of the BCF plan. The indicative roles of these boards is described in the diagram below:



The membership of the IHWB Programme Board is designed to enable swift change and will be supplemented with additional capacity when required.

Membership:

- MD – Western Locality, CCG (Joint-Chair and Senior Responsible Officer)
- Director of People, PCC (Joint-Chair and Senior Responsible Officer)
- Director of Public Health
- Chair of CCG
- MD – Partnerships, CCG
- AD – Joint Commissioning, PCC
- AD – Education, Learning and Families, PCC
- Area Team representatives, NHS
- Programme Manager, IHWB Programme

Key activities that require the Governance structures to work together to achieve a coherent plan. These activities include:

1. Protecting Social Care - a condition of the BCF transfer is that the PCC agrees with CCG on how the funding is best used within social care, and the outcomes expected from this investment. The agreement on how funding should be spent will be developed by the BCF project Group. This will be ratified by the IHWB Programme Board and signed off as part of the BCF Plan by the Health and Well Being Board.
2. Risk Sharing Agreement – an agreed approach to risk sharing and mitigation will be developed by the BCF project group. The agreement will cover the impact on existing NHS and social care delivery and the steps that will be taken if activity volumes do not change as planned. (e.g. if emergency admissions or nursing home admissions increase).

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

Programme Activity	HWB	CCG Board	PCC Transform-ation	IHWB Programme	Project Group	PMO
Sign-Off BCF plans	✓					
Ensure alignment to NEW Devon CCG priorities and strategy		✓				
Ensure alignment with Health and Wellbeing Strategy	✓					
Define BCF project scope					✓	
Identify improvement opportunities					✓	
Design Solutions and Plans						
Identify investment and resources					✓	✓
Development of Risk Sharing Agreement				✓	✓	
Sign-off investment, plans and resources	✓			✓		
Deliver planned initiatives					✓	
Report on progress, benefits and risks				✓	✓	

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Protecting social care services in Plymouth means ensuring that those in need continue to receive the care and support they require to remain healthy, well and independent for as long as possible. This entails maintaining current eligibility criteria for those assessed as needing statutory services but also promoting a comprehensive universal offer, for those who are not FACS eligible, based around information, advice and low level preventative services.

We will adopt an evidence based approach for all service redesign changes. This will ensure all decisions to reduce or disinvest in social services will deliver better outcomes for services user/patients.

Please explain how local social care services will be protected within your plans.

Funding currently provided under the Social Care to Benefit Health grant has to date been used to enable Plymouth City Council to sustain current eligibility criteria and to work with providers and CCG colleagues to further integration plans.

This level of investment will need to be sustained, if not increased, to meet increasing demand and complexity of need, as well as meeting the requirement to deliver seven day working and meet the requirements of the Social Care Bill.

In order to change the balance of care towards a more community based model that promotes independence, well-being and choice and that reduces reliance on residential and nursing care and prevents hospitals admissions and improves discharges, then a strengthened social care offer based around the following priorities is required:

- Maintenance of eligibility criteria at Substantial and Critical
- A focus on improving the quality of service provision
- An enhanced Community Equipment Service
- Hospital Discharge Services
- Increased Reablement Capacity
- Rapid Response Domiciliary Care
- Greater choice and control through Self Directed Support
- Promotion of Telecare and Telehealth
- An enhanced universal offer focusing on early intervention and prevention.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Current position

Our starting point for consideration of seven day services has been to evaluate the services we currently provide. Our Care Co-ordination team is available 7 days per week to complete assessments and arrange plans for discharge from hospital. This team also has wider responsibilities around admission avoidance, Reablement, domiciliary care, and step down placements. Out of hours arrangements are also in place for social care and community nursing teams. However, these services are not extended to other areas

such as mental health services, stroke services or community therapy.

