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Published 24 February 2015

#caringplymouth

CARING PLYMOUTH

Thursday 5 March 2015
2.00 pm
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair

Councillor James, Vice Chair

Councillors Mrs Bridgeman, Sam Davey, Dr. Mahony, Mrs Nelder, Mrs Nicholson, Parker-Delaz-Ajete, Dr. Salter, John Smith and Stevens.

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 panel 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 11 December 2014.

5. PLYMOUTH PLAN (Pages 7 - 8)

The Panel are requested to feedback and provide input on the content of the specific policies set out in the draft Plymouth Plan.

6. INTEGRATED HEALTH AND WELLBEING (Pages 9 - 208)

The Panel to receive a presentation on Integrated Health and Wellbeing.

7. CARE ACT (Pages 209 - 240)

The Panel to receive a presentation on the Care Act.

8. CARING ACHIEVEMENTS 2014 - 15

The Panel to reflect on their achievements for 2014-15.

9. TRACKING RESOLUTIONS (Pages 241 - 246)

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

10. WORK PROGRAMME (Pages 247 - 248)

The panel to review the Caring Plymouth Work Programme 2014 – 15.

11. 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.

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 11 December 2014

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor James, Vice Chair.
Councillors Mrs Bowyer, Mrs Bridgeman, Sam Davey, Dr. Mahony, Mrs Nelder, Parker-Delaz-Ajete, Dr. Salter, John Smith and Stevens.

Apologies for absence: Councillor Mrs Nicholson.

Also in attendance: Kelechi Nnoaham – Director for Public Health, Councillor Sue McDonald – Cabinet Member for Children, Young People and Public Health, Councillor Tuffin – Cabinet Member for Health and Adult Social Care; Karen Kay – NEW Devon CCG, Dr Gary Lenden, Joe Teape – Director of Finance and Lee Budge, Director of Corporate Business, Plymouth Hospitals NSH Trust, Ross Jago – Lead Officer and Amelia Boulter – Democratic Support Officer.

The meeting started at 2.00 pm and finished at 4.03 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.

31. DECLARATIONS OF INTEREST

There were no declarations of interest made.

32. CHAIR'S URGENT BUSINESS

The Chair reported that agenda item 6 relating to Urgent and Necessary Measures to be presented by NEW Devon CCG had been pulled from today's agenda. Ben Bradshaw MP secured a debate in Parliament this afternoon and depending on the outcome of the debate the Panel would either look at this item at the next meeting or call an urgent meeting to look at this.

33. MINUTES

Agreed that the minutes of the meeting 11 September 2014 were confirmed.

34. THRIVE PLYMOUTH (4-4-54)

Kelechi Nnoaham, Director for Public Health and Councillor McDonald, Cabinet Member for Children, Young People and Public Health provided the Panel with a presentation on 4-4-54. It was reported that –

(a) Thrive Plymouth was triggered as a result of a recommendation made at budget scrutiny to address health inequalities across the city;

(b) Thrive Plymouth is a simple framework that the whole city can sign up to;

(c) Thrive Plymouth is 4 behaviours that lead to 4 diseases which in turn lead to 54% of deaths in Plymouth;

(d) they would ensure that Thrive Plymouth was considered in the development of all of the city's policies;

(e) this was a 10-year approach changing the course of health and wellbeing in the city.

In response to questions raised, it was reported that -

(f) all lifestyle behaviours were taken into account. They had used simple descriptors and substance abuse and mental health were the platform for Thrive Plymouth to sit;

(g) there were sufficient finances to cover Thrive Plymouth and from the outset did not want to set up an initiative that would cost additional money;

(h) the focus of Thrive Plymouth was about the behaviours and not on the deaths;

(i) Public Health England were not making any contributions towards Thrive Plymouth but they had lobbied Public Health England for better public health settlement for Plymouth;

(j) they had spilt the team into four groups which fed into the different directorates and were working closely with planning officers to ensure that public health has influence in all planning applications;

(k) in year 2, Thrive Plymouth would focus on children. A survey was conducted in secondary schools and they were in a good position when Thrive Plymouth is introduced to schools in September;

(l) they had strong input into the Plymouth Plan and how they worked with partners was key to the success of Thrive Plymouth and want to replicate with all key partners across the city.

The Panel noted the presentation and agreed to invite the Director for Public Health to a future meeting to provide an update on the progress made.

35. **URGENT AND NECESSARY ACTIONS**

This item was withdrawn from the agenda.

36. **PENINSULA TREATMENT CENTRE**

Karen Kay, Head of Locality Commissioning (Planned Care), NEW Devon CCG and Dr Gary Lenden provided the Panel with an update on the Peninsula Treatment Centre. It was reported that -

(a) the NEW Devon CCG Western Locality Board made the decision not to renew the contract for orthopaedic surgery at the Peninsula Treatment Centre. The contract would come to a natural end on 31 March 2015;

(b) this was not connected with the urgent and necessary measures;

(c) two interactive workshops with consultants, GPs, Healthwatch and 'expert' patients took place looking at the future of orthopaedic care for the city;

(d) ideally the service would move away from surgery as the end point and ensuring that GPs were better informed before making a referral. Those patients that need surgery would be seen more rapidly if required;

(e) alternatives to surgery includes weight management, pain management and improving people's wellbeing. They were looking at prevention and getting people fitter;

(f) the service would be provided in the same way but with less providers;

(g) they would continue to engage with members of the public, Healthwatch and Age Concern to shape the future of what the service would look like. An event was taking place on 17 February 2015 looking at specific service development for potential users of the service in the future.

In response to questions, it was reported that -

(h) demand for surgery had decreased and growth of the city was built into the planning across all services;

(i) the choice for Plymouth patients would continue;

(j) money saved would be invested into active conservative management and would also fund underfunded areas of care.

Agreed that the Panel to monitor the supply and demand following the closure of the Peninsula Treatment Centre; looking at capacity and ensuring Plymouth residents receive the best service.

37. **DERRIFORD HOSPITAL FUNDING**

Lee Budge, Director of Corporate Business and Joe Teape, Director of Finance provided the Panel with an update on the current funding issues at Derriford Hospital. It was reported that –

(a) they were extremely proud of the hospital and the wide range of services offered;

(b) more hospitals were getting into financial difficulty and at Derriford they were facing big saving challenges over the next two years;

(c) there were three structural funding issues –
- urgent care
- market forces factor
- education and training

(d) they were facing an extremely challenging landscape but wanted to continue to provide the best possible service. There was no intention to stop providing any services.

It was raised that Derriford Hospital has been in deficit for some time and how this compared with Royal Devon and Exeter Hospital who were running a larger deficit. It would be useful for this panel to have an understanding on this.

In response to questions raised, it was reported that -

(e) all hospitals receive the same tariff. Adjustments were made to the tariff for the work undertaken and Exeter's tariff was slightly higher than Plymouth;

(f) most of the undergraduates after receiving training would often stay at the hospital. They were looking at ways to reduce the £8m deficit spent on teaching health professionals.

It was felt by the Panel that the Health Sector was facing very challenging climate and for this Panel to look at in more detail the Health Deal for Plymouth. It was agreed that a review would be undertaken by the Caring Panel looking at Plymouth's Health Economy.

38. **TRACKING RESOLUTIONS**

The Panel noted the progress made with regard to the tracking resolutions and letter sent to the Secretary of State on the Better Care Fund.

39. **WORK PROGRAMME**

The Panel agreed the following changes to the work programme –

- Urgent and Necessary measures to be looked at in January.
- remove CAMHS, Devon Doctors Out of Hours and Dementia.

40. **EXEMPT BUSINESS**

There were no items of exempt business.

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PLYMOUTH PLAN

Caring Plymouth Scrutiny Panel

Thursday 5 March 2015

1. The Plymouth Plan is a ground-breaking plan which looks ahead to 2031 and sets a shared strategic direction of travel for the long-term future of the city. An important principle is that local people and communities of geography, identity and interest are at the heart of the plan.

2. The Plymouth Plan is being published in two parts;

- Part one sets out an overarching strategy for future change and growth in the city.
- Part two will set out detailed policies for different areas of Plymouth (Published for consultation in the autumn of 2015).

The Plymouth Plan Team would like feedback and input from the panel on the content of specific policies set out in the draft Plymouth Plan.

Do you have any concerns about the content of any of the below policies?

It's important that any gaps or weaknesses in the content are identified at this early stage to inform decisions going forward so we would welcome any thoughts you may have.

4. **Module 5 – How Plymouth will become a healthy city** (pg.35 of the Plan)**:** The main aim of the content set out in this module is to bring together all aspects of what a healthy city might look like in 2031, particularly around the current integration agenda between health and social care and promoting choice and personal responsibility. It sets out health-enabling local policy to assist in the development of good quality local services that will serve generations to come.

5. **Strategic outcome for this module:** People in Plymouth live in happy, healthy, safe and aspiring communities, where social, economic and environmental conditions and services enable choices that add quality years to life and reduce the gap in health and wellbeing between communities.

6. Relevant policy areas in summary include:

Policy 11 - Addressing health inequalities and non-communicable diseases (see pg.37 for full policy)

- Delivering a 'Plan for health', prevention and promoting healthy lifestyle choices
- Healthy weight - effective prevention, identification, early intervention – addressing access to unhealthy diets
- Alcohol related harm and changing attitudes
- Smoke free Plymouth
- Misuse of substances - focus on recovery
- Mental wellbeing - improving access to services, integrating physical and mental health care, improving quality of life
- Health Impact Assessments.

Policy 13 - Supporting healthy lifestyles (see pg.40 for full policy)

- Access to healthy diets
- Access to food growing opportunities, allotments
- Access to healthy catering at sporting, leisure and cultural facilities
- Increasing participation in active lifestyles, opportunities for walking and cycling
- Planning powers - protect sporting facilities; refuse planning applications for new hot food takeaways (A5 use) in areas within a 400m radius of schools.

Policy 16 - Delivering a safe and health-enabling transport system (see pg.44 for full policy)

- Local transport system – improve health, protect environment, tackling air pollution
- Active travel - transport infrastructure, safe and convenient facilities
- Well connected neighbourhoods – transport that connects to jobs, health services, healthy food, sport and leisure
- All residents live within 400m of a bus stop, 20 mph speed limits.

Policy 19 - Delivering clinical excellence and innovation (see pg.49 & 50 for full policy)

- Derriford Hospital as a regional centre of excellence, influencing the local National Health Service - shaping health and care commissioning
- Commission for prevention, technological innovation
- Access to primary care services.

COMMISSIONING STRATEGY FOR CHILDREN AND YOUNG PEOPLE DRAFT

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Part: I

DOCUMENT CONTROL

Version	Date	Author	Change Ref	Pages Affected
0.1	18.09.2014	Liz Cahill		
0.2				
0.3	22.09.14	Karlina Hall	Sections 3, 4 and 5.6	
0.4	03.10.14	Liz Cahill	Full edit	
0.5	08.10.14	Sophie Slater		
0.6	09.10.14	Liz Cahill	Section 7.0	
0.7	31.12.14	Liz Cahill	Amendments from initial feedback	
0.8	15.01.15	Liz Cahill/ Nicola MacPhail / Anita Pearson	Imput of health focus and changes to SEND section, now Children with Specific Health and Special Education Needs	
0.9	13.02.2015	Katy Shorten	Introduction and finances	
1.0	19.02.2015	Liz Cahill	Annual Commissioning Plan (p 48) Addition of KPI's	

QUALITY REVIEWERS: (General QA and accuracy)

Name	Position	Signature	Date

FINANCE SIGN OFF:

Name	Position	Date

CONSULTATION PATHWAY:

NAME

Table of Contents **Page Number**

1. EXECUTIVE SUMMARY

2. INTRODUCTION

2.1 Background – Strategic Challenge

Public Sector organisations across the country are facing unprecedented challenges and pressures due to rising demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities. Until recently the complexity and scale of our system-wide challenge has been difficult to understand and local organisations have, as a result, focussed mainly on meeting their own challenges. A lot of this work has been successful and this has delivered much that is good right across our system. However we know that this existing good practice will not be enough to meet the current challenge. This means a new imperative for joint and collaborative working across all the organisations that commission and deliver health and wellbeing in our area.

Recognising these challenges and within the context of a system's leadership approach Plymouth Health and Wellbeing Board has agreed a vision that by 2016 we will have developed an integrated whole system of health and care based around the following elements:

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

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

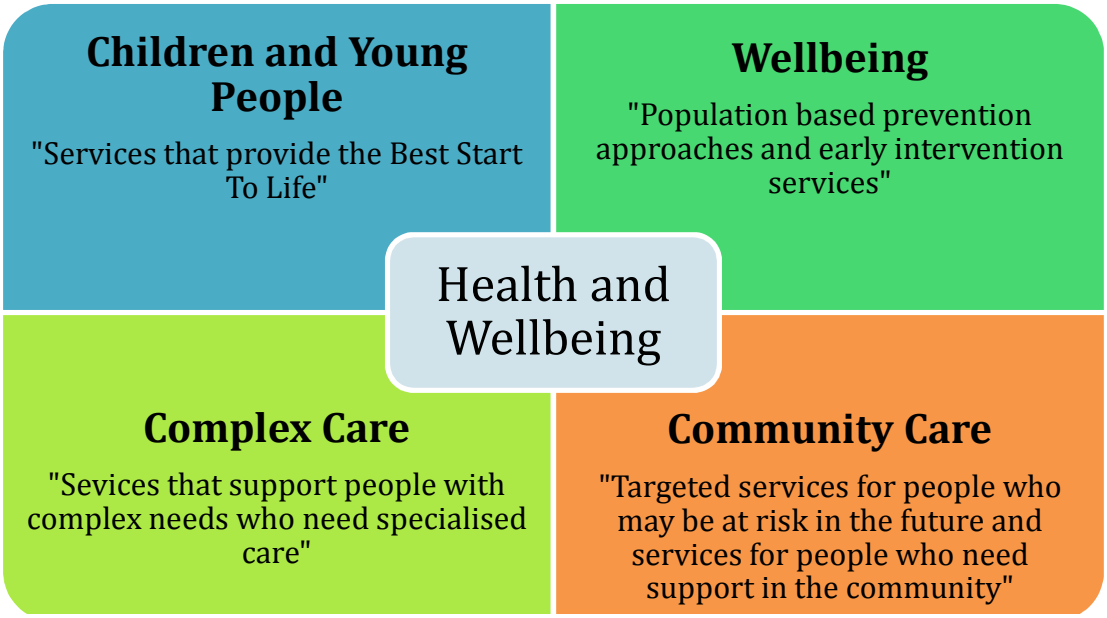
Integrated system of health and wellbeing: A focus on developing joined up population based, public health, preventative and early intervention strategies; and based on an asset based approach focusing on increasing the capacity and assets of people and place

2.2 An Integrated Commissioning Response

In order to meet the challenges facing Plymouth New Devon CCG and Plymouth City Council have agreed to develop a single commissioning function working towards jointly approved commissioning strategies and pooled budgets.

The primary driver of this is to streamline service delivery and provision with the aim of improving outcomes for individuals and value for money. Integrated commissioning must deliver integrated wellbeing.

To support this strategic aim 4 commissioning strategies have been developed that stretch across the spectrum of early years, health, social care, and wellbeing need in Plymouth.



These co-dependent Commissioning Strategies aim to move the balance of care towards prevention in order to improve life chances, manage demand and improve health outcomes. Specific aims of this system's approach includes;

- Provide and enable brilliant services that strive to exceed customer expectations
- People will receive the right care, at the right time in the right place.
- Improve pathways and transitions
- Help people take control of their lives and communities.
- Children, young people and adults are safe and confident in their communities.
- People are treated with dignity and respect.
- Prioritise prevention
- Sustainable Health and Wellbeing System
- Improve System Performance

2.3 Purpose of the Strategy

Each strategy describes the current and projected need in Plymouth, as well as the local and national strategic context that the future system will need to address / respond to. They also describe current provision how the existing system is performing.

This then builds into a vision of Plymouth's future system over a 5 year period, and details of how commissioners in Plymouth will achieve this through a series of annual implementation plans setting out and signalling to the market commissioning priorities, and how the impact of these will be measured across the system.

Plymouth wants to ensure that children, young people and families receive a quick response to their needs as and when they present, experiencing a positive journey through a system of services that supports them to build their resilience and enables them to meet their full potential.

This strategy sets out the scope of resources across the Council and NEW Devon CCG, current spend and sets clear commissioning intentions to achieve this ambition.

A core aim is to make the best use of resources to meet the need ensuring young people and families are at the heart of service delivery and experience a seamless journey through services.

In order to achieve this we need to build on what has worked and change what hasn't, ensuring we use models of best practice and demonstrate improved outcomes for children and people, thus preventing entrenched lifelong problems.

2.4 Implementation and Action

System Design Groups against each strategy will drive the implementation of the identified commissioning priorities within each strategy.

2.5 Finance

Table 1 provides an overview of how the current commissioning budgets in scope for integration are currently spread across the system.

Full detail on the existing resources allocated within each strategy area is provided in the 'current provision' section.

Table1

Strategy Area	Approximate total spend	% of spend in each Strategy area
Children and Young People	£27,150,102*	6.72%
Wellbeing	£60,752,235**	15.03%
Community Care	£119,742,637	29.62%
Complex Care	£196,616,072	48.64%
TOTAL	**£404,261,046**	

*Currently only reflects contracted spend.

**Includes approximately £40 million of prescribing spend

2.6 Definition and Scope

The opportunity that the Integrated Health and Wellbeing Commissioning agenda presents is to undertake a whole system review of a wide range of service provision in order to consider how and what changes are needed to meet the needs of children, young people and families and deliver outcomes.

In scope of this strategy therefore are the services currently commissioned for Plymouth Children and Young People by NEW Devon CCG and services commissioned and provided by Plymouth City Council for Children, Young People and Families.