We have also undertaken initial analysis to understand the level of discharges from our acute and community providers if full weekend working was to be implemented. We will use this information, along with consideration of the effect of our other commissioning intentions, to develop our plan for seven day services to support discharge.

Future plans and intentions
We are committed to providing seven-day health and social care services. Our urgent care commissioning intensions include the aim of providing a service which is available 7 days a week, including bank holidays. We would also expect to extend operating hours so that referrals can be made between 7am to 10pm. This would be delivered by an integrated team comprised of a centralised hub of health and social care staff and resources. During 2014/15 providers and commissioners will be working together to increase the number of relevant and appropriate services operating 7 days a week.

c) Data sharing
Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

This presently is not the case however work is presently progressing to resolve (see below)

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Plymouth City Council is committed to adopting the NHS number as its primary identifier for correspondence. PCC is PSN compliant and has recently gained N3/IGSOC connectivity and therefore is working towards the pre-requisites for PDS connectivity. Plans are being constructed now, with the first step application to become an End Point Site, following which detailed plans will be constructed. Technical and business discussions will take place shortly to determine the impact on business processes to inform the planning exercise and hence determine timescales for full implementation.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

PCC and CCG are committed to adopting systems that are based on Open APIs and Open Standards where it is appropriate and necessary for them to be so. All solutions requiring interoperability are procured as such and will contain contractual references to ensure compliance with the necessary standards.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Both partners are committed to ensuring that the appropriate Information Governance controls are in place to support this implementation. All business processes will be reviewed and adapted where necessary to meet Caldicott requirements.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The integrated service model delivered via the care Co-ordination Team consists of a centralised hub of health and social care staff and resources. The service receives referrals for individuals who need urgent access to support; it provides real time information and advice about urgent care options using a directory of services linked to the Plymouth online directory. There is a joint process for the rapid assessment of need/risk, development of a support plan and ongoing progress monitoring for the individual. Each individual supported by the service has an appropriate lead professional who is responsible for their care during the crisis period.

The team manages all hospital discharges for the acute and community providers in Plymouth, delivering timely access to integrated discharge plans. By delivering both crisis support and hospital discharge arrangements from one team, information can be shared and duplication of resources avoided.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Savings delivered from the integration are not sufficient to meet the funding gap	High	• Scrutiny and validation of schemes, and the projected benefits in further phases. • Account for optimism bias in financial model when developed.
Service changes mean providers become unviable	High	• Plan changes in a phased and managed way • Work with providers re business planning and service developments
Disruption to service delivery with an impact on service quality and reputation	High	• As part of contingency planning undertaken as part of implementation planning. • Key scenarios identified and mitigation plans developed.
Negative impact on service users and threat to continuity of care	High	• Early engagement of key service user representative groups.
Staff/union resistance to the proposed changes and service redesign	Medium	• Early consultation with Unions. • Union representation at key workshops.
Difficulty in securing agreement across the partners to service redesign causes delay in delivery	Medium	• Areas of potential disagreement highlighted and discussed early in the process.

leading to savings targets being leaked, and delaying benefits realisation		• Identification of key decision makers and a dispute resolution process. • Formal agreements and protocols in place to enable teams to work together.
Statutory or regulatory differences between Health and Social care lead to tensions	High	• Potential areas of conflict identified early and formal protocols or agreements put in place.
New legislation introduced which impacts on plans (e.g. Care Bill and Dilnot)	High	• Remain well-informed of policy and legislative developments and build in necessary changes early and challenge solution development.
Legal challenge regarding competition and contracting	High	• Ensure notice periods to providers are duly followed and all consultation is documented.
Resources required to deliver integration are not available/ funding does not exist to commission external resources	Medium	• Develop programme delivery plan and get cross party sign up to this. • Cross- party investment planning meeting to agree resource commitment.

Better Care Fund

Metrics

Introduction

The purpose of this report is to provide an analysis of the potential performance metrics that could support the delivery of the better care fund. The report will consider the following factors:-

- Lead for the metric (eg PCC, CCG, Joint)
- Current baseline (suggestions for best period to use)
- Recent trends
- Benchmarked performance (including comparisons to others, England average, top quartile etc)
- Alignment between metrics and current initiatives/ schemes
- Any recording/ data quality issues
- Scope for improvement including any recommended targets
- Local monitoring arrangements

The report will also consider any local metrics that could fit within the scope of the BCF and the approach that is being adopted locally.

National metrics

Delayed transfers of care from hospital per 100,000 population

Lead

Joint between PCC and CCG

Current position

	2012/13	2013/14 (FOT)
Plymouth LA	238.0	365.7
England (average)	272.6	275.3

Note: This target is different from the measure in the outcomes framework and is the average monthly number of days delayed per 100,000 population aged 18+

The forecast outturn for 2013/14 is showing a significant increase in performance compared to the 2012/13 position should be used to provide the baseline performance against which an improvement can be set.

Alignment between metrics and current initiatives

The following BCF initiatives are expected/ could have an impact on this metric:-

- Support for community equipment service
- ICE team
- Reablement

The following CCG commissioning intentions are expected/ could have an impact on this metric:-

- Non elective care

Any recording/ data quality issues

There are concerns that there are data quality issues that could be resulting in under reporting of the current performance. This was a particular concern in the 2012/13 year which may explain its relatively low performance. There are concerns that not all MH related delays are being recorded which could increase the number of non-acute delays.

Suggested baseline

2013/14 data for the period April to November is the latest information that is available. As there are possible recording issues it would be prudent to use the 2013/14 FOT as opposed to 2012/13 which could be artificially low.

Scope for improvement including any recommended targets

A target has been proposed that means that the monthly number of days delayed will improve from 365.7 per 100,000 population in 2013/14 (FOT) to 355.1 (Apr – Dec 2014) and a further improvement to 352.8 (Jan – Jun 15). This target is based upon achieving a statistically significant improvement from the 2013/14 baseline. It is considered that this level of improvement is achievable.

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	365.7	355.1	352.8
	Numerator	6129	6740	4491
	Denominator	209484	210902	212141
		(April - November 2013)	(April - December 2014)	(January - June 2015)

Note: The population figures used in the denominator have been based upon the ONS population projections

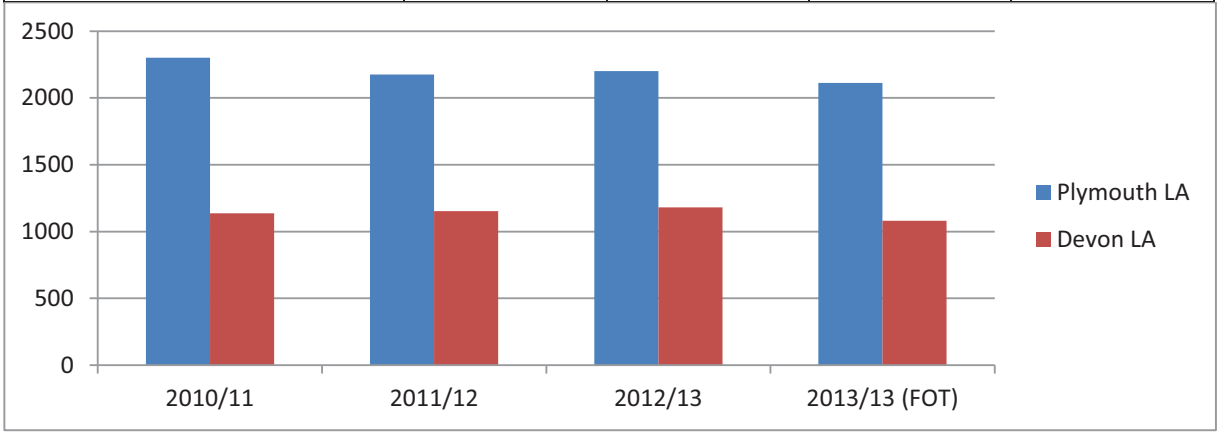
Avoidable emergency admissions (composite measure)