There are a significant proportion of services for children and young people that this strategy does not encompass as part of the activity undertaken by the CCG and Council in the Commissioning Agenda. This includes:

Not in scope	Caveats and Interdependencies
The offer from nurseries, schools, colleges, training agencies, The Police, JobCentre Plus, Primary Care (Including GP' Services), non-commissioned voluntary and community support alongside families and communities themselves, plays a critical role in whole systems approach to meeting need.	However it is clear that a whole cannot be delivered for children, without shared vision across the partnerships. The on-going opportunities to develop services together are still a priority and can be achieved through the existing Strategic Partnerships, in particular The Children and young People's Partnership,

	Alongside this there is a continued need to look for opportunities for co-commissioning across partnerships.
Aspects of services that are commissioned by NEW Devon CCG and NHS England whose offer remains determined by other influences, (e.g GP's, Dental Services, Tier 4 Mental Health Services) or are determined by a national specified core offer, such as some aspects of Maternity Services.	Whilst there is limited ability to change the offer within these health services, the way in which they are delivered and how they integrate with other service offers through pathways of care, are in scope for this strategy.
Services paid for by the Dedicated Schools Grant (DSG), this is ring-fenced for schools and is allocated through a minimum funding guarantee for schools alongside local formulas agreed with the Schools Forum. This strategy does not, therefore, cover the majority of this funding, nor the functions of school improvement, allocation of school places, school transport, school catering and other school support services.	Some schools use their funding allocation to "buy back" services from the Council, such as Education Welfare and Education Psychology. Again this strategy does not seek to set the commissioning direction of the traded element of these services. However it does seek to review best use of the resource for these services that is funded through Council revenue funding, some of which is to fulfil local authority statutory duties, as part of the integrated design. Whilst the majority of services are commissioned using Dedicated Schools Grant are out of scope, there are times when children are excluded, for example, that this funding is used to commission the alternative education. The new funding system introduced in 2013 makes Councils responsible for commissioning and funding all additional high needs provision across early years, schools and post-16 education and training, Schools, academies, FE colleges and other providers from DSG funding. A formula is agreed with Schools Forum funds all special schools across the city, and provides top up funding for all high needs pupils. This has been included within this strategy in recognition of the market development and management involved in this commissioning and to review how we can better integrate the commissioning of education, health and care plans for these children and young people.
The Dedicated Schools Grant budget for other provision for funding for nursery placements for vulnerable 2 year olds.	Whilst the funding for the actual nursery placements for vulnerable two year olds has not been included in this strategy, the process to ensure families eligible for this funding have access to wider support from Early Years Services. Alongside this Plymouth City Council's Early Years Department who

	provider significant support and workforce and development to settings are in scope.
All age public health services, such as the health promotion team, are covered by the Wellness Strategy rather than the Children, Young People and Families Commissioning Strategy	There is a clear need to ensure these system are designed together with a whole system view in order to ensure universal strategies target children and young people, for examples Healthy Weight Strategy and Smoking cessation.
The statutory function of Children's Social Care for child protection and looked after children, as defined in the Local Authority Social Services Act 1970. The design of the future of this service will be held with the Council.	Whilst core statutory duties of social care are not included, there is still a focus on how we might better integrate services for children in and on the edge of care. There is a significant commissioning focus on children's placements and relevant multi-agency support. The interface with the functions of social care is therefore critical to the developments a systems approach to children and young people and will be managed in co-design and through the transformation agenda.
Acute care and elective health care for children and young people is also out of scope of this strategy.	Whilst acute and elective health care is out of scope, there is a need for the strategy to consider the impact of services on reducing the demand for hospital admissions. Alongside this elements of the Acute contract held by NEW Devon CCG are in scope as they deliver community services that would benefit from an integrated approach.

This strategy therefore does look to identify how we can support integration, collaborative working and capacity building so that the offer in the whole system for prevention, "Early Help" and statutory intervention is strengthened. There is a need to continue to work closely with partners to co-design our responses to need, and set out how our services interface with each other, and where possible to look to build on and develop co-commissioning approaches with commissioning partners such as the police and schools.

3.0 STRATEGIC CONTEXT

3.1 NATIONAL DRIVERS

Key national drivers include the following:

Children and Family Act 2014

The Children and Family Act 2014 sets out some key reforms legislation relating to:

- Eliminating the delay in Child Protection court proceedings
- Securing permanency for children in a timely fashion, linking to adoption reform
- Increasing the availability of Family Mediation instead of court proceedings in family dispute, where safe and appropriate
- Children with Special Educational Needs and Disabilities; for these children the Act aims to ensure that families receive support when they need it and have greater involvement in the decision making for education, health and social care plans.

The Care Act 2014

The Care Act represents the most significant reform of care and support in more than 60 years, putting people and their carers in control of their care and support. Under the Care Act, local authorities have taken on new functions. This is to make sure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- Can get the information and advice they need to make good decisions about care and support
- Have a range of high-quality care providers to choose from.

The Act also says that when an assessment is carried out, information should be given about whether the young person, child's carer or young carer is likely to have eligible needs for care and support when they turn 18. The Care Act (and the special educational needs provisions in the Children and Families Act) requires that there is cooperation within and between local authorities to ensure that the necessary people cooperate, that the right information and advice are available and that assessments can be carried out jointly.

NHS England's Five Year Forward Plan 2014

This sets out an agenda to further modernise NHS Services, ensuring there is a focus on tackling the causes of ill health, such as obesity, smoking and alcohol use, alongside creating more diverse and locally shaped service models, designed to meet local need.

Within this is a clear agenda to work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government

Better Health outcomes for Children and Young People: Our Pledge 2013

This pledge was signed by key health organisations following the report of the Children and Young People's Health Outcomes Forum. The Pledge includes several shared ambitions and determinations, including that "Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority" and that "Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life".

The Munro Review of Child Protection: Final Report - *A child-centred system* Professor Eileen Munro 2013

This review made clear recommendations for a strong system to support vulnerable families. The report highlights the need for a knowledgeable and skilled social care workforce who are able to use research evidence to help them reach the most appropriate decisions. Alongside is the need for the effective contributions of all local services, including health, education, police, probation and the justice system.

Munro established a number of principles that all work with children and young people should strive to include. These principles are:

- The system should be child-centred
- The family is usually the best place for bringing up children and young people, but difficult judgements are sometimes needed in balancing the right of a child to be with their birth family with their right to protection from abuse and neglect
- Helping children and families involves working with them and therefore the quality of the relationship between the children, family and professionals impacts on the effectiveness of help given

- Early help is better for children
- Children's needs and circumstances are varied so the system needs to offer equal variety in its response
- Good professional practice is informed by knowledge of the latest theory and research
- Uncertainty and risk are features of child protection work
- The measure of the success of child protection systems, both local and national, is whether children are receiving effective help

Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays

In her report, the CMO makes recommendations on how to improve the health of children and young people and why this is important to do. It highlighted that England has poor outcomes for children and young people with respect to mortality, morbidity and inequality. Recommendations included:

- Raising the profile of children and young people and encouraging the public sector and other institutions to work together more closely
- Early action matters: we need to move from reactive to proactive care
- We need to ensure that efforts to improve outcomes are underpinned by proportionate universalism: improving the lives of all, with more resources targeted at the more disadvantaged
- Developing further the evidence base for how to nurture resilience in young people and how this can assist in educational attainment
- Thinking about the family, not just the child or young person in front of you, should be a professional norm.

Health and Social Care Act 2012

The Health and Social Care Act 2012 sets out the legislative framework that provides the basis for better collaboration, partnership working and integration across local government and the National Health Service (NHS) at all levels. The act establishes the role of the Health and Wellbeing Boards, the transfer of Public Health responsibility to Local Authorities and establishes CCGs. The focus of this is to ensure the promotion of integration based on the knowledge of need, and the commissioning power to design new services that integrated care around the needs of the person.

Child Poverty Act 2010

The Child Poverty Act 2010 and The National Child Poverty Strategy in 2011 set out the ambition to eradicate child poverty by 2020 and ensure that as far as possible no child experiences socio-economic disadvantage. At the centre of the strategy is the strengthening of families, combating worklessness and educational failure, encouraging responsibility, guaranteeing fairness and providing support to the most vulnerable.

3.2 LOCAL DRIVERS

Key local drivers include:

Our Plan: The Brilliant Cooperative Council

The Strategy will support the achievement of the following Council objectives and outcomes:

- Pioneering Plymouth: A Council that uses its resources wisely
- Growing Plymouth: A top performing education system from early years to continuous learning opportunities
- Caring Plymouth: We will prioritise prevention.

- Caring Plymouth: Children, young people and adults are safe and confident in their communities.
- Confident Plymouth: Government and other agencies have confidence in the Council and partners: Plymouth's voice matters.

NEW Devon CCG 5-Year Strategic Plan Summary 2014-2019 and 5 pillars

This plan provides the basis for moving forward with a whole-system strategy for health and social care, setting out how we will work together as a system to tackle the challenges we face and move forward to deliver changes in the way we meet the needs of people who use our services. The vision has 5 key aims to improve a patient's experience of local health services.

1. Partnerships to deliver improved health outcomes
    - Informed users of healthcare through improved lifestyle advice, support and preventative services, to be healthy and reduce the need for treatment
    - Services designed & delivered in a targeted way to reduce health outcome inequalities
    - Organisations and businesses across local communities supporting schemes to improve health and wellbeing with greater local co-ordination

2. Personalisation and integration
    - Greater access to personal health and social care budgets supporting and empowering those in most need
    - Personalise community health and social care services
    - More services for individuals will be coordinated by a single agency
    - Improved services will see people stay safe, well and at home for longer

3. At scale general practice registered populations as the organising units of care
    - Improved access to wider primary care teams for longer hours over 7 days with a range of different locations to visit for urgent care
    - Registered GP lists ensure regular contact with the same professional for long-term care
    - Enhanced range of services delivered around a GP practice with more care organised by the wider practice team; more flexible access for minor conditions

4. A regulated system of elective care that delivers efficient and effective care for patients
    - More one-stop treatment will be the norm for elective services personalised for patients, some provided in bigger centres, but with less visits
    - More support to self-manage conditions and reduce the need for surgery or specialist care in the first instance
    - More care provided in the GP practice with support to find the right place when specialist input is required

5. A safe and efficient urgent care system
    - Supported to self-manage and stay safe, well and at home for longer
    - A single organisation to organise all care needs and respond to personal requests
    - A single number making it easy to seek advice, navigate urgent and emergency care and access the right local services the same day
    - Most specialist care available in the CCG with some further afield.

Children and Young People's Plan 2014

The Strategy sets out the key ambitions and ultimate outcomes for Plymouth children and young people:

- Raise Aspirations: Ensure that all children and young people are provided with opportunities that inspire them to learn and develop skills for future employment
- Deliver Prevention and Early Help: Intervene early to meet the needs of children, young people and their families who are 'vulnerable' to poor life outcomes
- Deliver an Integrated Education, Health and Care Offer: Ensure the delivery of integrated assessment and care planning for our children
- Keep our Children and Young People Safe: Ensure effective safeguarding and provide excellent services for children in care

Plymouth's multi-agency transition pathway for young people with additional needs

The Strategy contributes towards the pathways vision that working in partnership with young people, their families and other interested parties; we will achieve a natural, person centred transition into adulthood for those young people with additional, complex and special educational needs.

Early Intervention and Prevention Strategy 2012-15

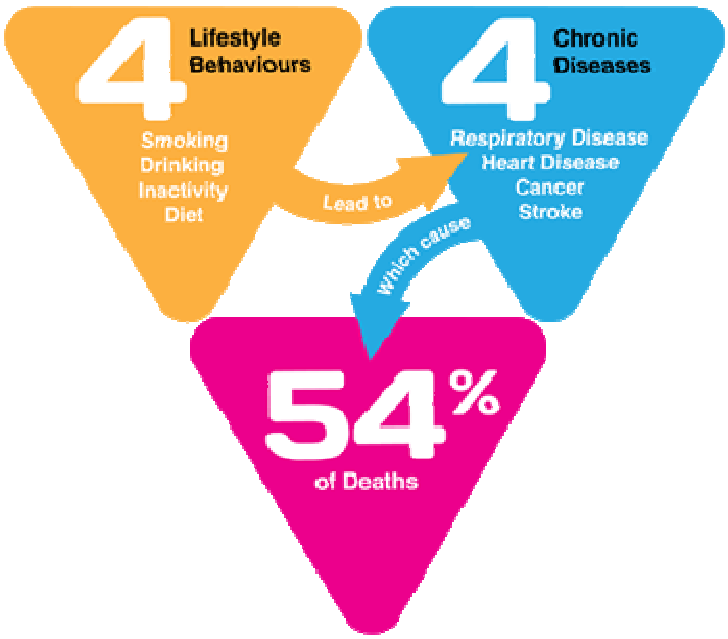
The Early Intervention and Prevention Strategy set out a clear ambition to ensure the system of support to children, young people and families can respond to need appropriately when it arises. The core aim was to prevent escalation to specialist services and ensure the system had capacity to support on-going change for children young people and families exiting specialist interventions.

The Early Intervention and Prevention Strategy outlined the shared processes that all services use to identify and meet need. It outlined the need to ensure there is a whole family approach and where multiple and complex need are identified with lead professionals holding onto the co-ordination of a plans designed to meet the needs of individual children and their wider family. This would enable a wrap-around response from services covered in the scope of this strategy, alongside the adult services and the offer from education and community providers.

Thrive Plymouth 2014

Plymouth's Public Health Strategy sets the key ambitions to improve health and wellbeing of everyone in the city, with a aim to close the life expectancy gap of 12.2 years between neighbourhoods in Plymouth. This is the city's 10 year plan to improve health that will involve working with partners and communities to support positive health-enabling choices.

The strategy focuses on things that cause us the most ill-health largely result from the choices we make - what we eat and drink, whether we smoke or how physically active we are.



4.0 OVERVIEW OF NEED AND PERFORMANCE

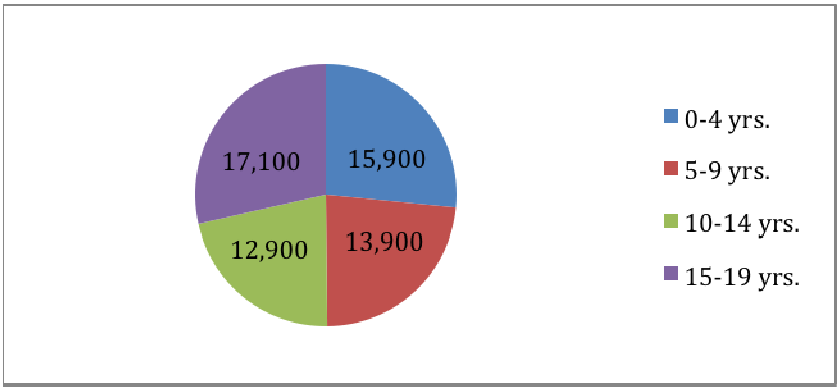
There has been a range of analysis that have recorded key areas of need for children, young people and families over the last few years, including needs data developed for The Early Intervention and Prevention Strategy 2012, The Child Poverty Needs Analysis 2012, The Looked after Children's Strategy 2014, The Fairness Commission 2014 and The Plymouth Plan 2014.

This section therefore highlights some the key messages and needs, focussing on the areas of pressure in the system in Plymouth. A more detailed needs analysis is being developed jointly between Plymouth City Council and CCG has been included as a working document in Appendix X.

4.1 Local Demography

The National Census 2011 tells us that of the 109,307 households in Plymouth, 26.4% (28,881) have dependent children. 8,496 of these households are lone parent households.

The ONS mid- year estimates 2013, demonstrates that the largest proportion of children are in the 0-4 and 15 – 19 age group, as below.



Up until the end of 2012 there had been a steady increase in the number of births in Plymouth with 31% more births in 2011/12 than 2001/02. Many of these have been in areas of social deprivation. Within this increase there has also been a steady increase of births to non UK born mothers, nearly doubling since 2001 (6.4% - 11.7%).

Nationally teenage conceptions are at the lowest level they have been since records began in 1969 at 27.9 (per 1,000 15-17 year olds), with the figure in Plymouth standing at 39.5% one of the higher rates seen in the Country. Whilst still high in Plymouth, the rate has been steadily reducing

2013 figures released in July 2014 interestingly show a decline in the number of live births for the first time in recent history and follow the trend seen nationally where live births have dropped to the lowest level seen in nearly 40 years.

4.2 Deprivation and Vulnerable Families

Deprivation in Plymouth is higher than average and about 22.4% (10,100) children live in poverty. Plymouth's Child Poverty Needs Analysis 2012, demonstrates that there is a greater concentration of families with multiple and/or complex needs living in the most deprived areas of the city. Multiple and complex needs may include lone parents, disability, health problems, parenting problems or social isolation amongst others.

A number of national reviews have provided an evidence base that demonstrate a strong correlation between exposure to parental poverty, mental ill health (including postnatal depression), addiction and violence in families with negative outcomes for young people and adults, including poor examination results, higher rates of teenage pregnancy, lower rates of employment, higher rates of depression and suicide and substance misuse.

Levels of reported domestic abuse are higher in neighbourhoods with higher levels of deprivation. For the last three years over 2000 incidents to which the police were called and a child was present, with 2332 incidents in 2013/14.

An initial analysis in 2012, identified over 800 families with two or more of the indicators under the Troubled Family Agenda; (family worklessness, school absenteeism and/or youth crime/family anti-social behavior). Analysis of the initial cohort identified highlighted

- There is a high correlation between absenteeism and worklessness with 72% of the cohort presenting with these criteria.
- Many of the families were concentrated in the same neighborhoods and lower super output areas. These neighborhoods correlate to those with high levels of child poverty highlighted in the child poverty needs analysis.

From a sample analysis some of the most vulnerable identified for the programme[1]

- 86% had presenting issues of family chaos, domestic abuse, parental mental illness, parental substance misuse alongside risk taking behaviour in children / young people.
- The remaining 14% the main presenting issues were adolescent mental illness, risk taking behaviour and perceived threat to younger siblings.

4.3 Public Health Outcomes

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.

Whilst there are some clear successes, such as uptake of immunisations and vaccinations and good levels of development in the Early Years, Plymouth compares negatively to national figures in relation to key public health outcomes, such as breastfeeding, hospital admissions for self-harm and unintentional injuries, youth unemployment and youth crime. (see Child Health Profile 2014 below).

[1] case notes were taken from 35 of the 60 families who met all three FWAF criteria and had enough information about presenting need on social care and family information project records.

The health outcomes gap between those living in the most deprived areas and those in more affluent areas remains significant, with life expectancy 9.5 years lower for men and 4.0 years lower for women in the most deprived areas of Plymouth than in the least deprived areas.

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

4.4 Academic Achievement

Plymouth has seen a year on year improvement in attainment at GCSE, including an increase in achievement for Children in Care (8% in 2011, 12.5% in 2013)

% achieving 5+ A*-C GCSEs (or equivalent) including English and Maths GCSEs				
2009	2010	2011	2012	2013
49.1%	54.2%	56.8%	57.5%	60.6%

Whilst we have seen an ongoing improvement in achievement in all stages in Plymouth, there is still a significant gap between the achievement of vulnerable children and their peers. - Including young offenders, children in care, children with special education needs, those receiving free school meals and those in the Alternative Complementary Education (ACE) service.

4.4.1 Exclusions and Absenteeism

In Plymouth, in 2013, the total absence rate remained the same as the previous year while it slightly increased nationally and in the stat. neighbours. However, Plymouth total absence rate is still higher than the national average but slightly better than the stat. neighbours.

Plymouth is performing significantly well to manage the unauthorised absence rate which is lower than both the national average and the stat. neighbours.

Persistent absence is also on a decline throughout the country for last couple of years. In 2013, Plymouth is better performing against its stat. neighbours but slightly underperforming against the national average.

Overall Permanent and Fixed Term Exclusions (in all type of schools) is significantly lower than the national average and the stat. neighbours. Fixed term exclusion shows a consistent decreasing trend in Plymouth, nationally and in the stat. neighbours, however there has been a slight increasing trend in fixed term exclusions in primary schools.

4.5 Children with Special Educational Needs or Disability (SEND)

In 2013 Plymouth identified 20.3% of pupils as having a special educational need or disability, compared with a national average of 18.7%. In total 3.6% of pupils had a Statement of SEN, compared to 2.8% nationally.

Within SEND is a clear category for children with Medical Conditions/Syndromes, including those with Epilepsy, Asthma, Diabetes, Anaphylaxis, Downs and other syndromes, complex medical needs including continuing health care needs and Mental Health Issues.

The largest groupings of this need are with those who have in Behavior, Emotional and Social Difficulties (BESD), Autistic Spectrum Conditions (ASC) and Speech, Language and Communication Needs (SLCN). There has been a steady year on year increase in the number of children identified with those needs.

There are currently about 1500 CYP on the ASC school aged caseload, and 20% of them have been highlighted to the Disability Service as having challenging needs Within the cohort of CYP, professionals are reporting increased anxiety or lack of social understanding, which can results in

- self-harm or suicidal thoughts,
- outbursts of rage and anger which involve harm to others (often parents) and the police / social care becoming involved,
- depression
- withdrawal from usual activities and attending school.

In 2013/14 the increasing number of pupils with BESD in primary schools contributed to the rise in a rise in exclusions.