Lead

CCG

Current position

	2010/11	2011/12	2012/13	2013/13 (FOT)
Plymouth LA	2301	2176	2202	2112
Devon LA	1136	1152	1182	1082



This indicator is the same composite indicator used in the quality premium

- unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)
- unplanned hospitalisation for asthma, diabetes and epilepsy in children
- emergency admissions for acute conditions that should not usually require hospital admission (all ages)
- emergency admissions for children with lower respiratory tract infection.

CCG wide performance is generally very good for most of the above metrics. The one area that is a concern is the number emergency admissions for children with lower respiratory tract infection.

Metric	CCG performance
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)	Top quintile
Unplanned hospitalisation for asthma, diabetes and epilepsy in children	3rd quintile
Emergency admissions for acute conditions that should not usually require hospital admission (all ages)	Top quintile
Emergency admissions for children with lower respiratory tract infection	4th quintile

Alignment between metrics and current initiatives

The following BCF initiatives are expected/ could have an impact on this metric:-

- ICE team
- Reablement – ie to reduce readmissions

The following CCG commissioning intentions are expected/ could have an impact on this metric:-

- Non elective care
- Ambulance conveyance
- House of care
- Diabetes

There are a number of schemes that are generally aligned to this group of measures but they tend to reflect those measures that are already performing well. This could impact on the potential scope for improvement.

Any recording/ data quality issues

Query been raised with the H&SC Information Centre around the reporting of emergency admissions for ACS conditions from PHNT as the national data is not consistent with local evidence. It is known that national data significantly under-reports PHNT activity. Following resolution of this query it may be necessary to recalculate this indicator.

Suggested baseline

2012/13

Scope for improvement including any recommended targets

Confirmation is required with regard to the data quality query that has been raised with the H&SC Information Centre before any targets can be formally agreed. However, as a general principle it is proposed that there should be no growth in emergency admissions even against a backdrop if increasing demand (ie aging population).

Metrics		**Current Baseline (as at….)**	**Performance underpinning April 2015 payment**	**Performance underpinning October 2015 payment**
Avoidable emergency admissions (composite measure)	*Metric Value*	2202	2202	2202
	Numerator	N/A	N/A	N/A
	Denominator	N/A	N/A	N/A
		(TBC)	(April - September 2014)	(October 2014 - March 2015)

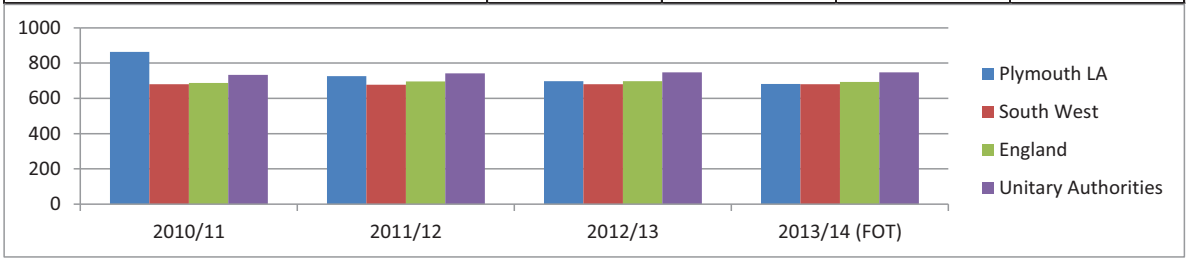
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000

Lead

PCC

Current position

	2010/11	2011/12	2012/13	2013/14 (FOT)
Plymouth LA	863.9 (355)	726.3 (305)	697 (303)	680.9 (296)
South West	680.4 (7040)	677.7 (7080)	680.8 (7390)	679.6
England	686.6 (59090)	695.9 (60750)	697.2 (63140)	693.2
Unitary Authorities	733.2 (14530)	741 (14865)	746.8 (15540)	747.9



The forecast out-turn for 2013/14 is for further reductions in the rate of long term admissions for older people. This is based on a sharp drop in admissions in quarter 3 and with admissions in quarter 4 expected to be similar to quarters 1 and 2. The forecast out-turns for SW; England and Unitary authorities are based solely on the average over the previous 3 years as no in year data for these groups is available. If these forecasts prove correct this would see Plymouth's rate per 100,000 drop remain below England and Unitary averages.

Our 2012/13 return (697/100,000) places us 72nd of 152 LA's for this measure and within the 2nd quartile, although our performance is predicted to improve in 2013/14. When compared to other unitary authorities we have the 19th lowest rate per 100,000 population (of 56 UA's).

Alignment between metrics and current initiatives

- ICE team
- Reablement

Other ASC initiative aimed at reducing long term admissions to residential and care homes include;

- Choice and Control as mainstream

Any recording/ data quality issues

Implementation of new SALT returns may encounter teething problems; suggest continued use of current automated ASC-CAR report for the medium term.

Suggested baseline

2012/13

Scope for improvement including any recommended targets

The rate of long term admissions to residential and care homes has dropped for the past three years. Efforts continue to be made to reduce the number of permanent admissions; however given other social factors a large reduction in admissions is unlikely. A 2% reduction in 2014/15 from the 2013/14 out-turn (yet to be determined) should be considered as a target. Should the 2013/14 out-turn be considerably lower than predicted this % reduction should be revisited.

Metrics		**Current Baseline (as at….)**	**Performance underpinning April 2015 payment**	**Performance underpinning October 2015 payment**
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	697	N/A	667
	Numerator	305		290
	Denominator	43475		43475
		(April 2012 - March 2013)		(April 2014 - March 2015)

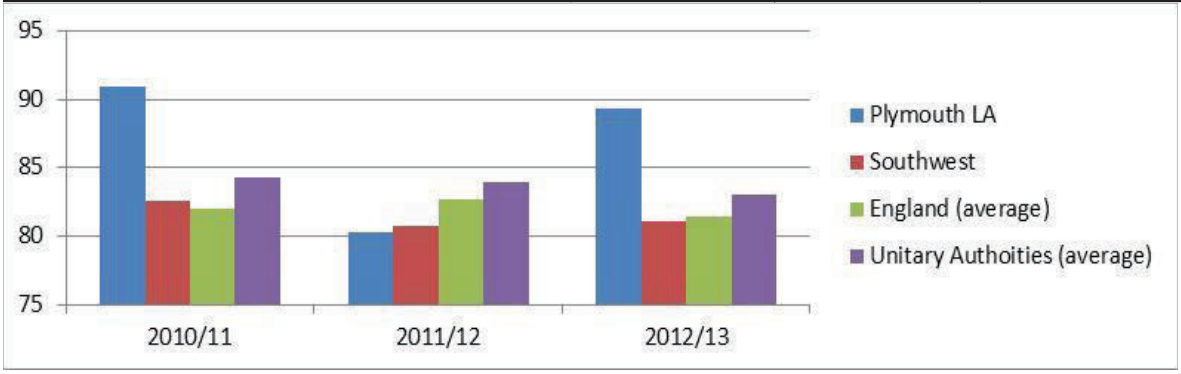
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

Lead

Joint between PCC and CCG

Current position

	2010/11	2011/12	2012/13
Plymouth LA	90.9	80.3	89.3
Southwest	82.6	80.8	81.1
England (average)	82	82.7	81.4
Unitary Authoities (average)	84.3	84	83



Following difficulties experienced previously in generating returns against this measure it is difficult to forecast a 2013/14 out-turn. Our 2012/13 return showed marked improvement on 2011/12 putting Plymouth ahead of the SW, England and UA averages.