4.6 Increased in Demand on Specialist Services

Plymouth has seen a steady increase in the number of referrals to specialist services.

In 2013/14 there were 4776 referrals to Children's Social Care in, 71% (3391) of these proceeded to assessment. This represents an 18.9% increase in referrals from the previous year. Children's Social Care has received 1832 referals for this financial year to date, this represents a 25.1% increase when compared with referrals in the same period in 2013/14. There were 380 Children with a child protection plan by the end of March 2014, representing a 21.4% increase since the end of the previous financial year. In July this figure was 404.

As at March 2014 the main problems facing families with children subject to a Child Protection Plan are Domestic Abuse (29.5%), Unsafe Parenting (32.78%), Drug Misuse (7.4%), Alcohol Misuse (8.8%), Parental Mental Health Problems (12.9%) and at Sexual Risk from an Adult (6.1%)

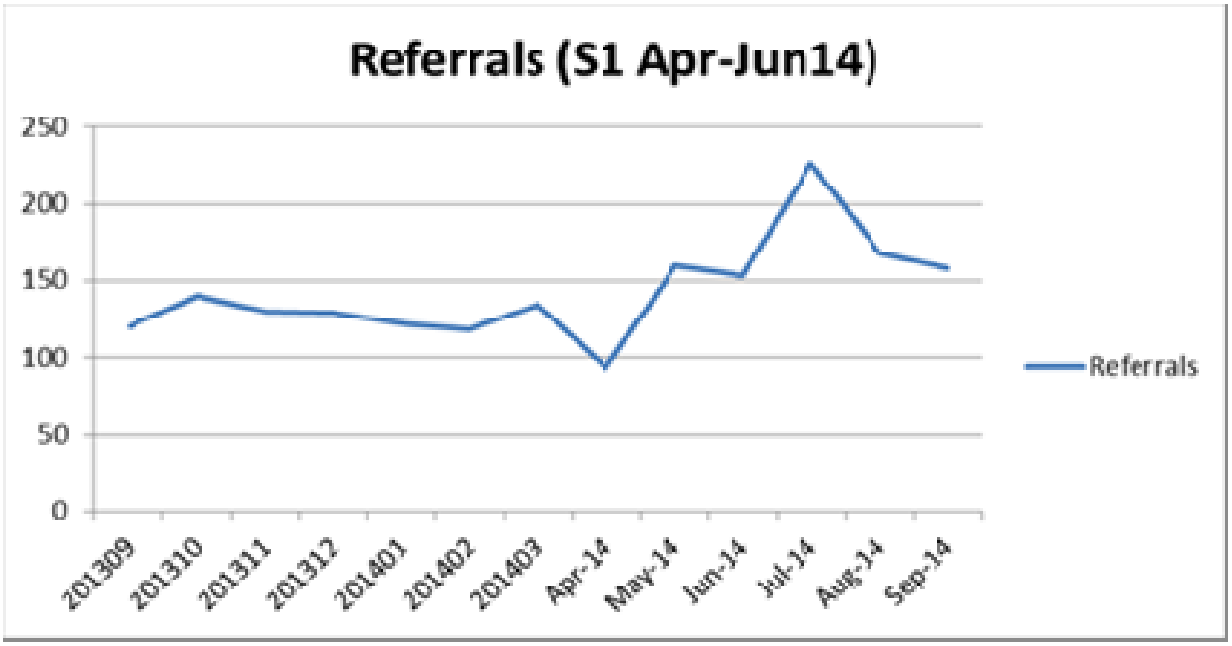
Since September 2013 we have seen an increase in numbers of children in care from a steady position of approximately 380 to 414, as of the 18th August. 253 (61%) of these were aged 11-18.

The complexity of the presenting needs has also meant that for the first time in some years we have seen an increase the use of high cost placements. Until 2013 approximately 20 children were placed in residential placements at any one time, with limited use of welfare secure, however complexity of need has meant a significant increase, with a peak use of 32 in residential and 5 secure unit placements in May 2014. The presenting issues in this cohort have been, high levels of risk taking behaviour, such as crime and substance misuse, mental health problems, risk of harm to others, including sexual harm and risk of sexual exploitation.

Similarly there has been an increase in referrals to CAMHS (from 93 in April 2014, peaking at 227 in July 2014 and dropping slightly to 158 in September); this has impacted on the waiting times as all of the referrals have required an assessment due to the high levels of risk. This is consistent with the increased levels of need we are seeing elsewhere in the system and the service reports they are mainly due to self harm and children with neurodevelopmental issues who present with comorbid mental health need.

The diagram below demonstrates the increase in referrals that the service has experienced during the twelve month period from September 2013-September 2014.

CAMHS REFERALS (ACCEPTED)



The Hospitals Trust have also experience increased demand on the emergency department, with significant number of attendances for teenagers. Just over 50% of children attendances in the Emergency Department were discharges "not requiring any follow up treatment".

There has also been an increase in inpatient admissions, over 50% of whom are aged 0-4. A significant proportion of these are in relation to respiratory problems.

4.7 Feedback from Stakeholder Engagement

There has been a range of stakeholder engagement over the last year or so, including engagement with children and young people and parent and carers, including consultation for the following:

- Participation projects with young people in respect to their requirements of professionals and in particular areas of need, such as domestic abuse and alcohol misuse.
- The reshaping of Children's Centres,

- Consultation for the implementation of new Special Educational Needs and Disability (SEND) requirements,
- Stakeholder engagement in respect to the Pledge 90 Mental Health Service review,

These have impacted upon and influenced the direction of this Commissioning Strategy. More details about key messages can be found in Appendix 3.

4.7.1 Children and Young People's 10 Wishes[2]

Consultation undertaken in 2013 with children and young people about their experiences of services have produced an agreed "wish list" of what children and young people need from professionals.

- **Wish 1:** We will make sure that all adults have a telephone number and an online way of being contacted, such as email, social media or text.
- **Wish 2**: We will make sure that all adults try their best to keep agreed appointments and not be late. If they are delayed or staff are sick we will contact you, as soon as possible, to say sorry and find a good time to meet again.
- **Wish 3**: We will make sure that adults that work with children and young people are properly trained to meet national standards. We will involve children and young people in this training as much as we can.
- **Wish 4**: We will ask you if you understand what is happening. We will ask how we can help you.
- **Wish 5**: We will listen to you all of the time, tell you what we are going to do, and make sure that you are safe.
- **Wish 6**: Safeguarding means "keeping you safe". We will talk with you and ask if any words we use are not clear.
- **Wish 7**: We will always tell you what we are going to do, when it will start and how long it should take. If anything changes, we will tell you as soon as possible.
- **Wish 8**: When it is safe to do so, we will give children and young people the chance to talk about themselves on their own.
- **Wish 9**: We will make sure that all adults ask you, "Do you feel safe?"
- **Wish 10**: We will ask all adults to show you respect by meeting all of your ten wishes, and treating you fairly at all times.

4.8 Evidence based / good practice

This strategy will incorporate good practice and build on an evidence base to improve the health and social care outcomes of people in Plymouth. The following good practice resources, research and data can be accessed by health and social care professionals and commissioners:

- Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/
- National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/
- The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/
- NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/
- Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/

[2] http://www.plymouth.gov.uk/homepage/socialcareandhealth/childrenssocialcare/localsafeguardingchildrenboard/pscbchildrenandyoungpeople/pscbtenwishes.htm

- Care Quality Commission (CQC) - http://www.cqc.org.uk/
- Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/
- Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm
- Healthy Child Quality Mark - http://www.plymouth.gov.uk/srnewsitem?newsid=280245

5.0 CURRENT PROVISION

5.1 Strategic overview

In Plymouth the existing pattern of services for children has been designed and developed around specific service responses to specific need or built around pathway developments, in reference to the priorities set within the Children and Young People's Strategies. This has created a pattern of services with their own access criteria or thresholds, outcomes and targets.

Whilst there has been considerable work done to align the design of services between Health and Council both operationally and through commissioning and pathway development, integrated commissioning still only applies to a few services, such as the Community Equipment Fund, Domiciliary Care and CAMHS.

There has also been significant work undertaken to improve and promote multi-agency responses, and develop an increase in the targeting of support to those who need it most driven through Plymouth's Early Intervention and Prevention Strategy. This strategy has also promoted collaborative working and some co-location with school funded support services.

The Council continues to be a significant service provider with services, such as Disability Services, Youth Services and Children's Social Care. In these services there is some operational integration of provision. The Council also commissions a range of providers to deliver services for children and young people such as Children's Centres, Fostering and Residential Accommodation, Information, Advice and Guidance, Young Carers and Drug and Alcohol Services.

In health the majority of community services for children and young people are provided under the NEW Devon CCG contract with Plymouth Community Healthcare. Some of the health offer is also commissioned by Plymouth City Council from this service under the Public Health agenda. Under the Plymouth Community Healthcare structure these services sit in a locality area based design that integrates their management and governance with adult services.

Plymouth Hospitals Trust are also contracted to delivers two other significant services identified in this strategy these are the Community Development Centre and Maternity Services.

Finally there is a range of bespoke funding for individuals across health, social care and allocation of specialist education, some of which is done through framework contracts. Whilst a joint funding panel looks to ensure some co-ordination of this, the separation of budgets, processes and functions of this allocation can cause delay in establishing a wrap-around package for young people/families requiring a service, and confusion for those referring in with regards to oversight responsibility of these services/provisions.

5.2 Existing service provision

Service	Current commissioner	Provider
Social Care Family Support	n/a	Plymouth City Council Provided – Social Care

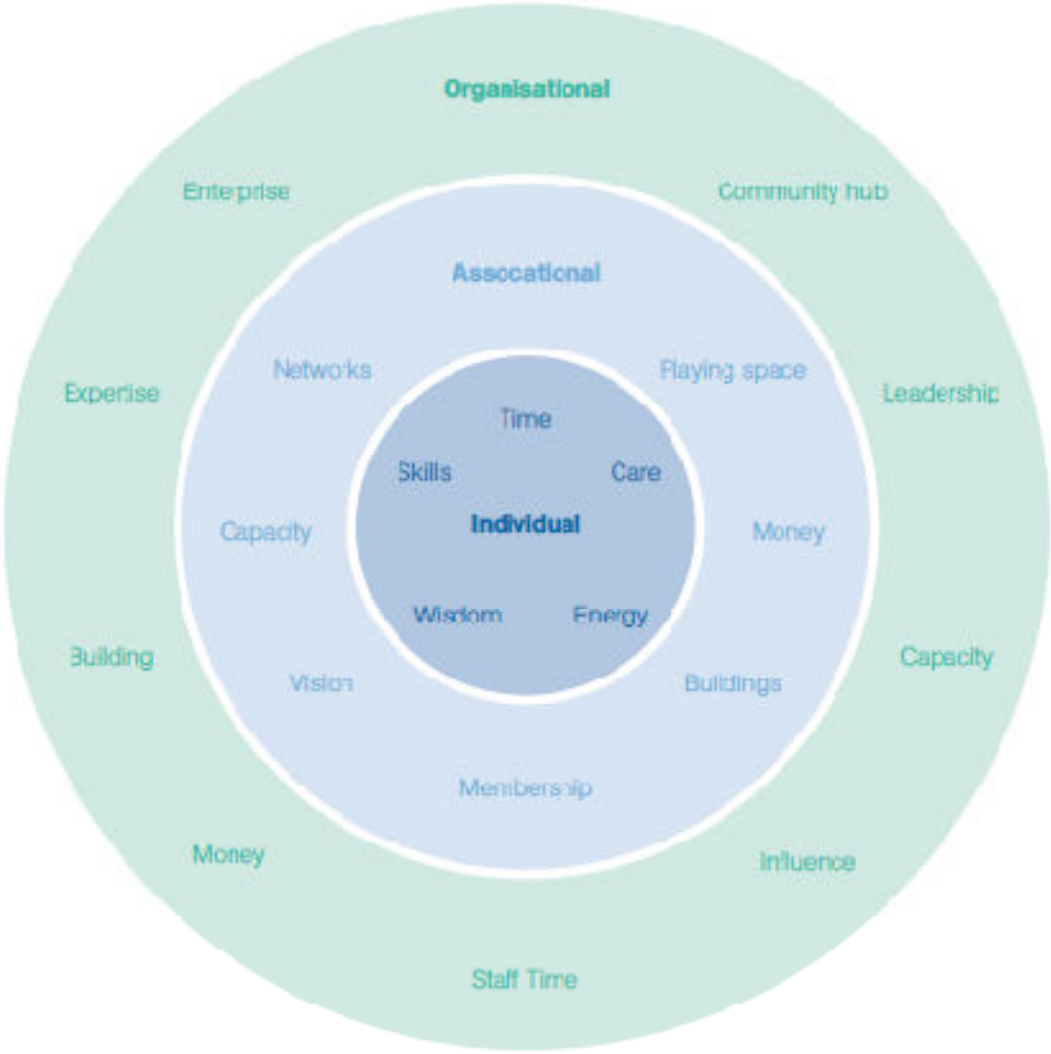
Parent Partnership	n/a	Plymouth City Council Provided – ELAFS
"Families with a Future"	n/a	Plymouth City Council Provided – Homes and Communities and Various
Family Intervention Service	n/a	Plymouth City Council Provided – Homes and Communities
Family Group Conferencing	n/a	Plymouth City Council Provided – Social Care
Maternity Services	New Devon CCG	Plymouth Hospital Trust
Children's Centres	Plymouth City Council	Voluntary and Community Sector (VCS)
Health Visiting	NHS England (coming to PCC 2015)	Plymouth Community Healthcare
Family Nurse Partnership	NHS England (coming to PCC 2015)	Plymouth Community Healthcare
Early Years Advisors	N/A	Plymouth City Council Provided
Community Paediatric Services – Children's Community Nursing – Community Paediatricians – Children's Development Centre – Occupational Therapy	New Devon CCG	Plymouth Hospital Trust
Education Psychology	n/a	Plymouth City Council Provided
Short Breaks	Plymouth City Council	Various VCS and Education Providers
Education placements, including 16+ (high needs block)	DSG - schools funding formula agreed with Schools Forum	Education Providers (various)
Personalised health budget	New Devon CCG	Various
Social care budget for individual support	Plymouth City Council	Various
Children's Integrated Disability Services - Early Years Inclusion Service (0-5) - Advisory team for sensory support - Communication Interaction Team - Children's Occupational Therapy - Social Care	n/a	Plymouth City Council Provided
Speech and Language	New Devon CCG	Plymouth Community Healthcare
Community Equipment (in with Adult CES)	Plymouth City Council and NEW Devon CCG	
CAMHS	Plymouth City Council and New Devon CCG	Plymouth Community Health Care
Education Welfare	Plymouth City Council and	Plymouth City Council- ELAFS

	schools	
Early Intervention Psychosis 16-25 (joint delivery CAMHS and The Zone)	New Devon CCG (adults)	VCS
Early Intervention Personality Disorder 16-25	New Devon CCG (adults)	VCS
Integrated Youth Service (Community, Youth Offending, Care Leavers and Targeted Services)	Youth Offending Service jointly funded by Plymouth City Council	Plymouth City Council – Homes and Communities
YP Substance Misuse Service	Plymouth City Council	Harbour Drug and Alcohol Services
School Nursing	Plymouth City Council – Public Health	Plymouth Community Healthcare
Alternative Complementary Education	DSG funded placements	Plymouth City Council
Information advice and guidance	Plymouth City Council	Careers South West
Young Carers and Affected Others	Plymouth City Council	VCS
Small contracts - Family Therapy and Relate	NEW Devon CCG	VCS
Placements (foster, residential and secure)	Plymouth City Council	Plymouth City Council – and Independent FA Residential Care
Bespoke individual commissioning and court ordered assessments, secure transport etc)	Plymouth City Council	Various
Adoption Support	Plymouth City Council	Plymouth City Council social care
Advocacy and Independent Visiting	Plymouth City Council	VCS
Children and Young People's Participation	Plymouth City Council	VCS
Dedicated Nurse for Looked after Children	NEW Devon CCG	Plymouth Community Healthcare
Looked after children Virtual School Service	n/a	Plymouth City Council – ELAFS

5.3 Community asset mapping

Asset mapping will be utilised to determine existing informal provision, assets and resources that people have access to in the community. A co-production approach will improve the understanding of local needs and assets and will be part of the wider needs assessment work carried out across the four strategies. The asset maps would then support the formally procured services as part of the long-term commissioning strategies (Adapted from *Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014*). An example of the wide range of assets that could be included in the mapping exercise is presented in figure 1 below.

Figure 1 Asset Mapping



Source: Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014). Adapted from Foot, J. and Hopkins T. (2012). The Collaborative. (n.d.) Our Vision. The Collaborative: London. Retrieved from http://lembethcollaborative.org.uk/about/our-vision.

Consultation with parents in 2013 in respect to the future of children's centres highlighted a strong message that any parent could have periods where they feel vulnerable, both because of their own needs, or lack of knowledge around parenting and child development. However most families have strong resilience, due to protective factors such as strong parent child relationships, affection, consistent parenting, good communication skills and good support networks.

In order to develop a whole systems approach it is important to recognise the role that nurseries, schools, police, JobCentre Plus, primary care, communities and families themselves play in meeting needs of children and young people

Even when children, young people and families experience crisis, such as job loss, financial crisis, separation or bereavement, children with strong protective factors and a lack of other risk factors, (such as domestic abuse or hostile and rejecting family relationships), will be able to have their needs met through the wider service offer.

This strategy therefore sets a clear function to support collaborative working and capacity building with partners so that the offer in the whole system for prevention and "Early Help" is strengthened, by ensuring we empower parents to make the right decisions for their families, without the need to access services unless necessary.

6.0 THE FUTURE SYSTEM OF SERVICE PROVISION – KEY DESIGN PRINCIPLES

6.1 Overarching Outcomes

The Local Government Association's agenda for Rewiring Public Services that set an ambition for an overarching framework for children to be:

- All children and young people should feel that they are cared for and that they are safe and secure
- All are healthy, happy and free from poverty
- All get a good education that allows them to fulfil their potential and achieve their ambitions
- All are well-prepared for adulthood and the world of work, making a positive contribution as active citizens.

6.2 The "Early Help" agenda.

In order to achieve this clear consideration needs to be given to appropriate interventions across the spectrum of need. In an environment of reduced budget and increasing demand on resources, it is critical that we are able to target support to families who need them most. It is therefore important to revisit some key principles in ensuring the use of our resources to meet the varying levels of need, in line with the Early Intervention and Prevention Strategy.

6.2.1 Early Help Single Point of Contact (Gateway)

Under the work of the EIP Strategy and in response to the requirement for improved "Early Help" has come the emerging ambition to create a point of contact for families and professionals who are struggling to meet need.

This new contact point will consolidate a number of early help access points that currently exisit whilst establishing a clear inter-relationship with access points to specialist services, including multi-agency Advice and Assessment for Safeguarding and the Devon Referral Support Service for Medical and Clinical need.

- Provide good quality information and advice that can be delivered by community-based services, or accessed by parents through web-based information, through Plymouth Online Directory (POD).

- Support school and community based services in their delivery of early help plans, through supporting assessment and care planning processes, ensure consistent professional consultation and brokering access to the right support from the wider offer.

- Create a repository of information from services to enable a single view of families with multiple needs, in order to quality assure plans, track outcomes and identify if additional resource required.

- Enable access to the targeted support offer.

6.2.2 Early Help and Workforce Development

Whilst this strategy seeks to develop some earlier and better interventions to respond to need within the service offer, a critical way forward is also to build the capacity of the whole workforce,

including the workforce in schools, settings and adult services in order to ensure they are provided with the tools and skills to identify need early, and appropriately support and empower parents.