Plymouth benchmarks well having the 12th best outcome in 2012/13 among other Unitary Authorities.

Alignment between metrics and current initiatives

- ICE team
- Reablement

Any recording/ data quality issues

Difficulty in establishing a consistent approach to counting this measure, an established method is required for new ASC annual returns.

Suggested baseline

2012/13

Scope for improvement including any recommended targets

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	89.3	N/A	89.96
	Numerator	335		337
	Denominator	375		375
		(April 2012 - March 2013)		(April 2014 - March 2015)

Estimated diagnosis rate for people with dementia

Lead

CCG

Current position

The estimated dementia diagnosis rate for NEW Devon CCG is 43.9% in 2012/13. This is a significant improvement on the previous year but is expected to be lower than the national average (45%). Plymouth has historically had a higher dementia diagnosis rate than the rest of Devon due to improved focus within primary care and Plymouth Community Healthcare.

Further work is being undertaken to ensure that a definitive baseline is established for the Plymouth area.

Alignment between metrics and current initiatives

There is a limited alignment to current BCF schemes as it has a much greater focus around primary care services and Plymouth Community Healthcare. However, it is a key area for improvement across the NEW Devon CCG and there could be scope for greater alignment to the BCF in both the short and longer term.

The relatively low levels of diagnosis mean that a high number of people across the city with dementia remain undiagnosed which the potential knock on effect of not receiving the necessary support they require.

Any recording/ data quality issues

Indicator to be locally calculated based upon those GP practices that are in the Plymouth City boundary. This is equivalent to the methodology that would have been used for Plymouth PCT.

Numerator: The number of people on the QOF dementia register
Denominator: The estimated number of people with dementia for the given year (this will need to be calculated from the correct methodology)

No significant concerns around data quality.

Suggested baseline

2012/13 is the latest full year for which data is available.

Scope for improvement including any recommended targets

NEW Devon CCG has a current target to improve the dementia diagnosis rate to 49.5% in 2013/14 and a further increase to 54.5% in 2014/15. The target has provisionally been set to the NEW Devon CCG target. Further work is required to separate the performance for the Plymouth area but it is expected to be slightly better than that for the whole of NEW Devon CCG.

Metrics		**Current Baseline (as at….)**	**Performance underpinning April 2015 payment**	**Performance underpinning October 2015 payment**
Estimated diagnosis rate for people with dementia (locally defined for the Plymouth area)	*Metric Value*	43.9% (estimated)	N/A	54.5% (NEW Devon CCG)
	Numerator	TBC		TBC
	Denominator	TBC		TBC
		(April 2012 - March 2013)	(April - December 2014)	(April 2014 – March 2015)

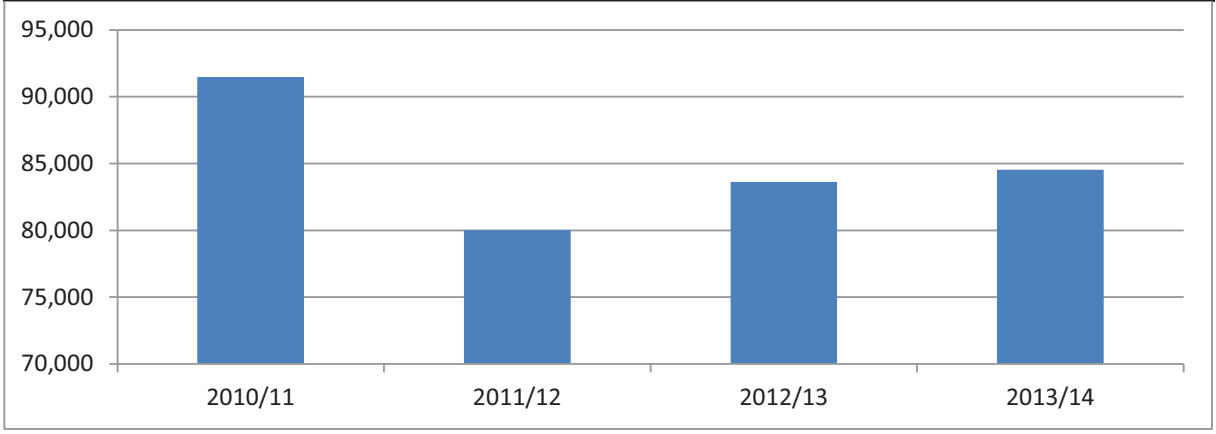
Emergency bed days for people aged 65+ (locally derived)

Lead

CCG

Current position

	2010/11	2011/12	2012/13	2013/14 (FOT)
Plymouth	91,464	80011	83615	84526



The number of emergency bed days for the over 65s has been increasing steadily for the last couple of years. This is creating a significant financial pressure on Plymouth Hospitals NHS Trust. The number of emergency admissions as well as the average length of stay have both been increasing over the last couple of years.

Whilst it is not possible to benchmark the suggested metric directly it is known that both the number of emergency admissions and the average length of stay are performing well compared to similar areas

Alignment between metrics and current initiatives

There is good alignment between this indicator and the current BCF schemes. This indicator takes into account both the number of emergency admissions as well as the drive to reduce length of stay. This indicator has a wider definition than both the nationally prescribed metrics in the Better Care Fund (ie avoidable emergency admissions and delayed transfers of care).

Any recording/ data quality issues

The suggested local metric is not reported nationally but will be calculated from nationally available SUS data. Data can be reported on a monthly basis and further detailed breakdowns would also be available.

There are no significant data quality issues

Local indicator to be developed to capture the total emergency beds of people aged over 65 who are registered with a GP practice in the Plymouth area.

Suggested baseline

The period from October 2012 to September 2013 should be used as the baseline as there have been further demand pressures seen in recent months.

Scope for improvement including any recommended targets

The number of emergency bed days is performing well compared to other areas but there remains scope for further improvement. However, it is known that an aging population is putting a significant upward pressure on both the number of emergency admissions and the average length of stay. Thus it is recommended that the target is based upon achieving no growth in emergency bed days for the over 65s.

Emergency bed days for the over 65s are strongly linked to winter pressures and the number of bed days does increase during the winter period. The suggested targets covering the periods from April – December 2012 and January – June 2015 have been adjusted to take into account the average levels of demand in the corresponding months.

Metrics		**Current Baseline (as at….)**	**Performance underpinning April 2015 payment**	**Performance underpinning October 2015 payment**
	Metric Value	84983	62494	43883
	Numerator	N/A	N/A	N/A
	Denominator	N/A	N/A	N/A
		(Oct 2012 - Sept 2013)	(April - December 2014)	(January - June 2015)

Local metrics

The BCF guidance states in addition the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

Metric	Assessment of current performance	Data quality	Alignment to schemes	Other comments	Potential metric for consideration
NHS Outcomes Framework					
Proportion of people feeling supported to manage their (long term) condition	Good performance but improving performance against a backdrop of H&SC funding makes this challenging	N/A – national survey	Relatively good	Survey based metric so statistical significance is important	Difficult to see how a statistically significant improvement could be achieved
Estimated diagnosis rate for people with dementia	Acceptable and improving but performance still below national target thus a lot of people remain undiagnosed	N/A	Limited link to BCF but good link to CCG priorities	Being considered by Devon County Council as a possible local priority	Current links to BCF schemes is not good but there is a clear focus for improvement
Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days	Not yet seen data at Plymouth level – published as NHS total			Potentially small numbers which make statistically significant improvements challenging	Statistical confidence makes this challenging
Emergency bed days for people aged 65+ (locally derived)	Good as both SAR and LOS are the lowest for the regional centres cluster group	Good	Good as trying to reduce both emergency admissions and length of stay	Not reported nationally but can be derived from national data sources	Possible as a key focus for PHNT to ensure financial stability but further improvement may be limited