Our needs analysis highlights critical areas where we need to better manage the needs of children whose current trajectories display a pattern of escalation, creating demand on high end and expensive service provision. This includes

- Assessment, including clear understanding of child development and risk and protective factors.
- Skills and tools to respond to children with behavioural, emotional or mental health and social difficulties.
- Skills and tools to respond to Speech, Language and Communication Needs
- Skills and tools to respond to children with Autistic Spectrum Conditions and risk taking behaviours
- Skills to support the disclosure of Domestic Abuse, assess risk to children, intervene appropriately or help families access appropriate support
- Ability to assess the impact of parental mental health, learning difficulties, and substance misuse on parenting capacity and intervene appropriately or help family's access appropriate support.
- Ability to support family aspiration and promote financial inclusion.
- Consistent and evidenced based approach to support parenting skills, especially for parents with children with behaviour problems and learning difficulties.

6.2.3 Early Help and the Targeted Offer

Long standing research evidence indicates a range of risk factors that a child or young person will have poor life outcomes. Whilst differing research highlights slightly different factors there is enough commonality to indicate that if certain risk factors are present in a family and there are few corresponding protective factors, that a high percentage of these children will have poor life outcomes, such as poor health, offending, drug taking or other risk taking behaviour, mental health problems or will be at risk of repeat abuse or neglect.

It is important to remember that these are only predictive indicators: we do not fully understand why some children 'escape' these poor outcomes. However a good understanding of these factors can help us ensure we target our offer of support to children, young people and families who need them most.

These are usually grouped into three domains:

- Individual risk factors: e.g. learning disability, communication needs, low self-esteem, early bonding and attachment, ill health
- Risk factors in the family: e.g. domestic abuse, inconsistent boundaries, hostile or rejecting relationships, parental mental health problems or substance misuse issues
- Risk factors in the school or community: e.g. socio-economic disadvantage and parental unemployment, discrimination or bullying, absenteeism from school

Interventions to develop protective factors in these three domains have been shown to alleviate some of the predicted negative outcomes for children by building resilience, such as

- For the individual: problem-solving skills, the ability to reflect
- In the family: at least one good parent/carer - child relationship, affection, clear, firm and consistent parenting

- In the community: engagement in education, financial inclusion

Critical to the early identification of these factors are some of the universal services commissioned within the health offer, such as Maternity and Health Visiting, who have a clear mandated universal role for screening and assessment, alongside with wider offer within Primary Care, Schools and the Community. The Early Help Gateway should enable better quality of referrals to the commissioned support offer.

Targeted services are characterised as those that are more intensive, often implementing evidence based interventions that can require specific skills and training. Within this there may be a range of "brief interventions" or consultancy that more specialist services can offer to enable the Early Help Plan meet need, without taking on the care coordination (or lead professional) role for the whole care package.

However, where family need is multiple and complex this may require a more intensive care plan coordination by one of the commissioned services. Importantly, as children and families move in and out of specialist services, these roles remain should in contact with the child, young person and family, providing continuity for and supporting them to maintain changes made through specialist interventions.

With clear increase on demand of services this targeted and intensive support is critical at this stage to de-escalate need.

Diagram 1: Key aspects of the commissioned service offer in scope

<table>
<tr><td colspan="3">Improve outcomes and empower families so that they can manage their own need with the support of Universal Services
  </td></tr>
<tr><td colspan="2"></td><td>Specialist /Statutory Service Interventions</td></tr>
<tr><td>Early Help - Support to the whole system to meet need
• Early Help Single Point of Contract
• Universal Health Offer and Health Promotion offer</td><td>Early Help – Brief Intervention
• Additional support to existing early help plans for families presenting with multiple risk factors
• Evidence based targeted interventions</td><td>Targeted Support and Intervention
• To meet multiple and complex need in children, young people and families.
• Preventing escalation to specialist provision (including repeat referrals)
• Enabling exit from specialist interventions and ongoing support to implement change or recovery</td></tr>
<tr><td colspan="3">Consolidation of Workforce Development Offer</td></tr>
</table>

6.3 Transition

When a young person turns 18, although legally an adult, ideally their needs should determine which service they are supported by. In the SEND agenda and Leaving Care agenda, Children's Service retains responsibility for young people up until 25 and 21 respectively. Alongside some vulnerable

young people may not be ready for an adult service. Equally some 16 year olds may be ready to receive support from an adult commissioned service. It is therefore important to consider building in flexibility across the four strategies to enable young people to access the service that best placed to meet their needs. This could involve some review of how we commission services across the age range.

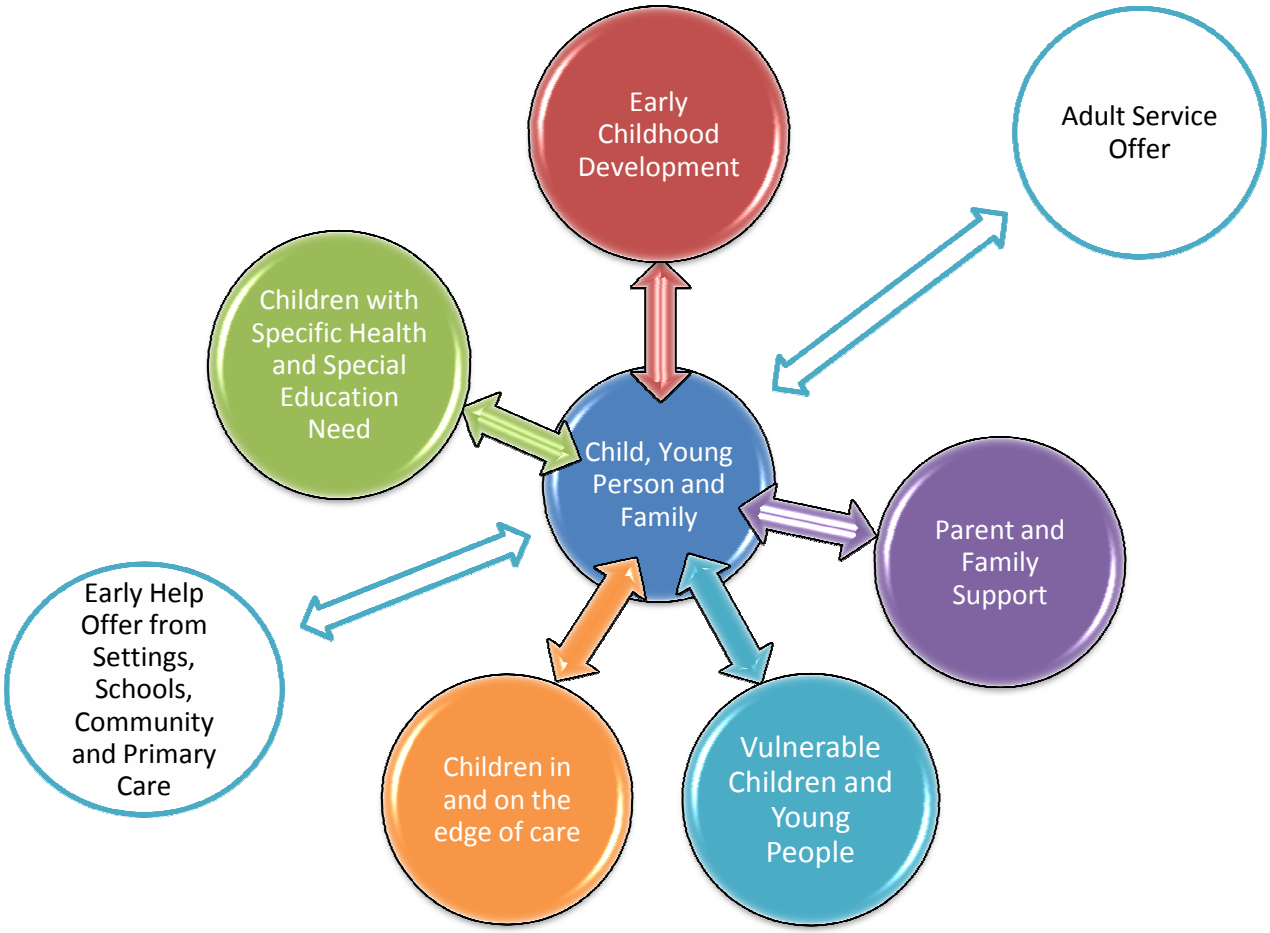
7.0 VISION FOR THE FUTURE SYSTEM OF SERVICES

The future design of children's services needs to be able to describe a clear offer for children, young people and families based on need that cannot be met through the wider system of services within schools and the community. In order to start to describe this offer, it is helpful to create some categories under which a service response sits.

The purpose of services categories is to move children's service provision away from individual service response to narrowly defined groups of children, or single need presentation and outcomes expectations. They are therefore predicated on a response to groupings of children and families who may require a similar type of service response or whose risk factors to positive outcomes are similar.

However, whatever presenting issues are chosen to determine these categories, we will not necessarily create whole system of support within a single category that will meet whole family need, as family need is complex. The offer within these categories therefore needs to be seen building blocks that sit alongside each other and are accessed according to the most appropriate response to the child and family.

This strategy sets out five core categories of services to inform future commissioning to form an offer of integrated service provision to meet presenting need. Using these categories we can appropriately review the effectiveness of our responses to particular need and facilitate an appropriate review for opportunities for integration.



7.1 Parent and Family Support

There is a strong evidence base, which demonstrates the need to ensure a holistic response to whole family need that understands the impact of adult need on children and the interdependency between intervention for both children and adults.

In many ways Parent and Family Support is central tenant to an offer in all children's services and is delivered as a part of a range of service offers, including the offer in early years and from schools.

This category is not therefore designed to encompass the whole offer of family support, but rather the focus on developing systematic workforce development approach to families and the provision of relevant family support and interventions for those who need them most.

Where are we now?

Currently there are several family support offers across a number of Council delivered services. They have all been developed to meet slightly different needs, and have their own criteria, thresholds and targets.

Despite the impact of individual services, our needs analysis highlights a picture of increased demand on specialist services, including an increase number of child protection cases for families with multiple needs.

A review of the current Family Support offer in Council undertaken by the transformation team, highlights that whilst there was some really good examples of positive impact on families, there are some clear challenges in respect to the system of support as a whole:

- Consistent and meaningful recording of family need, making it unclear that the right families are targeted.

- Too many different referral points and separate service offers, making it difficult to negotiate thresholds and access support.
- Lack of ability to identify duplication of support and track families through the offer.
- Lack of consistency in measuring the impact of intervention on the whole family

What works?

National evidence in relation to domestic abuse, neglect, improving outcomes for "troubled families" and children at the edge of care, presents a case for a strong offer of a whole family approach, underpinned with evidence based practice.

There is little documented hard evidence for one type of family support model providing a footprint for a Family Support Service. However "Working with Troubled Families: A guide to the evidence and good practice" reviews the work of family intervention projects (FIP's) and identifies five "family intervention factors" that families report making a difference.

There is an emerging evidence base that combining this intervention approach with workforce development that ensures all workers are trained in an evidence based parenting intervention can be effective in improving family resilience

In Plymouth

- Our Family Intervention Project has been evaluated by Plymouth University in successive years and demonstrated positive impact on families.
- We deliver a range of evidence based parenting interventions. Whilst drop out between referral to uptake of these is significant, families who do attend report positive outcomes.
- Plymouth also implements an alternative to a family intervention model in Family Group Conferencing, this evidence based model which is focussed on the wider family making safe plans for children, enabling many to stay within their family network as an alternative to going into care.

Future Service Delivery

Plymouth will develop a single response through a Targeted Family Support Offer, through:

- Developing the role of the "Single Point of Contract" to identify family risk factors and enable whole family care planning where in Early Help plans for children are not able to deliver outcomes because of family need.
- Creating a single set of criteria for intervention to the targeted intervention, based on focussing resources to families with multiple risk factors that prevent positive outcomes for children and young people.
- Delivering a range of brief interventions and more intensive evidence based interventions to meet need.
- Ensuring consistent workforce development across the service and implementing a family intervention model combined with an evidence based parenting support model, with an offer of training to the wider family support workforce.

Ultimate Outcome Expectations:

a) Ensuring children and young people are able to remain safe and healthy with families, where appropriate

b) Increase in aspiration across the whole family

c) Prevent intergenerational poor outcomes, ensuring positive transition to adulthood

<table>
<tr><td colspan="3">Improve outcomes and empower families so that they can manage their own need with the support of Universal Services
  </td></tr>
<tr><td colspan="2"></td><td>Specialist /Statutory Service Interventions
Complex birth deliveries
Access to specialist medical services (midwifery)</td></tr>
<tr><td>Early Help - Support to the whole system to meet need
• Single Point of Contract
• Support to Early Help Plans for families with multiple needs to ensure whole family view and identification of family risk factors
• Tracking outcomes for families (including implementation of FWAF cost benefit tracking requirements)</td><td>Early Help – Brief Intervention
• Additional support to existing early help plans for families presenting with multiple risk factors
• Evidence based targeted interventions</td><td>Targeted / Intensive Support and Intervention
• To meet multiple and complex need in children, young people and families.
• Preventing escalation to specialist provision (including repeat referrals)
• Enabling “step down” from specialist interventions.
• Centrally managed but deployed across the system where necessary
• Retaining specialisms with ability to transfer knowledge to wider workforce
• Crisis response</td></tr>
<tr><td colspan="3">Workforce development to implement a family intervention model combined with an evidence based parenting support model, with an offer of training to the wider family support workforce.</td></tr>
</table>

Commissioning Approach

Internally remodel services into a single service to meet this need, with some resource identification to transfer to the Early Help single point of contract.

Due to the significant pressure in children’s social care, this service will remain Council provided at this time. This will allow an ability to forge clear links with social care and ensure families are appropriately “stepped down” from child protection plans and children are diverted from care.

Remodelling to be complete January 2015. As a part of this remodelling the service will have a detailed service specification and new performance framework.

A full review will be undertaken after 2 years of the demand on this service and performance and outsourcing through tender will be re-considered at this point in time.

7.2 Early Childhood Development

There is a significant evidence base that identifies that the first few years of a child's life are pivotal in securing life opportunities. This is a critical period in the child's cognitive, language, health, social and emotional development, where the brain develops most rapidly. Negative impact from parental poverty, chaotic lifestyles and poor parenting in these years can affect the lifelong outcomes including poor examination results, higher rates of teenage pregnancy, lower rates of employment, higher rates of depression and suicide and substance misuse.

This category is therefore designed to ensure we make the most of our resources in key health, and wellbeing services we commission to provide the best start to life for children, with a core aim of maximising our opportunity to reduce lifelong inequalities

Where are we now?

The business case presented to Cabinet in Oct 2013 highlighting the new model for Children's Centre provision set out a clear vision for an Integrated Early Childhood Offer. This was based on an evidence for a clear national review of best practice. Our consultation with parents also gave us some clear messages about choice, access to information and advice and early help.

Since 2013 we have therefore been developing the infrastructure to enable easier planning between services, including:

- Clustering children's centres from 17 individual centres to 6 clusters to enable easier contact and planning between services
- Ensuring ICT in children's centres to enable health visiting, midwifery and council employees to access their case notes and files
- Developing co-location of delivery in children's centres

Over the course of the last three years there has been significant investment in Health Visiting service for families with 0-5 year olds. This has involved a focus on training new recruits alongside increased expectations in the delivery of a universal health advice and assessment offer to ensure children are developing well in their first few years. By March 2015 Plymouth will have 90 qualified health visitors, from a position of 46 in 2012. In October 2015 the responsibility to commission this service comes into the Local Authority.

Alongside this core to the expectations of both the Health Visiting and Children's Centre Contracts since 2014 has been the expectation to implement an asset based approach to building the capacity of the community to support each-other in early childhood. Aside from peer support in breastfeeding, this offer is still in its infancy.

However the refocus of support and investment in health visiting has not yet impacted significantly on some of our key outcomes. As the needs analysis reflects that, despite some good practice and some improvement, we are still struggling to meet core public health outcomes, such as breastfeeding and reduction of smoking in pregnancy. We also have an on-going increase in the number of families being referred to social care and on child protection plans.

The changes made over the last year, and the conclusion of the training of health visitors is genuinely significant opportunity to build on our history of partnership working to develop a clear integrated response to need through the co-design of critical pathways of support to meet our priority needs.

Some examples of good practice are

- Our Great Expectations ante-natal course, which is a delivered as a collaboration between Midwifery, Health Visitors and children centre staff is currently nominated for a national good practice award. Evidence suggests positive impact on combating social isolation and improving breastfeeding rates.

- Our Early Years Panel helps the allocation of additional resource for children with additional needs.
- We provide a good range of workforce development opportunities to staff from nursery and pre-school settings to help them support additional needs.

What works?

A core element of the Early Years offer is a universal health offer, in maternity some of this sits in a payment by results framework. Key to successful service models across the country, is how this universal health offer enables the early identification of additional needs that can then be managed through a range of interventions, some medical or health based and some from the rest of the Integrated Early Years offer. At the core of this delivery is an integrated response from health visiting and children centres that utilises the skills within these services to best effect.

There are several ways of delivering this, from full integration, with management in children's centres (Brighton), to the development of integrated pathways to meet need, with clear requirements for differing services cascaded into contracts with services.

Work done by the Early Intervention Foundation has been researching a number of best practice options for integration, including:

- Identifying outcomes frameworks for all early years' services. .
- A toolkit for Integrated Pathway Approach – including a pathway for universal and early intervention services from conception to five that is populated with evidence based programmes to support key outcomes
- A workforce competency framework
- Information sharing and joint management of family need

Ultimate Outcome Requirements

a) Improve child development & school readiness (reducing inequalities)
b) Improve parenting to ensure children are safe
c) Improve child and family health and life chances (reducing inequalities)

Future Service Delivery

<table>
<tr><td colspan="3">Improve outcomes and empower families so that they can manage their own need with the support of Universal Services
  </td></tr>
<tr><td colspan="2"></td><td>Specialist /Statutory Service Interventions</td></tr>
<tr><td>Early Help - Support to the whole system to meet need
• Early Help Gateway
• Development of more information and advice, including a more broad approach to ante-natal education, available through Plymouth Online Directory
• Universal Health Offer – an increase in the universal screening and assessment</td><td>Early Help – Brief Intervention
• Coordination of Early Help plans for families presenting with multiple risk factors
• A range of evidence based targeted and group interventions to meet known need including
○ Breastfeeding and nutrition
○ Early help for low mood as part of the post natal</td><td>Targeted Support and Intervention
• To meet multiple and complex need in children, young people and families.
• Preventing escalation to specialist provision (including repeat referrals)
• Enabling "step down"</td></tr>
</table>

offer, including an integrated two year old development check and the implementation of the emotional and social development screening module of "ages and stages" • Universal Healthy Child Programme • Access for Vulnerable children to nursery provision • Building Community Capacity - including volunteering and peer support.	depression pathway ○ Parenting programmes and increasing parental capacity ○ Speech language and communication ○ Emotional development and behavior problems	from specialist interventions.
Clear pathway that enables an appropriate response to priority needs including: • Pre-natal identification and intervention for vulnerable families (including those with parental substance misuse, previous children taken into care, domestic abuse) • Breast feeding and nutrition • Identification of additional needs through the implementation of the social and emotional screening tool		
Review of workforce development offer to ensure building capacity to meet emotional wellbeing and behaviour problems, child development, working with vulnerable families and speech language and communication		

7.3 Children with Specific Health and Special Educational Need or Disabilities

The Children and Families Act 2014, outlines a clear new approach to ensuring that children with special educational needs and disabilities receive coherent education, health and care plans to enable them to achieve the best outcomes they can.

The core focus for this are those with moderate to severe learning disability (including where the young person also has an autism spectrum condition), a physical disability or sensory impairment where there is a significant impact on day to day life, complex health needs where there is a significant impact on day to day life. However within this agenda is also a clear drive to capacity build "Early Help" to meet need of those with broader educational needs, as soon as they are identified.

Within SEND there is a clear category for children with Medical Conditions/Syndromes, including those with Epilepsy, Asthma, Diabetes, Anaphylaxis, Downs and other syndromes, complex medical needs including continuing health care needs and Mental Health Issues. This agenda therefore covers a significant aspect of community paediatric care, with a focus on how this integrates with education and social care support systems.

SEND Code of Practice: 0 to 25 years: Statutory guidance for organisations who work with and support children and young people with special educational needs and disabilities sets out core ambitions for joint commissioning to ensure the best use of resources to achieve:

- personalised, integrated support that delivers positive outcomes for children and young people,
- bringing together support across education, health and social care from early childhood through to adult life,
- improved planning for transition points such as between early years, school and colleges, between children's and adult social care services, or between paediatric and adult health services

Where are we now?

Plymouth has been undertaking a whole system review of services for children and young people with SEND in order on from the changes brought about by Children and Families Act 2014, including changes that encompass

- Existing Statements of special educational needs and Learning Disability Assessments (LDAs) will be replaced by Education, Health and Care Plans
- Age eligibility for Education, Health and Care Plans extends from 0-25 years
- 'Local Offer': Local Authorities must publish, in one place, information about Education, Health and Care provision they expect to be available in their area for children and young people from 0 to 25 years who have special educational needs and disabilities (SEND).
- Joint Commissioning arrangements to be in place.
- All children and young people with an Educational, Health and Care Plan will have the option to request a Personal Budget.

The full service education review will be completed by the end of January 2015 and will inform decisions regarding future requirements for a commissioning business case.

However there is also a need to fully review the health system, particularly to meet children with medical needs, clearly defining the extent of gaps that are currently being reported, such as the continuing healthcare offer, interventions for children with ASC. A full review of the paediatric service offer is therefore needed.

Some examples of good practice are:

- Plymouth Local Offer developments have re-shaped the Plymouth Online directory and initial feedback from stakeholders, including parents has been very positive
- Plymouth's model to deliver integrated "wrap around" care for children with severe and profound Learning Disabilities has prevented high cost out of area placements
- Plymouth's Short Break Offer has developed a wide choice for families from holiday play schemes to overnight care that help build resilience and independence for children and support the family in delivering care and support for their disabled children.

What works?

The SEND reforms are an area of work that demand a significant shift to integrated commissioning in order to enable the delivery of services that provide holistic care for children and young people.

In 2013 the DfE established SEND pathfinder projects to test new arrangements for the commissioning and delivery of services. Under these pathfinders a number of good practice examples have been implemented, including:

- The development of coordinated assessment and planning processes for Edcuation,. Health and Care Plans
- Establishing joint commissioning teams across health to drive forward integration of delivery.
- Establishing pooled budgets for children with complex needs, including those with Continuing Health Care.

Ultimate Outcome Expectations:

a) Children and young people are able to remain safe and healthy with their families, where appropriate

b) Children and young people have good health outcomes, including mental health, behavioural and emotional need

c) Children and young people are engaged in education to achieve their full academic potential

d) Young People are successful prepared for adulthood, including independent living and employment

Future Service Delivery

Improve outcomes and empower families so that they can manage their own need with the support of Universal Services

		Specialist /Statutory Service Interventions
Early Help - Support to the whole system to meet need	Early Help - Brief Intervention	Targeted / Intensive Support and Intervention
The expectation is that the majority of SEN support will be the responsibility of the school or provider where the student attends. • Resource into the Single Point of Contract to support early help system co-ordination and tracking of Early Help plans • Keep Local Offer up to date • Information and advice available through the Plymouth Online Directory/Single Point of Contract for parents and professionals. • Training and consultation to schools and the wider workforce.	Provide training and consultation model that promotes toolkits to into the wider service offer to mainstream the ability to manage BESD, SLCN, ASC and complex behavior problems, including up skilling workforce delivering: • Family Support • Vulnerable CYP • Early Childhood Development • School Pastoral Support Continue to develop brief interventions to meet specific need, including health promotion interventions.	Commission an Integrated Health and Social Care Service that has the ability to respond flexibly and appropriately to wrap care around the needs of the child. Ensure framework contracts in place for a range of support, such as • Domiciliary Care • Short Breaks • Residential School Placements

7.4 Vulnerable Children and Young People

We know that whilst a family approach to this need is crucial, we still need an offer of support focussed on children and young people as individuals to promote wellbeing and address the needs of

for those at risk of, or presenting with risk-taking behaviour, emotional, social and mental health problems, including:

- aggression and violence;
- sexually harmful behaviour;
- drug and alcohol misuse;
- mental health problems;
- offending and anti-social behaviour
- BESD or other learning needs;
- risk of sexual exploitation;
- missing from school and education
- difficulty engaging in education, employment or training
- caring for an adult or sibling (young carers)

The rational for this individual support being seen as a system is that there are a range of risk factors and protective factors that are similar predecessors for children and young people developing these difficulties. There is also a similarity the interventions to address these needs at a prevention, early help and targeted level that promote resilience. Even some more specialist interventions for these differing presentations have their roots in a similar theoretical framework. Alongside this many children and young people who present with one of these issues, often present with at least one of the other needs listed, and therefore require a holistic response that takes this into account.

Where are we now?

In response to the Emotional Wellbeing and Mental Health Strategy 2009 – 2014 and the Early Intervention and Prevention Strategy, there have been a number of developments to better target the services in this system. This includes a range of brief interventions into schools, and some targeted service response to need.

The Healthy Child Quality mark has also been developed to improve the schools offer in respect to emotional wellbeing and mental health education, sex and relationship education and healthy lifestyles.

In order to promote better interagency working for children with multiple and complex need, the CAF is implemented to achieve a team around the child. However the delivery of these multi-agency plans is often hampered by individual services thresholds, targets and outcome requirements. The response to the child or young person can be overly determined by the originating difficulty or indeed the service they originally present with, rather than a system response to the holistic need. The feedback from stakeholders is that is can still be difficult to secure the right support for the child.

The increased demand on specialist services, such as social care, mental health, emergency department and inpatient paediatrics also indicated an inability of service to intervene early to prevent escalation of need.

We also need to try and secure service planning that moves from a risk/ deficit model of intervention to an asset based approach, building on the skills, talents and resilience of our children and young people.

Some good practice examples are:

- An Intensive Support Team (IST) for young people has reduced the number of 16/17 year olds entering care
- A Missing, Intervention and Support Team (MIST), supports those missing from home and at risk of child sexual exploitation

- Emotional Literacy Support Assistant training to school support workers, providing them with tools to manage emotional distress

What works?

Learning from best practice, research and local services evidenced that where co-ordination of response is built into the design of services responses are more effective. Reviews of integrated systems successful joint working relies on four key principles: 1. sharing responsibility, decision-making, planning of services and intervention. 2. Partnerships between professionals that rely on trust and respect and valuing contributions in pursuing common goals, 3. Interdependency, with each professional able to rely on the others' contribution and expertise to achieve improvement in family outcomes. 4. Sharing power with all those in partnership, including the young person and, where applicable, the family.

There is a need to further explore service models that truly allow service collaboration, stripping away the barriers and processes which can prevent young people getting the right support at the right time. This could be done through commissioning an increasingly integrated system based upon a 'value chain' whereby the work done by one provider or source of support is built upon and amplified by another – achieved through focusing on relationships between providers and all other forms of support collaborating to achieve a set of shared outcomes.

Ultimate Outcome Expectations:

e) Children and young people are able to remain safe and healthy with families, where appropriate

f) Improve health outcomes, including mental health, behavioural and emotional need

g) Engagement in education to their full academic potential and have confidence and ambition to successfully transition to further education, training or employment

h) Positive transition to adulthood

Future Service Delivery

<table>
<tr><td colspan="3">Improve outcomes and empower families so that they can manage their own need with the support of Universal Services
  </td></tr>
<tr><td colspan="2"></td><td>Specialist /Statutory Service Interventions
Drug and alcohol treatment
Dual Diagnosis
Mental Health Treatment</td></tr>
<tr><td>Early Help - Support to the whole system to meet need
Health Child Quality Mark
Creation of a core and traded offer to education providers from all services in respect to</td><td>Early Help – Brief Intervention
• Early help brief interventions on arrange of issues to meet need.</td><td>Targeted / Intensive Support and Intervention
One threshold, wrap around support and joint ownership of outcomes for those with multiple and complex need.</td></tr>
</table>

• Sexual health and healthy relationships • Drug and alcohol education • Emotional Wellbeing		
An collaborative service model delivering to a shared set of outcomes across a range of health, education and community based services. Creative solutions to address these needs with our young people and focus on "strengths" based, rather than "deficit" based model. Confident, competent and collaborative workforce able to undertake joint assessments and share risk management.		

7.5 Children in and on the edge of care

When families are struggling to protect their children from harm or are not able to cope with their needs, more focussed and intensive support is needed. Working Together to Safeguard Children 2013 is clear of the duty on all services to respond to the needs of these families. All services in the other categories play a key role in delivering intensive support to families under a child protection plan.

This category is therefore designed to cover the more bespoke assessments and enhanced interventions needed to address the complex need of this cohort. If a child is taken into care there is a range of other additional provision is then needed to enable the creation of stable and permanent alternatives to family homes.

Where are we now?

The Looked after Children Strategy 2014-15 highlights some key achievement for our looked after children population, including good performance in placing children to adoptive parents and improvement in academic achievement.

However there are some critical challenges, as highlighted in the overview of need and performance, including

- An increase in numbers subject to a plan
- An increase in numbers of children in care
- A core cohort of complex children for whom placement stability is hard to achieve
- An increase in the number of young people needing residential care or secure placements, including placement out of area.

What works?

Information from Ofsted Inspections highlight Local Authorities achieving better outcomes children and young people in and on the edge of care, have a focus on permanency planning for the children and young people in care, including ensuring timely planning for those who can move to adoption.

Critical to this are good processes in respect to placement matching and a sufficient and high quality provider market of appropriate placements that can meet the wide range of needs in this cohort.

However the placement itself may not provide all the support needed and to enable future stability and permanency. The right multi-agency support needs to be in place to enable children and young people to overcome trauma and build resilience. This applies equally to those needing to remain in care, those moving to adoption and those who have the potential to return home.

Critical, then, to meeting the needs of this cohort is ensuring a multi-agency response to their needs, where all professionals planning a response together, especially to meet the needs of high risk and vulnerable young people.

There are a range of developing integrated and evidence base models that support this approach, elements of which need to inform future service planning.

In Plymouth there are some good examples of how we are addressing some of this need:

- We have established an independent parent and child assessment team to enable robust assessments of attachments and parental capacity to inform court decisions for young children. This has been successful in maintaining attachments at the same time as safeguarding young children whilst assessments are undertaken in a timely manner, informing clear permanency decisions can be made.
- We have developed a missing person's service, with Police, Youth Workers and Social Workers working together to ensure looked after children missing from their placements children are located quickly, a review of placement is undertaken and on-going support is provided.
- We have developed residential placements within Plymouth to prevent children with complex needs being placed outside of the city boundaries.

Ultimate Outcome Expectations:

a) Permanent arrangements for children who cannot live with their families, which will meet their needs through to adulthood.

b) Children who present with complex needs and high-risk behaviour to remain safe and stable, with increased resilience.

c) Looked after children participate in education, reach their full academic potential and have confidence and ambition to successfully transition to further education, training or employment

d) Improve health outcomes, including mental health, behavioural and emotional need

Future Service Delivery

	<u>Specialist /Statutory Service Interventions</u> Sufficient high quality placements with pooled budget for education, health and social care funding where necessary. Further development of Adoption Support Offer Joint Local Authority

			arrangements for adoption placing
Early Help - Support to the whole system to meet need	Early Help	Targeted / Intensive Support and Intervention	
Commissioning of links between services and Early Help and Multi-Agency Advice and Assessment	Personal Education Plan from the education setting.		Clear integrated health, social care and education response with one common threshold and a flexible service offer to meet the needs of children in and on the edge of care. Multi-agency "wrap around" response to ensure permanency for children and young people, with clear focus on those at risk of residential care or placement instability.
Workforce development offer to ensure create a confident, competent and collaborative workforce that is able to assess and appropriately manage and de-escalate risk.			

7.6 Available Resources

The current approximate commissioning budget against each service element is described in the table below. This does not reflect the total investment in the system and much of the provision is out of scope of this strategy or delivered through 'in house' services.

Table

System element	Approximate current budget
Children with specific health, special educational needs or disability	£6,865,572
Early childhood development	£8,931,663
Parent and family support	£324,511
Vulnerable children and young people	£2,186,655
Children in and on the edge of care	£8,841,701
Total	£27,150,102

7.8 Measuring Future System Performance

The following outcome performance indicators have been identified as key to measuring how this strategy contributes to improvements across the whole health, wellbeing and social care system in Plymouth. These will form part of a comprehensive performance dashboard that will be used to monitor an overview of the system.

Indicator	National	Plymouth	Impact on system – why is this a measure	Trajectory
PHOF 1.01i Children in Poverty	18.6	20.2	Improvement in these indicators will impact positively on the life chances of life chances of children reducing potential future pressure on the wider health, wellbeing and social care	
PHOF 1.05 16-18 year olds not in education, employment or training	5.3	7.7		
PHOF 2.08 Emotional wellbeing of looked after children	13.9	16.6		
PHOF 2.02i Breastfeeding initiation	73.9	71.5	Children will lead healthier lives which sustain into adulthood and prevent / delay need for care and support service in the 'community' and 'complex' strategies	
PHOF 2.06i Excess weight in children	23.5	25		
Number of Children in Care	TBC	TBC	These are indicators of how well our system in managing and de-escalating need, with the clear aim to enable as many children as possible to live at home or in a family environment as in order to secure more positive outcomes.	
Number of Children in Residential, Tier 4 Mental Health or Secure Placements	TBC	TBC		

8.0 COMMISSIONING INTENTIONS

In order to deliver this service model the following commissioning activities will need to be undertaken.

Create a system for Early Help Coordination			
Commissioning Intention	Milestones 2015/16	Milestones 16/17	Milestones 17/18
Implement agreed Early Help operating model	Partnership review and shaping of Operating Model and Gateway	Clear inter-relationship between Gateway, DRSS, Multi-Agency Advice and Assessment (Safeguarding), Schools Early Help Offer and Early Years Offer in place and understood by partners.	
	Review the Information, Advice, Guidance, Consultancy / Mediation offer in commissioned services to scope what might go into Gateway	All appropriate resources are available for the Information, Advice, Guidance, Consultancy and Mediation Offer are directly accessible from the Gateway (as part of an actual and/or virtual integrated team)	
	Review and integrate the current systems for referral to targeted services.	Gateway has become the referral point for the targeted offer	
	Agree outcome monitoring framework (including Families with A Future Payment by Results Framework and tracking)	Payment by Result Claims for agreed target of families generating income for future service delivery.	Payment by Result Claims for agreed target of families generating income for the Council
Ensure Gateway is fully able to facilitate support in line with requirements of the SEND agenda, including an up to date and refreshed Local Offer	Integration of SEND single Point of Contact and migration of functions and processes into the Gateway		

Further develop the use of the Plymouth Online Directory	Review of resource needed for Plymouth Online Directory (POD), ensuring on-going refresh of the Local Offer.	Further develop the Information and Advice capability of the POD.	
Family Support			
Commissioning Intention	Milestones 2015/16	Milestones 16/17	Milestones 17/18
Implementation of model of one Targeted Family Support Service	Development and Agreement of new service model for operations (including Service Specification and Outcome Monitoring)	Ensure appropriate interface of targeted family support offer with the rest of the Family Support offer within Early Help System. Review sufficiency of specialist leads within the service.	Full review of demand on and impact of new model with due consideration of future commissioning options.
Create sufficiency of evidence based Parenting Support Programmes designed to improve parenting capacity to manage behaviour issues.	Develop business case and implementation of findings of Parenting Support Programme review - including agreeing partnership approach with schools as part of co-commissioning for vulnerable children and young people.	Sufficient availability of parenting courses and reduced disengagement	
Integrated Early Childhood Services			
Commissioning Intention	Milestones 2015/16	Milestones 16/17	Milestones 17/18
Implement shared outcome framework for Early Years Contracts	Negotiate and implement shared outcomes and KPI's for contracts with Maternity, Health Visiting in line with Children Centres/ 2013 parent consultation and CCG Maternity Commissioning Strategy.	Review of delivery of Joint KPI's, to drive improvements to integrated offer.	Review of delivery of Joint KPI's, to inform improvements to integrated offer.

Ensure successful transition of commissioning of Health Visiting Service, with greater operational integration with Children Centres	Implementation of new Service Specification agreed with NHS England and provider (March 2015) Contract in place with Local Authority (October 2015)		
	Development of joint operating models, including opportunities for joint funding/ resourcing of activities, in line with agreed pathways.	Review progress and developments under the Building Community Capacity strand of the Health Visiting and Children Centre Contracts, including progress in developing volunteering.	
Development of and accessible Early Years Community Based Offer	Co-location and joint delivery plan in place for Health Visiting and Midwifery in Children's Centres, making the best use of accessible community buildings.	Full co-location of Health Visiting	
Develop and deliver new pathways across maternity, health visiting and children centres in response to priority need	Develop and implement priority pathways and interventions for: • Vulnerable parents and families • Breastfeeding nutrition and exercise • Children with developmental or additional needs Implement early help brief interventions to prevent parental low mood and improve attachment Review need and agree next set of priority pathways.	Integrated Early Years Review (Autumn 2016). • Joint pathways are developed and embedded, with clear improvement in integrated working (stakeholder review) • Families tell us their experience of the service has improved (since the 2013 consultation) • Interventions we have identified as gaps are implemented. • Impact on KPI's Agree future commissioning approach as a result of the review options for future delivery.	Implement agreed option for future delivery through either: • Tender for new service • Take up option to extend existing contracts • Take up option to extend contracts with agreed variation contracts Variation to Maternity Services Contract if necessary

Integrated Health, Education and Disability Services for children and young people with SEND			
Commissioning Intention	Milestones 2015/16	Milestones 16/17	Milestones 17/18
Develop greater join up in the Short Break Offer	Develop Commissioning Plan for Short Breaks Reshape the targeted and specialist services (including in house) Pool Short break funding with health	Business case for tender short specialist short break and brokerage services with clear rational for any potential outsourcing of existing PCC resource. Strengthen a single pathway for all short breaks	New offer implemented
Develop greater choice, and quality in16+ Education Placements for Children with SEND	Market Development - including review of quality and sufficiency and referral processes	Business Case and tender for Framework contracts for 16+ education placements	Implementation
Improve the Autistic Spectrum Condition Pathway, including transition arrangements.	Establish a joint transition pathway with health, education and adult social care.	Business case for capital investment to develop short break provision for children with ASC and/ or complex behavior problems (supporting prevention from care agenda)	Short breaks for ASC vulnerable children implemented
Full Integration of Education, Health and Social Care Services	Implement initial agreed changes to specifications developed in light of new SEND requirements. Functional analysis and scoping of PCC delivered SEND offer. Full review of CCG contracts relevant to SEND, including the Paediatric service offer. Develop initial changes to ensure co-delivery for 16/17.	Implement initial co-delivery models. Develop business case for Full Integration, including • Scope • Full options appraisal in respect to delivery body and commissioning processes.	Implementation of new model
Develop greater access to Personal Budgets	Health and social care budgets up and running	Education personal budgets available	

Ensure specialist provision for education matches need	SEN review regarding special school and specialist provision completed and considered at schools forum	Re-commissioning of provision commences	Implementation of SEND place planning continues
Commissioning pathways of care for vulnerable children			
Commissioning Intention	Milestones 2015/16	Milestones 16/17	Milestones 17/18
Develop a Co-Commissioning Plan with schools for a mental health and behaviour pathway across tiers 1 – 4.	Partnership co-design of an integrated pathway from prevention to intervention, to meet known gaps in provision including • Complex and risk taking behavior • Children with ASC and complex behavior • Self-Harm Develop joint funding / resourcing approaches with schools, for contribution to business case for collaborative services - see below	Appropriate procurement activity – see below	
	Develop the market in respect to opportunities for the purchase of support to the Healthy Child Programme in relation to: • Sexual health and healthy relationships • Drug and alcohol education • Emotional Wellbeing • Healthy lifestyle (incorporating public health TRIVE)	Develop the market in respect to their options to offer bespoke services to schools and social care. (see also services for children in and on the edge of care). Develop options appraisal for the commissioning and quality assurance of the bespoke offer (see also children in care).	