Metric	Assessment of current performance	Data quality	Alignment to schemes	Other comments	Potential metric for consideration
Adult Social Care Outcomes Framework					
The proportion of people who use services who say that those services have made them feel safe and secure	Based on 2012/13 ASCOF outcomes 81.5% stated that services they have received had made them feel safe and secure. This places Plymouth 67th best in the country and in the 2nd quartile.	N/A Annual client survey	QAIT team ICE team	Outcome should be to improve performance and be top quartile, which based on 12/13 ASCOF would equal 84%	This metric is a safeguarding measure within the ASCOF. Whilst in 2nd quartile there is room for improvement.
Proportion of adults with learning disabilities who live in their own home or with their family	Based on 2012/13 ASCOF outcomes 71.6% of learning disability clients live in their own home or with their family. This places Plymouth 94th best in the country, and within the 3rd quartile.	N/A	Re-ablement	Outcome should be to increase the proportion of known LD clients who live at home or with their families and to be 2nd quartile. Based on 12/13 ASCOF outcomes 2nd quartile would equate to 73.2%	The measure is intended to improve outcomes for adults with learning disabilities by demonstrating the proportion in stable and appropriate accommodation. Current performance would suggest this is worthy for consideration as Plymouth sits in 3rd quartile.

Metric	Assessment of current performance	Data quality	Alignment to schemes	Other comments	Potential metric for consideration
Public Health Outcomes Framework					
Injuries due to falls in people aged 65 and over	The 2011/12 public health outcomes record a rate of 1,747/ 100,000 population. An outcome statistically similar to the England average. 4th highest rate among SW authorities.	Hospital episodes statistics	QAIT ICE team Re-ablement	Public Health guidance on health and social care integration recognises the importance of recognising integration and the impact on customer's health.	A measure where current performance would suggests there is potential for improvement.

HEALTH AND WELLBEING BOARD

Work Programme 2014 - 2015

PLYMOUTH CITY COUNCIL

Date of meeting	Agenda item	Reason for consideration	Responsible Officer
April	Better Care Fund – Final Draft.	Consideration of commissioning intentions is a statutory obligation of the Board.	Paul O' Sullivan Craig McArdle
	Children and Young People's Health Outcomes and Pledge		Julie Frier
	Update on Alcohol Plan and Systems Leadership Pilot	Priority identified by Board members.	Stephen Horsley / Kelechi Nnoaham
July	Healthy Weight Strategy	Priority identified by Board members	Julie Frier
	Pledge 90 Mental Health Review	Priority identified by Board members	Katy Shorten
	Feedback from Solution Shops		
October	Joint Strategic Needs Assessment		Rob Nelder
	Feedback from Solution Shops		
January			
	Feedback from Solution Shops		

This page is intentionally left blank

SOLUTION SHOPS

Work Programme 2014 - 2015

Health and Wellbeing Board (through discussion) will allocate a member or members to lead each solution shop. The leader of each solution shop will be responsible for the following –

- Devising the programme and content of the shop
- Providing briefings, documents around the issue / priorities to be explored
- Feeding back on outcomes to the Board / Participants

The Shops will -

- allow communities to hold the leader/Board to account
- encourage creativity
- ensure an equal voice
- reformulate activities to develop better outcomes
- include cross boundary considerations and learning
- allows ideas to be fully explored and built upon
- do the work

Solution shop resources will be provided from the pooled resources of Health and Wellbeing Board members.

Dates	To consider	Officer Contact	Board Lead Member
March '14	Tobacco Control Strategy	Russ Moody and Dan Preece	
June '14	Pledge 90 Mental Health		
August '14			
October '14			
December '14			

This page is intentionally left blank