Develop outcome focussed and flexible service response to meet the needs of vulnerable children (in conjunction with schools)	Create a business case for alliance or collaboration of provision to meet key needs in respect to mental health, risk taking behaviour and educational/ social exclusion. To include: Scoping of services best placed in an alliance approach, with review of: • In house/ outsourcing decisions re: Plymouth City Council based services • Current offer in health preferred provider.	Tender for an alliance or collaboration including the delivery of • Evidence based brief interventions • Intensive support for most at risk • Diversionary activities, (maximising access to the assets of leisure, business and community services) • Building community capacity (including the use of volunteers)	Implement new service model.
Children in and on the Edge of Care			
Commissioning Intention	Milestones 15/16	Milestones 16/17	Milestones 17/18
Shape the residential market through a pilot of a block contract with a provider to secure appropriate bed spaces in 20 mile radius of city	Agree model on business case, implement procurement. Establish clear implementation plan and referral processes.	Review the model with a view to whether to: • Continue to commission a block contract • Integrate into the expectations within the Peninsula Tender Process	
Develop integrated "wrap-around" support service response to the needs of adolescents	Pilot approach with small number of high risk young people, through the creation of bespoke packages of care.	Agree commissioning and quality assurance model for bespoke and personalised commissioning. (see also vulnerable children)	

(and their families) at the edge of care (and able to live at home), at risk of placement instability, in or at risk of need high cost or out of area placement.	Implement project to scope and manage the transformation of services to meet known need in this cohort of adolescents.	Agree final business case for a wrap-around approach including scoping and options to: • Commissioning as part of the vulnerable as a part of a collaboration/alliance tender • Developing an in-house integrated multi-disciplinary service for this cohort	Implement and review
Shape the sufficiency and quality of the foster and residential market.	Complete residential cost and quality benchmarking process. Develop quality assurance and service modeling for the residential market. Create business case for the future Peninsula Framework	Tender Peninsula Framework Contracts Re-tender foster care cost and volume contract	Implement new contracts

ANNUAL COMMISSIONING PLAN 2015/16 - Children and Young People's Services

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
Early Help	Agree outcome monitoring framework (including Families with A Future Payment by Results Framework and tracking)	Outcome Monitoring Framework in place to track effectiveness of Early Help	Joint	April 2015
	Review the Information, Advice, Guidance, Consultancy / Mediation offer in commissioned services to vary contracts to ensure Single Point of Contact for Early Help	Integration of information and advice functions into Gateway.	Joint	September 2015
Family Support	Service Specification and Performance Monitoring in place for Targeted Family Support Service (in house)	Performance Monitoring Framework Agreed Demonstrable impact on improving outcomes for children and young people at the edge of care	Plymouth City Council	April 2015 September 2015
	Business case to improve sufficiency of evidence based Parenting Support Programmes - including agreeing partnership approach with schools and partners.	Improved sufficiency of evidence based Parenting Support Programmes to improve parenting capacity to manage behaviour issues – including agreement of co-commissioning with schools.	Plymouth City Council	September 2015
Integrated Early Childhood Services	Shared Outcome Framework across 1. Maternity, 2. Health Visiting and Children's Centres	Agreed KPI's in contracts	1. New Devon CCG 2. Plymouth City Council	October 2015
	Successful transition of commissioning responsibility for Health Visiting Contract from NHS England to Plymouth City Council – with agreed specification that	Contract in place	Plymouth City Council	October 2015

	reflects local need.			
	Develop and implement priority pathways and interventions for: 1. Vulnerable parents and families 2. Breastfeeding nutrition and exercise 3. Children with developmental or additional needs	Pathways in place	Joint	1. July 2015, 2. October 2015 3. December 2015
Children with Specific Health and Special Educational Needs and Disability	Develop plan / business case for tender to achieve greater join up in the Short Break Offer	Clear coherent offer planned	Plymouth City Council	December 2015
	Establish a joint transition pathway with health, education and adult social care.	Transition Pathway Agreed	Joint	Sept 2015
	Develop business case for full Integration of Specialist Services, including • Scope • Full options appraisal in respect to delivery body and commissioning processes.	Future model to integrate service agreed, for implementation for April 2017	Joint	March 2016
	Personal budgets for 1. Health and 2. Social Care up and running	Access to personal budgets available	1. NEW Devon CCG 2. Plymouth City Council	December 2015
	Market development for greater choice, and quality in 16+ Education Placements for Children with SEND	Broader offer of appropriate placements	Plymouth City Council	August 2015
	Partnership co-design of an integrated pathway from prevention to intervention, to	More coherent and seamless offer of services in place	NEW Devon CCG	December 2015

	meet known gaps in provision including 1. Complex and risk taking behaviour 2. Children with ASC and complex behavior 3. Self-Harm	Clear understanding of future commissioning requirements to meet gaps. Reduction of demand of CAMHS and Social Care Development of joint funding / resourcing approaches with schools, for contribution to business case for collaborative services		
Vulnerable Children and Young People	Create a business case for alliance or collaboration of provision to meet key needs in respect to mental health, risk taking behaviour and educational/ social exclusion. To include: Scoping of services best placed in an alliance approach, with review of: • In house/ outsourcing decisions re: Plymouth City Council based services • Current offer in health preferred provider.	Future model of service agreed, for tender for service to begin April 2017	Joint	March 2016
Children in and on the Edge of Care	Develop Wrap Around Support Model of Care:	New Service model/ way of working in place and delivering improved outcomes for high risk children, including	Plymouth City Council	

	1. Pilot approach with small number of high risk young people, through the creation of bespoke packages of care. 2. Create business case to scope and manage the transformation of services to meet known need in this cohort of adolescents. 3. Implement new way of working	• Diversion of children from care • Reduction in use of high cost placements		1. April – September 2015 2. September 2015 3. March 2016
	Develop a pilot for a block contract with a provider to secure appropriate bed spaces in 20 mile radius of city (in conjunction with Cornwall)	Development of more bespoke models of care Keeping children within 20 miles of Plymouth Continuity of care	Plymouth City Council	Implementation October 2015
	Begin the development of the Peninsula business case for the future Peninsula Framework for placements	Business case for tender for services April 2017 onwards, including • Development of more bespoke models of care • Keeping children within 20 miles of Plymouth • Continuity of care • Value for Money	Local Authority Peninsula Commissioning Board	March 2016,

APPENDIX 3 KEY MESSAGES FROM STAKEHOLDER ENGAGEMENT

Emotional Wellbeing, Mental Health and Behaviour Difficulties – Key Messages

The need for an improved response to mental health needs is a common theme within consultation. This includes:

- A desire for greater early help so that people can access support prior to need escalating
- Improving access to services and reduction of waiting lists
- Clearer understanding of thresholds

From stakeholder feedback, this also appears to be linked to the rise in Behaviour, Emotional and Social Difficulties (BESD) and Autistic Spectrum Conditions (ASC), and a challenge the separation of the "mental health" system from challenges of the wider behaviour and social difficulties children experience. This is particularly acute in children presenting with complex behaviour problems to disability services and social care.

For children with co-morbid presentations of potential ASC and mental health conditions there is an interagency protocol between community paediatrics and CAMHS to manage referrals. However the pathway is managed from with two different service responses and feedback from families suggests children and young people can continue to be passed between services, with an unsatisfactory holistic care plan.

Young People's Feedback

In 2013/14 a number of participation projects were commissioned to review the offer around particular vulnerabilities for young people, including alcohol and substance misuse, domestic abuse, and key work with vulnerable young people. Some key messages from young people engaged in this work were:

- Young People want and need quality information about all aspects of domestic abuse and violence. They report knowing and being taught very little about it in school, or in any other part of their lives.
- Young People were not aware of characteristic warning signs in a relationship that might signal or lead into an abusive relationship.
- Young People feel that in general, the school curriculum focuses too much on Sex Education and on contraception, and not enough on relationships.
- Single sex work should be promoted within current commissioned and provided services to ensure that women and young girls have the best opportunity to consider the issues from their perspective – this should also be considered with the school curriculum.
- PHSE should be supported by specialist or independent professionals from outside of the school staff. It is important for young people to feel that they can trust viewpoints as being authentic and well informed.
- The skill level and commitment of staff are paramount to successful outcomes being achieved.
- The establishing of a meaningful and trusting relationship with a young person and their family takes time and the workers needs to be afforded adequate time to enable this relationship to develop.

Key messages from professionals

There are a number of key messages that have arisen in consultation respect to how the system of services responds quickly to emerging need, this includes:

- The need to better equip parents to support behaviour difficulties and children with ASC

- Better join-up/integration of services – including whole family approaches;
- Improvement in information sharing between services
- Increase awareness across stakeholders of what support/services are available
- Improve the capacity of the workforce who have contact with families and parents to deliver Identification and Brief Advice (IBA) interventions should be built – consideration of how parents role model drinking should be explored within this approach.
- There should be more training and support for the staff in areas such as communication with children with SEND
- Need to deliver flexible "wrap around" support to children in care and vulnerable children, which meets their individual needs and helps to sustain their home or placement
- Need to streamline and coordinate the planning, assessment and evaluation tools used by workers as this may enable an effective measurement of impact.

Early Years – Key Messages

In 2013 an extensive consultation was taken with parents and stakeholders, which produced some key messages:

- Parents overwhelming wanted the ability to choose the most appropriate children's centre services for their family, regardless of postcode boundaries**.**
- Parents highlighted gaps in the provision provided by Early Years Services, these included;
    - Practical demonstrations: how to make up a bottle feed, bathing a baby, coping with twins.
    - Support with early parenting: children's eating and sleeping routines.
    - Increased support: when a parent leaves hospital especially in the first few days and with breastfeeding.
    - Mental Health: Many parents shared their experiences of suffering with low mood and/or Post Natal Depression. Many of these women suffered in silence, until they hit crisis point.
- Parents over whelming embraced the idea of parents becoming trained volunteers. They also wanted to play an active part in fund raising, paying donations for services and/or helping to fund raise in order to help the sustainability of services into the future.

More recent consultation with stakeholders has highlighted some other key pressures, including:

- Access to interpreting and translating services to manage the increase in families with EAL
- Supporting parents with children with behaviour problems, reflecting the increase in ASC and BESD
- Understanding the importance of creating effective home learning environments;
- The importance of engaging fathers, who are often not well engaged with Early Years Services.

SEND - Key Messages

The changes to support for children and young people with special educational needs and/or disabilities (SEND) started from 1 September 2014 and have involved consultation and joint planning with all stakeholders including schools, providers Health services and Commissioners and parents and young people.

COMMISSIONING STRATEGY FOR WELLBEING

DRAFT

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Part: I

DOCUMENT CONTROL

Version	Date	Author	Change Ref	Pages Affected
1.0	080914	Sarah Lees / Dave Schwartz	-	-
1.1	011014	Sarah Lees / Dave Schwartz	Removal of substance misuse/ offending/mental health/ homelessness and transitions services	Across document
1.2	151014	Sarah Lees / Dave Schwartz	Incorporation of Katy Shorten input	Across document
1.3	261114	Sarah Lees / Dave Schwartz	Refinement of document through feedback from ODPH + updating latest needs data	Across document
1.4	031214	Sarah Lees / Dave Schwartz	Refinement of document through feedback	Across document
1.5	161214	Sarah Lees / Dave Schwartz	Further refinement	Across document
1.6	231214	Sarah Lees / Dave Schwartz	Wellbeing definition & action plan	Relevant pages
1.7	170205	Sarah Lees / Dave Schwartz	Redraft following initial consultation with LA and CCG colleagues	Across document

QUALITY REVIEWERS: (General QA and accuracy)

Name	Position	Signature	Date

FINANCE SIGN OFF:

Name	Position	Date

CONSULTATION PATHWAY:

NAME

Table of Contents **Page Number**

1.0 EXECUTIVE SUMMARY

This Commissioning Strategy supports transformative change through creating a significantly enhanced focus on prevention at a population level as well as through targeted approaches. It supports healthy and happy communities in Plymouth by supporting and utilising social networks, increasing investment in public health and putting health and wellbeing at the heart of everything we do. It covers people of all ages across the whole life journey.

The Strategy drives forward a step change in how we will support and improve people's capacity to live healthy and happy lives and in doing so reduce the level of health inequality across the city. It does so by setting out the framework into which, over time, an increased proportion of investment from the whole health and social care system will be focused on prevention. Through targeting this investment in evidence based interventions this approach will improve outcomes for more people and so reduce pressure on services in the city. This approach will support value for money and produce efficiencies.

A successful strategy will:

- Improve the well-being and health of the people of Plymouth through increasing the capacity of individuals, families and communities to meet the challenges of everyday life
- Deliver stronger, safer more inclusive communities which will reduce demand and increase assets
- Reduce the number of preventable deaths in the city
- Reduce health inequality in the city
- Enable individuals, families and communities to be empowered to make decisions and influence decisions regarding their wellbeing and health including decisions regarding services they may need to use
- Enable key stakeholders including local communities to actively join in a shared process of system and service design
- Over time reduce the spend on high cost intensive interventions for the City

The Strategy will have at its heart the use of the 4-4-54 construct. This is known in Plymouth as 'Thrive'. This approach will tackle the key 4 behaviours that contribute to the 4 key illnesses that cause 54% of all deaths in the city. Focusing on these four behaviours will have the biggest impact on well-being and health across the city, and reduce the pressure on the wider health and social care system

The Strategy describes five key elements to a wellbeing system (with Thrive as the focus) into which the commissioning intentions sit. These elements area:

- Comprehensive advice, information and advocacy
- Strong safe communities and social capital (community networks and resources)
- Health promotion and healthy lifestyle choices
- Low level preventative support
- Emotional wellbeing and mental health

Commissioning intentions linked to these elements within a wellbeing system are set out for the first year.

Whilst the benefits of improving wellbeing are high so is the challenge. The health of people in Plymouth is varied compared with the England average. Deprivation is higher than average and an estimated 21.6% (11,335) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Plymouth than in the least deprived areas.

Out of the 32 health indicators presented in the Annual Health Profile, produced by Public Health England, Plymouth has 17 that are significantly worse than the English average.

Over the years many approaches have been taken to address the health inequalities in Plymouth. Whilst these have seen some success, inequalities still persist. What this tells us is that we must work differently as partners and leaders if we want to significantly reduce health inequalities.

The Health and Social Care Act 2012 provides new and exciting opportunities to work across health and social care and address the key issues that undermine the health and wellbeing people in Plymouth. In Plymouth we are implementing a single commissioning process and a single budget to work from that integrates the Health and Social Care agenda.

In Michael Marmot's landmark report, 'Fair Society Healthy Lives', he states, "The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes". We will be seeking to create an environment that builds social capital and facilitates co-production between commissioners, services and communities.

The opportunities provided through the Health and Social Care Act 2012 and the enhanced drive to engage with local communities is the key to how we work differently and this Strategy sets out our programme for improving health and wellbeing in that context.

2. INTRODUCTION

2.1 Background – Strategic Challenge

Public Sector organisations across the country are facing unprecedented challenges and pressures due to rising demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities. Until recently the complexity and scale of our system-wide challenge has been difficult to understand and local organisations have, as a result, focussed mainly on meeting their own challenges. A lot of this work has been successful and this has delivered much that is good right across our system. However we know that this existing good practice will not be enough to meet the current challenge. This means a new imperative for joint and collaborative working across all the organisations that commission and deliver health and wellbeing in our area.

Recognising these challenges and within the context of a system's leadership approach Plymouth Health and Wellbeing Board has agreed a vision that by 2016 we will have developed an integrated whole system of health and care based around the following elements:

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

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

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

2.2 An Integrated Commissioning Response

In order to meet the challenges facing Plymouth, New Devon CCG and Plymouth City Council have agreed to develop a single commissioning function working towards jointly approved commissioning strategies and pooled budgets.

The primary driver of this is to streamline service delivery and provision with the aim of improving outcomes for individuals and value for money. Integrated commissioning must deliver integrated wellbeing.

To support this strategic aim 4 commissioning strategies have been developed that stretch across the spectrum of early years, health, social care, and wellbeing need in Plymouth.

Figure 1

These co-dependent Commissioning Strategies aim to move the balance of care towards prevention in order to improve life chances, manage demand and improve health outcomes. Specific aims of this systems approach includes;

- Provide and enable brilliant services that strive to exceed customer expectations
- People will receive the right care, at the right time in the right place.
- Improve pathways and transitions
- Help people take control of their lives and communities.
- Children, young people and adults are safe and confident in their communities.
- People are treated with dignity and respect.
- Prioritise prevention
- Sustainable Health and Wellbeing System
- Improve System Performance

2.3 Purpose of the Strategy

Each strategy describes the current and projected need in Plymouth, as well as the local and national strategic context that the future system will need to address / respond to. They also describe current provision how the existing system is performing.

This then builds into a vision of Plymouth's future system over a 5 year period, and details of how commissioners in Plymouth will achieve this through a series of annual implementation plans setting out and signalling to the market commissioning priorities, and how the impact of these will be measured across the system.

2.4 Implementation and Action

System Design Groups against each strategy will drive the implementation of the identified commissioning priorities within each strategy.

2.5 Finance

Table 1 provides an overview of how the current commissioning budgets in scope for integration are currently spread across the system.

Full detail on the existing resources allocated within each strategy area is provided in the 'current provision' section.

Table1

Strategy Area	Approximate total spend	% of spend in each Strategy area
Children and Young People	£27,150,102	6.72%
Wellbeing	£20,752,235*	15.03%
Community Care	£119,742,637	29.62%
Complex Care	£196,616,072	48.64%
TOTAL	**£404,261,046**	

An additional £40 million of prescribing spend is currently being linked to the Wellbeing Strategy but further discussions need to take place to determine the best place to hold this budget and the implications in doing so

2.6 Principles for the commissioning of services to deliver well-being outcomes

- The focus will be on those issues likely to have the biggest positive impact on the whole system
- Services designed to incorporate and utilise community assets
- Co-produced with key stakeholders including service users and communities
- Services that empower people and communities to improve and maintain their own health and wellbeing
- Services commissioned to meet need across the whole life journey in line with the Marmot Review
- Services commissioned using high quality public health intelligence and delivering evidence based support and intervention

- Where needs cluster together (two or more needs that are often interdependent) then options appraisals on the commissioning approach will always include alliance contracting
- Services that have effective and seamless links and pathways including in and out of the community system, complex system and the children and young people's system
- Recognition that services need to be designed with families in mind
- Relevant services need to support transition for young people from children services to adult services
- Child protection and safeguarding is integral to system and service design
- Safeguarding adults at risk (vulnerable adults) is integral to system and service design
- Services need to be designed to meet an increasingly diverse population

2.7 Definition of Wellbeing

There are many descriptions and definitions of wellbeing. Plymouth's Health and Wellbeing Board recognised that people have different views of what it means to them personally and for their communities. The Board adopted a holistic view of health and wellbeing based on four broad and wholly interrelated and co-dependent components;

The Mind ; including mental health and wellbeing, happiness, personal growth, development and learning

The Body ; including physical health and wellbeing, having the best start in life, growing and ageing well, having access to good jobs, homes and health services

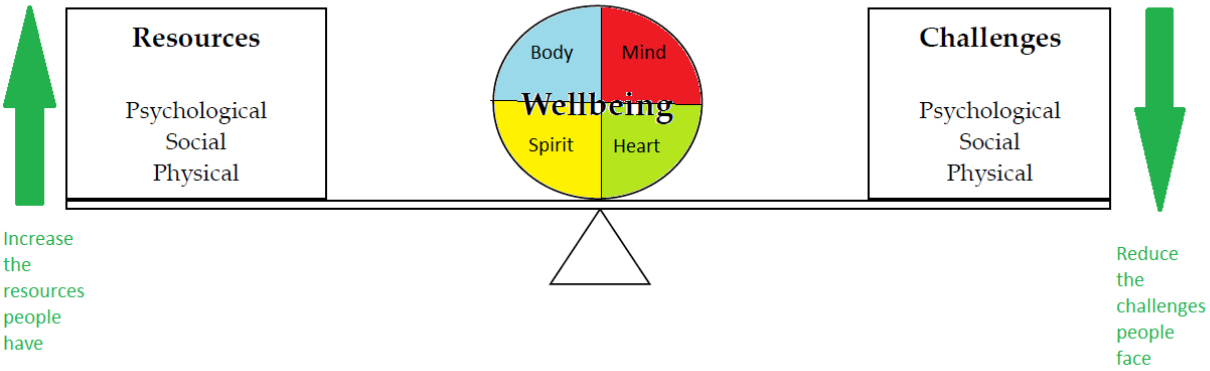
The Heart : including social health and wellbeing, having good friendships, loved and valued, valuing others and engaging with the world around us

The Spirit : including a sense of community, of meaning in life, a sense of belonging and of making a difference

In seeking a definition of wellbeing that is universally applicable, easily understood and yet conveys the multi-faceted nature of wellbeing, the following definition[1] will be used. This definition sees wellbeing as the balance point between and individual's resource pool and the challenges that they face. In the diagram below, the circle representing wellbeing can be seen to be in balance, at the centre of the see-saw. Balance or equilibrium is achieved when the resources of the individual are able to meet the challenges that they face. When individuals have more challenges than resources, the see-saw dips, along with their wellbeing. A lack of challenge for an individual would equally cause a dip in wellbeing. This represents a dynamic definition of wellbeing and reflects the human preference to return to a set point of wellbeing that is defined by the individual. The Health and Wellbeing Board definition can be incorporated into this diagrammatic representation if the circle of wellbeing is made up of four quadrants of mind, body heart and spirit.

[1] Dodge, R., Daly, A., Huyton, J., & Sanders, L. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing, 2*(3), 222-235. doi:10.5502/ijw.v2i3.4

Figure 2



In the context of this commissioning strategy, services that support wellbeing will be aiming to build an individual's capacity to meet the challenges they face in their lives and also contribute to a wider approach of addressing the determinants of health and wellbeing by reducing unacceptable challenges that people face e.g. poor quality housing. The scope of this commissioning strategy includes a wide range of public health services, such as health improvement, smoking cessation and sexual health promotion.

Services for children and young people that can be described as universal / preventative are covered within the accompanying Commissioning Strategy for Children and Young People.

2.8 Scope

Services covered by the Strategy include those that:

- empower people to maintain and improve their own health and wellbeing
- build active and supportive networks among people within communities (social capital)
- enable individuals, families and communities to meet a range of challenges they may experience in their lives
- provide low level support to help enable people to stay in their homes safely in their community

3.0 NEEDS ASSESSMENT

Further data, including data at a sub-city level, as well as the definitions clarifying the use of the data can be found among the suite of Joint Strategic Needs Assessment (JSNA) reports held on Plymouth City Council's JSNA web site[2]

PLYMOUTH'S DEMOGRAPHY

3.1 The population

Plymouth's population has grown by over 15,000 people (an increase of 6.4%) from 2002 to 2012 (mid-year population estimates shown in Table 1). All six localities have increased in population size, with the largest percentage increase in the South West (12.1%) and South East (12.0%) localities. The smallest percentage increase occurred in Plymstock (1.9%).

Table 2: Mid-year population estimates (all ages) for Plymouth localities and Plymouth, 2002-2012

Year	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
2002	49.727	51.805	29.301	24.234	35.118	52.365	242.550
2004	49.699	51.841	29.438	24.235	35.850	52.974	244.037
2006	50.316	52.180	29.345	24.545	37.554	55.238	249.178
2008	50.864	52.307	29.656	24.698	38.426	56.537	252.488
2010	50.855	52.261	29.747	24.680	39.063	57.621	254.227
2012	51.488	53.779	30.029	24.687	39.342	58.701	258.026
% change	3.5%	3.8%	2.5%	1.9%	12.0%	12.1%	6.4%

Source: Office for National Statistics

It is estimated that Plymouth's population will increase by over 16,000 by 2030 (Table 2). The largest increase will be seen in 75+ year olds (54.6%), whilst it is estimated there will be a 5.2% reduction in the 30-64 year old population.

Table 3: Sub-national population projections by age group, 2012-2030

Age group	2012	2015	2020	2025	2030	% change
Under 18	50.912	51.482	53.645	55.241	55.102	8.2%
18-29	52.613	53.779	53.169	52.133	54.820	4.2%
30-64	111.026	109.880	109.002	107.814	105.247	-5.2%
65-74	23.367	24.964	25.584	25.569	28.205	20.7%
75+	20.108	21.210	23.904	28.511	31.091	54.6%
90+	2.119	2.296	2.700	3.475	4.432	109.2%
All ages	258.026	261.315	265.304	269.268	274.466	6.4%

Source: Office for National Statistics

[2] www.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna.htm

3.2 'Protected Characteristics' (Equality Act 2010)

The Equality Act 2010 sets out nine personal characteristics that are protected by the law:[3] These are, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, Religion or belief, sex, sexual orientation

3.3 Age

As outlined in 3.1, Plymouth currently has a population of 258,026 (Table 1). Due to an estimated 35,000 to 40,000 students residing in the city, the proportion of 18-24 year olds (13.2%) is higher than that found regionally (8.8%) and nationally (9.3%). The proportion of the working-age (16-64 year old) population (65.7%) is higher than that regionally (62.1%) and nationally (64.1%). The city has the third lowest percentage of people 75 years and over, and the eighth lowest percentage of children and young people (under 18) of the 16 Southwest county and unitary authorities (2012).

3.4 Disability

According to the 2011 Census, 10.0% of Plymouth residents reported having a long-term health problem or disability that limits their day-to-day activities a lot and has lasted, or is expected to last, at least 12 months (including problems related to old age). The national value was 8.3%.

According to the 2011 Census, 46.0% of Plymouth residents reported their general health as 'very good'; this increased to 79.5% when also including those who reported their health as 'good'. In England 81.4% of people reported their general health as either 'very good' or 'good'. Plymouth's combined value is therefore nearly two percentage points lower than the national average.

3.5 Faith, religion or belief

According to the 2011 Census, Christianity is the most common religion in Plymouth. 32.9% of the Plymouth population stated they had no religion. Those following Hinduism, Buddhism, Judaism or Sikhism combined totalled less than 1.0%. 0.5% of the population had a current religion, such as Paganism or Spiritualism.

3.6 Gender - including marriage, pregnancy and maternity

Overall, 50.5% of Plymouth's population is female. According to the 2011 Census, of those aged 16 and over 90,765 (42.9%) people are married. There were 3,418 live births in 2012. The number of births has increased annually from 2,547 in 2001, except in 2011 when the number was the same as 2010 (3,280 births in each year).

3.7 Gender reassignment

In 2010, it was estimated nationally that the number of gender variant people presenting for treatment was around 12,500. Of these, around 7,500 have undergone transition. The median age for treatment for gender variation is 42 years. There is no precise number of the trans-gender population in Plymouth.

3.8 Race

There is relatively little ethnic diversity in Plymouth. According to the 2011 Census, 96.1% of Plymouth's population considered themselves White British. This is significantly higher than the England average (79.8%). Plymouth has lower percentages of residents within each ethnic group compared with the national average. However, despite the small numbers, Plymouth has a rapidly rising BME population which has doubled since the 2001 census. The main ethnic

3 http://www.equalityhumanrights.com/private-and-public-sector-guidance/guidance-all/protected-characteristics

minorities in Plymouth are the Polish (0.7%; just over 1,900) and the Chinese (0.5%; just over 1,200).

3.9 Sexual Orientation - including Civil Partnership

There were 21 Civil Partnership Formations in Plymouth in 2010, 24 in 2011, and 30 in 2012. 5,190 (2.5%) of people in Plymouth are separated and still either legally married or legally in a same-sex civil partnership. There is also no precise local data on numbers of Lesbian, Gay and Bi-sexual (LGB) people in Plymouth but it is nationally estimated at 5.0% to 7.0%. This would mean that approximately 13,300 people aged 16 years and over in Plymouth are LGB.

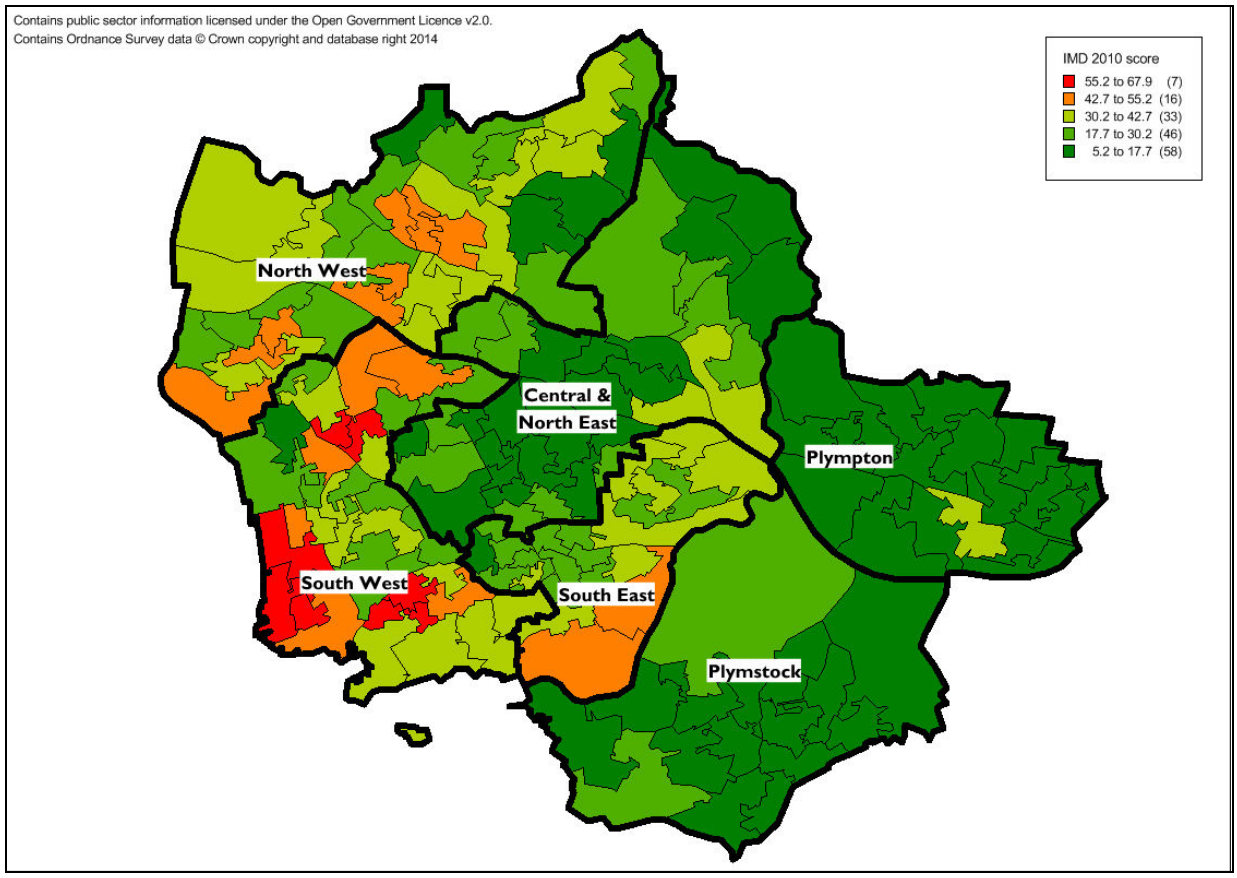
In summary

Key challenges for Plymouth are that there is expected to be a significant increase in the number of people living beyond 75; there are higher levels of long term health problems or disability when compared nationally; there are lower levels of reported good or very good health when compared nationally and there is a growing and diverse BME population.

3.10 Deprivation

The English Indices of Deprivation 2010 use 38 separate indicators to calculate the Index of Multiple Deprivation 2010 (IMD 2010). The IMD 2010 score is calculated for every Lower Super Output Area (LSOA) in England. LSOAs typically have a population of around 1,500.

Figure 3: Index of Multiple Deprivation (IMD) 2010 scores by locality and Lower Super Output Area (LSOA) within Plymouth. Higher scores reflect higher levels of deprivation.



Source: Department for Communities and Local Government

According to their relative level of deprivation, Plymouth is ranked 72 out of 326 (1=most deprived; 326=least deprived). This places Plymouth just above the bottom 20% of local authorities in England. In comparison, Salford was ranked 18, Bristol 79, and Newcastle-upon-Tyne 150. Out of 32,482 LSOAs in England, Plymouth has two in the 4% most deprived, two in the 3% most deprived, two in the 2% most deprived and one in the 1% most deprived in the country.

Separate analysis has been carried out by the Public Health Team in Plymouth City Council to identify the most or least deprived localities in the city. Table 3 sets out the findings. The locality with the highest score (i.e. the most deprived) is the South West, with the North West and South East localities also scoring highly. The locality with the lowest score (i.e. the least deprived) is Plymstock, followed by Plympton and Central & North East localities.

Table 4: Index of Multiple Deprivation (IMD) 2010 score by locality

Locality	IMD 2010 SCORE
Central & North East	16.4
North West	32.1
Plympton	12.1
Plymstock	11.4
South East	28.5
South West	39.7
Plymouth	25.6

Source: Produced by the Public Health Team, Plymouth City Council, from Department for Communities and Local Government data

In summary Plymouth is one of the more deprived areas in the country. There is a significant national and international evidence base that demonstrates the impact of deprivation across a wide range of measures covering wellbeing and health. Michael Marmot's report 'Fair Society Healthy Lives' provides a comprehensive overview of this for England and he reported:

- There is a social gradient in health – the lower a person's social position, the worse his or her health.
- 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.

OVERVIEW OF PLYMOUTH

3.11 Introduction

The Health Profiles published by Public Health England (PHE) provide an overview of the general health of the local population. They present a set of key indicators that, through comparison with other areas and with the national average, can highlight potential problems locally. They are designed to help local government and health services identify problems and decide how to tackle them to improve health and reduce health inequalities. Figure 4 sets out Plymouth's Health Profile for 2014. A summary of selected indicators is provided below Figure 4.

3.12 Public Health England's Health Profile for Plymouth 2014

Figure 4: General health profile for Plymouth 2014

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Health Summary for Plymouth

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

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

Regional average^ | England Average | England Worst | 25th Percentile | 75th Percentile | England Best | England Range

Domain	Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1 Deprivation	67,594	26.2	20.4	83.6	0.0
	2 Children in poverty (under 16s)	10,140	22.4	20.6	43.6	6.4
	3 Statutory homelessness	92	0.8	2.4	33.2	0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1,727	60.8	60.8	38.1	81.9
	5 Violent crime (violence offences)	4,585	17.9	10.6	27.1	3.3
	6 Long term unemployment	1,471	8.7	9.9	32.6	1.3
Children's and young people's health	7 Smoking status at time of delivery	564	16.7	12.7	30.8	2.3
	8 Breastfeeding initiation	2,327	69.1	73.9	40.8	94.7
	9 Obese children (Year 6)	392	17.5	18.9	27.3	10.1
	10 Alcohol-specific hospital stays (under 18)	43	84.7	44.9	126.7	11.9
	11 Under 18 conceptions	167	39.5	27.7	52.0	8.8
Adults' health and lifestyle	12 Smoking prevalence	n/a	24.0	19.5	30.1	8.4
	13 Percentage of physically active adults	n/a	59.2	56.0	43.8	68.5
	14 Obese adults	n/a	24.7	23.0	35.2	11.2
	15 Excess weight in adults	399	60.0	63.8	75.9	45.9
Disease and poor health	16 Incidence of malignant melanoma	53	20.7	14.8	31.8	3.6
	17 Hospital stays for self-harm	623	229.2	188.0	596.0	50.4
	18 Hospital stays for alcohol related harm	1,752	708	637	1,121	365
	19 Drug misuse	2,372	13.9	8.6	26.3	0.8
	20 Recorded diabetes	12,188	5.5	6.0	8.7	3.5
	21 Incidence of TB	5	5.9	15.1	112.3	0.0
	22 Acute sexually transmitted infections	2,281	889	804	3,210	162
	23 Hip fractures in people aged 65 and over	280	592	568	828	403
Life expectancy and causes of death	24 Excess winter deaths (three year)	142	19.5	16.5	32.1	-3.0
	25 Life expectancy at birth (Male)	n/a	78.3	79.2	74.0	82.9
	26 Life expectancy at birth (Female)	n/a	82.1	83.0	79.5	86.6
	27 Infant mortality	14	4.1	4.1	7.5	0.7
	28 Smoking related deaths	457	342	292	480	172
	29 Suicide rate	27	10.8	8.5		
	30 Under 75 mortality rate: cardiovascular	174	86.3	81.1	144.7	37.4
	31 Under 75 mortality rate: cancer	336	166	146	213	106
	32 Killed and seriously injured on roads	65	25.3	40.5	116.3	11.3

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

Out of the 32 health indicators presented in the Annual Health Profile (2014), produced by Public Health England, Plymouth has 17 that are significantly worse than England.

Table 5. Regional centre comparisons of health profiles (n=11)

		Number of significantly worse measures out of 32
1	Bournemouth	9
2	Brighton and Hove	12
	Bristol	12
3	Sheffield	14
4	Leeds	16
5	Plymouth	17
	Southampton	17
6	Newcastle upon Tyne	18
7	Portsmouth	20
8	Liverpool	21
9	Salford	22

Plymouth and Southampton are placed in the middle of our comparator regional centres with just over 50% of all the measures being significantly worse than the England average

Selected indicators where Plymouth's value is 'better' than the England average:

- Statutory homelessness
- People diagnosed with diabetes
- Road injuries and deaths
- Long-term unemployment
- Incidence of TB

Selected indicators where Plymouth's value is 'worse' than the England average:

- Under 18 conceptions
- Alcohol and drug misuse
- Adults smoking
- Sexually transmitted infections
- Incidence of malignant melanoma
- Early deaths from cancer

Selected indicators where Plymouth's value is 'not significantly different' to the England average:

- Obese children (Year 6)
- Obese / excess weight in adults
- Physically active adults
- Infant deaths
- Early deaths from heart disease and stroke
- Hip fractures in people aged 65 and over

3.13 Housing

There are over 114,000 dwellings in Plymouth with most of the city's housing stock being in the private sector. Plymouth has lower than average levels of home ownership, but greater amounts of private rented housing.

Table 6: Number of differing types of dwellings and proportion of total housing stock in Plymouth with a comparison with England

Owner occupied 64,998 dwellings	Plymouth 59.5%; England 64.2%
Privately rented 21,095 dwellings	Plymouth 20.2%; England 16.8%
Social housing 22,026 dwellings	Plymouth 19.3%; England 17.7%
Living rent-free 1,188 dwellings	Plymouth 1.1%; England 1.3%

Table 7: Housing Conditions in Plymouth 2010/11

Tenure	Non decent (%)	Category 1 hazard (%)	Disrepair (%)	Thermal comfort (%)	Fuel poverty (%)
Owner	32.0	19.3	8.5	13.0	12.9
Privately rented	37.2	26.1	19.0	20.1	18.4
Social housing	24.8	11.5	4.4	10.2	13.5

Housing conditions in Plymouth are worst in the private rented sector.

There is a clear link in Plymouth between the areas of worst housing condition and the areas of high deprivation and greatest health inequalities.

The most common Category 1 Hazard failure across the private sector is excess cold followed by falls on stairs and falls on the level, contributing to the poor health and well-being of residents and generating significant NHS and care costs.

There is an urgent need to improve housing conditions across the private sector, but notably private rented housing, which has the worst conditions across all sectors, as illustrated below:
8,208 non decent private rented dwellings.
5,758 private rented dwellings with Category 1 Hazards.
4,192 private rented dwellings with disrepair (Decent Homes Standard).
4,435 private rented dwellings failing thermal comfort (Decent Homes Standard).
4,060 private rented dwellings (households) in fuel poverty.

There are high levels of overcrowding in Plymouth. Of the 9,671 households currently registered for social housing through Devon Home Choice (DHC) 1,951 (20%) lack one bedroom and 190 (2%) lack two bedrooms.

3.14 Unemployment and under employment

In 2012 Plymouth's real level of unemployment was estimated at 9.8% of the working age residents, around 17,000 individuals.[4] Furthermore, 'under-employment' is comparatively high in Plymouth, reflecting the rise in part-time working and too few suitable full-time job opportunities being created. Between October 2010 and September 2011, there were 16,000 under-employed people in Plymouth, equating to 13.6% of the workforce.

4 Plymouth's Economic Review Issue 3

3.15 Crime

Despite the increase recorded in 2011/12 there is an overall decreasing trend in Plymouth's crime rate. There were 21,175 crimes recorded in 2009/10 compared to 18,425 in 2012/13 (a reduction of 2,750 or 13%)

Incidents of anti-social behaviour recorded by Devon and Cornwall Police were 40.1 per 1,000 Plymouth residents (2012/13). This is a decrease of 28% from 2011/12.[5]

There were a total of 6,092 domestic abuse incidents in 2012/13. This is a 5% increase (309 incidents) since 2011/12. Of these incidents 33% resulted in a crime being recorded. [6]

In 2012/13 the rate of violence with injury (offences including grievous bodily harm, actual bodily harm and malicious wounding) was 10.0 crimes per 1,000 population (a reduction of 173 crimes (6%) on 2011/12). Of these, 31% were domestic abuse related[7]

3.16 Carers

In England and Wales, there are around 5.4 million people providing unpaid care for an ill, frail or disabled family member or friend. Using data from the 2011 Census, there were 27,247 of these carers in Plymouth. This was a 13% increase on the 2001 census. The majority (57.3%) provided 1-19 hours of care per week but nearly 30% (7,566 individuals) were committing over 50 hours.[8]

ASSESSING NEED: PUBLIC HEALTH INDICATORS RELATED TO WELLBEING .

3.17 Introduction

This section provides more detailed examination of the different health needs of the population on a locality basis but with regards to public health indicators related specifically to wellbeing.

Table 8.

Indicator	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
Teenage pregnancy (rate per 1,000 women)	20.3	42.6	23.0	13.3	30.9	64.4	35.5
Smoking in pregnancy (%)	7.4	22.7	7.3	8.4	17.7	20.8	16.1
Parents who smoke (%)	17.7	29.5	9.2	16.1	32.9	35.9	26.2
Parents who misuse drugs (%)	1.0	4.3	0.8	0.8	2.5	3.7	2.7
Parents who misuse alcohol (%)	0.8	3.1	0.7	0.7	2.1	2.4	2.0
Depressed/mentally ill parents (%)	9.1	17.4	9.4	16.1	18.7	16.2	14.8
Social isolation (%)	2.3	4.2	1.8	4.2	7.8	8.8	5.3
Accident admissions (0-4 year olds) (rate per 1,000 pop)	12.4	20.9	21.6	10.2	27.8	21.6	19.6
Accident admissions (5- 14 year olds) (rate per 1,000 pop)	8.9	13.7	6.8	7.4	13.4	10.8	10.6

5 Strategic Assessment (Crime and Disorder) 2012/13
6 Strategic Assessment (Crime and Disorder) 2012/13
7 Strategic Assessment (Crime and Disorder) 2012/13
8 2011 Census

Accident admissions (15-24 year olds) (rate per 1,000 pop)	9.7	15.0	9.5	10.1	7.9	15.8	11.4
Emergency circulatory admissions (all ages) (rate per 10,000 pop)	107.7	132.1	88.4	100.9	139.4	124.0	116.2
Emergency circulatory admissions (under 75s) (rate per 10,000 pop)	60.2	76.4	45.1	55.2	77.7	81.6	67.7
Admissions from falls (65 years and over) (rate per 10,000 pop)	227.0	208.3	228.7	221.4	250.3	206.8	219.9
Admissions from falls (75 years and over) (rate per 10,000 pop)	388.0	363.8	382.9	380.1	417.2	381.7	381.7
Substance misuse (rate per 10,000 pop)	37.1	76.6	27.6	23.5	101.9	161.0	81.0
Mental health contacts (rate per 10,000 pop)	263.6	320.8	255.8	270.0	303.5	413.5	315.4
Self-harm admissions (rate per 10,000 pop)	29.8	64.8	32.0	19.3	78.5	96.5	53.0
Smoking status (GP referrals) (%)	13.9	22.5	11.9	12.1	21.1	26.5	18.9
Adult obesity (GP referrals) (%)	28.9	36.6	30.7	28.1	31.8	33.0	32.0
High blood pressure (GP referrals) (%)	16.5	17.4	14.4	16.1	12.7	16.5	16.3
One or more risk factors (smoking, obesity, high blood pressure) (%)	49.0	60.2	49.1	46.8	53.6	59.1	53.9
Incidences of melanoma (rate per 100,000 pop)	80.6	59.0	101.3	73.7	69.5	56.1	X
Cancer mortality (under 75s) (rate per 10,000 pop)	12.7	17.1	14.0	17.2	15.2	20.4	16.2

3.18 Teenage pregnancy

Information regarding Plymouth's teenage conception rate at the locality level is not available nationally and is therefore obtained via Plymouth Hospitals NHS Trust. As a consequence, direct comparisons with national statistics are not possible but local data provide a useful proxy. In 2013, Plymouth's conception rate was 35.5 per 1,000 women aged 15-17 years. Conception rates vary considerably across the city with the South West consistently having the highest rate except for 2009 and 2011. The locality with the lowest rate in 2013 was Plymstock. All areas have seen a decrease in conception rates since 2004, with the exception of Plympton.

3.19 Smoking in pregnancy

In 2013, 16.1% of mothers reported that they were smoking at the time of delivery. This equates to a reduction of 6.7 percentage points since 2005. The proportion of mothers smoking in pregnancy is unevenly distributed across the city, with the highest proportion found in the North West (22.7%), South West (20.8%) and South East localities (17.7%). The lowest proportion was in Plympton (7.3%), Central & North East (7.4%) and Plymstock (8.4%). The proportion of mothers smoking in pregnancy has fallen across all the localities except for Plymstock where it increased by 1.4 percentage points.

3.20 Parents who smoke

According to the 2014 survey of health visitor caseloads, 26.2% of parents with children aged less than five years currently smoke. This represents a reduction of 8.3 percentage points since 2002. The distribution of parents who smoke is uneven across the city with a higher percentage found in the South West (35.9%), South East (32.9%) and North West localities

(29.5%). The South West has reduced by 13.9 percentage points compared to Central & North East reducing by 1.8 percentage points since 2002.

3.21 Parents who misuse drugs

The survey of health visitor caseloads suggests that a small proportion (2.7% in 2014) of parents with young children misuse drugs and that this has increased slightly over the period 2002 to 2014.. The distribution across the city shows a higher percentage of parents misusing drugs in the North West (4.3%) and South West localities (3.7%). All localities except for the South West have had an increase in percentage points since 2002; South West has had a reduction of 1.1 percentage points. Anecdotal evidence from the Public Health Team, Plymouth City Council, suggests that these figures and those for alcohol below, may underreport the true position and so the data should be interpreted with caution.

3.22 Parents who misuse alcohol

The survey of health visitor caseloads suggests that a small proportion of parents with young children misuse alcohol and that this proportion has fallen slightly from 2002 to 2014. In 2014, 2.0% of families with young children misused alcohol. The distribution of parents who misuse drugs is higher in the North West (3.1%). All the localities except for the North West and Plympton have reduced percentage points; North West has increased by 0.7 percentage points.

3.23 Depressed or mentally ill parents

The survey of health visitor caseloads suggests that 14.8% of parents with young children were considered to be depressed or mentally ill in 2014; a reduction of 1.3 percentage points since 2002. In 2014, the distribution of depressed or mentally ill parents is uneven across the city, with higher proportions found in South East (18.7%) and the North West (17.4%) compared to Central & North West (9.1%) and Plympton (9.4%). The locality which has had the greatest reduction in percentage points was the South West (7.9%), while Plymstock has increased by 7.6 percentage points in the period 2002-14.

3.24 Social isolation within families

Social isolation has been shown repeatedly to prospectively predict mortality and serious morbidity both in general population samples and in individuals with established morbidity, especially coronary heart disease. The survey of health visitor caseloads suggests that 5.3% of parents with young children were considered to be socially isolated in 2014.

3.25 Emergency admissions in children and young people (unintentional and deliberate)

The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 0-4 years per 1,000 population has gone up by 1.3 from 2007-08 to 2012-13. The distribution of admissions is unevenly distributed across the city, with the South East having a rate of 27.8 per 1,000 population in 2012-13 compared to Plymstock with a rate of 10.2 per 1,000 population

The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 5-14 years has decreased by 1.1 from 2007-08 to 2012-13. The rate of admission is unevenly distributed across the city, with the North West having a rate of 13.7 per 1,000 population in 2012-13 compared to Plympton with a rate of 6.8 per 1,000 population.

3.26 Emergency admissions for circulatory diseases

The hospital admission rate for circulatory diseases has increased by 10.0 per 10,000 population since 2008-09. The South East locality has the highest rate of admissions (139.4 per 10,000 population) compared to Plympton (88.4 per 10,000 population).

The rate of hospital admissions for circulatory diseases in the under 75s has increased by 2.7 per 10,000 population since 2008-09. The South West has the highest rate of hospital admissions (81.6 per 10,000 population) compared to Plympton which has the lowest rate (45.1 per 10,000 population).

3.27 Hospital admissions for falls in adults aged 65 and over

The rate of hospital admissions for falls in adults aged ≥65 increased by 31.6 per 10,000 population from 2008-09 to 2012-13. All six localities have seen an increase in the rate of admissions due to falls since 2008-09. For 2012-13, the South East locality had the highest rate of admissions (250.3 per 10,000 population) compared to the South West locality which had the lowest rate (206.8 per 10,000 population).

During the period 2008-09 to 2012-13, the rate of hospital admissions for falls in adults aged ≥75 increased in Plymouth by 62.8 per 10,000 population. All six localities have seen an increase in the rate of admissions since 2008-09, especially in Plymstock, although the locality with the highest rate was the South East (417.2 per 10,000 population).

3.28 Alcohol-related hospital admissions (all ages)

The rate of alcohol-related hospital admissions in Plymouth has remained static since 2010-11 The rate remains significantly higher than for England.

3.29 Substance misuse (all ages)

Substance misuse is recorded by agencies commissioned by the Office of the Director of Public Health, Plymouth City Council. In 2012-13, substance misuse was unevenly distributed across the city with the highest rate of clients living in the South West locality (161.0 per 10,000 population) and the lowest rate of clients living in Plymstock locality (23.5 per 10,000 population).

3.30 Estimates of population with specific mental health problems

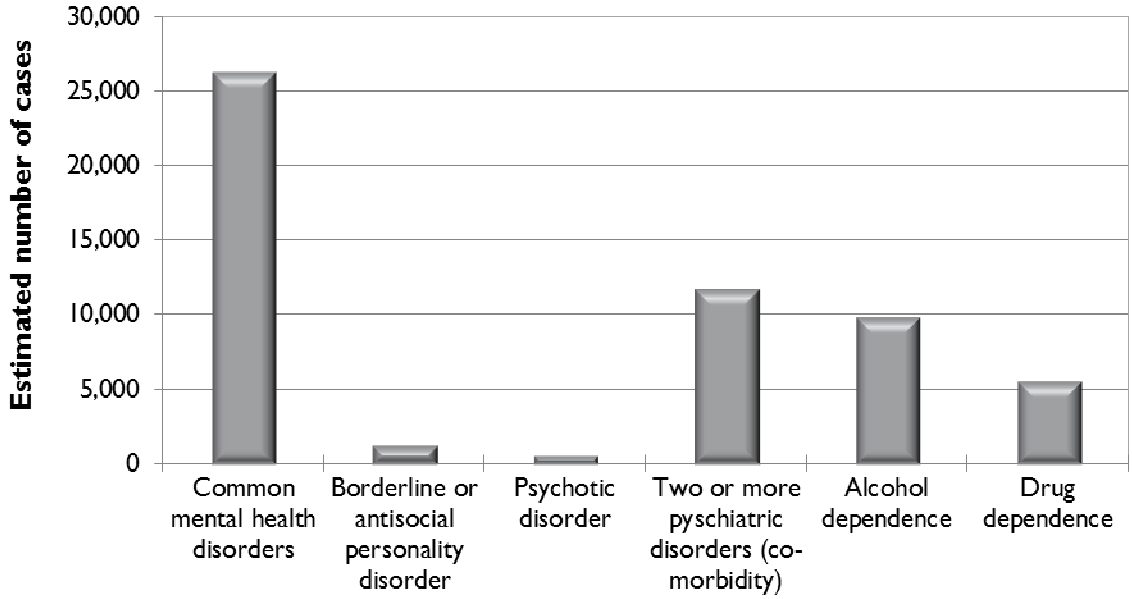
The number of males and females with specific mental health problems (common mental disorder, borderline personality disorder, antisocial personality disorder, psychotic disorder and two or more psychiatric disorders) is expected to increase, with females predicted to have a higher prevalence than males by 2020.

Contacts with the mental health service (a contact is defined as accessing the service for a spell of treatment; a person could have multiple contacts per spell) were unevenly distributed across the city in 2012-13. The South West locality had a crude rate of 413.5 contacts per 10,000 population compared to Plympton with a crude rate of 255.8 contacts per 10,000 population.

The graph below is produced by Public Health England and is from indicators calculated by taking some measure of mental health need. The two used are rates of hospital admission and the proportion of people rated as having a mental health problem in general population surveys.

Figure 5

Estimated 2014 prevalence of mental health problems in 18-64 year olds in Plymouth



The graph demonstrates that common mental health problems, including depression, anxiety and obsessive-compulsive disorder, constitute the greatest proportion of the mental health burden in Plymouth. Drug and alcohol dependence; as well as psychiatric co-morbidity are also very significant.

The mental health needs of Plymouth are estimated to be over 20% higher than would be expected for a city this size, indicating that the City has a high burden of mental ill health[9]

3.31 Hospital admissions for self-harm

The rate of hospital admissions for self-harm, has increased in Plymouth by 4.6 since 2008-09. For 2012-13, admissions were unevenly distributed across the city, with the South West locality having the highest rate of admissions (35.1 per 10,000 population) compared to Plymstock with the lowest (11.6 per 10,000 population).

3.32 Dementia

The estimated number of people with dementia in Plymouth is predicted to reduce for the 65-69 age group but increase in the over 69s by 2020. For the period 2014 to 2020 this increase is estimated to be 513 (from 2957 in 2014 to 3470 in 2020)[10].

The younger age groups (30-64 year olds) are not predicted to change over time.

9 North East Public Health Observatory. MINI and NPMS Needs Indices Data. http://www.mentalhealthobservatory.org.uk/mho/mini (accessed 2 January 2012)

10 Projecting Older People Population Information System (POPPI). www.poppi.org.uk (sourced 17 February 2015)

3.33 Long-term conditions (diabetes, respiratory problems, circulatory diseases, dermatological issues)

The prevalence of diabetes in Plymouth adults (aged ≥16 years) is predicted to increase by 1.1% by 2030 which is slightly less than the figure for England

The prevalence of circulatory diseases in Plymouth adults (aged ≥16 years) is similar to the prevalence for England. For Plymouth, the observed prevalence is less than the estimated prevalence.

The prevalence of Chronic Obstructive Pulmonary Disease (COPD) for the NEW Devon Clinical Commissioning Group (CCG) area is similar to England's average which is under the expected prevalence.

3.34 Smoking status, obesity and blood pressure (based on GP referrals)

The following sections on smoking status, obesity and blood pressure are based on data recorded at time of patient referral to Plymouth Hospitals NHS Trust (for any reason) by General Practitioners (GPs) in Plymouth.

The proportion of patients being referred (for any reason) who smoke in Plymouth, has decreased by 2.1 percentage points from 2010-11 to 2012-13. The locality with the largest proportion of smokers is the South West (26.5%) whilst Plympton has the smallest proportion (11.9%)

The proportion of patients being referred (for any reason) who were obese increased by 0.9 percentage points from 2010-11 to 2012-13. The locality with the largest proportion of obese patients is the North West (36.6%), compared to Plymstock which has the smallest proportion (11.9%).

The proportion of referred patients also experiencing high blood pressure has decreased by 0.3 percentage points from 2010-11 to 2012-13. The localities with the highest proportion of patients with high blood pressure are North West and Plympton (17.4% respectively). In the South East, 12.7% of referrals were for patients who were also experiencing high blood pressure.

3.35 Skin cancer incidence

The incidence of new cases of melanoma in adults in Plymouth (aged ≥16 years) has increased by 48 per 100,000 population from 2007-09 (426 cases) to 2010-12 (474 cases). This is due to a rise in the incidence of new cases of melanoma in males from 2007-09 (198 cases) to 2010-12 (268 cases). Females have seen a reduction in incidence from 2007-09 (228 cases) to 2010-12 (206 cases). For males, the incidence rate is higher in the less deprived localities (Central & North East, Plympton, and Plymstock). For females, the incidence rate is fairly similar across the localities

3.36 Cancer mortality in the under 75s

The directly age-standardised cancer mortality rate for persons aged <75 years per 10,000 population has fallen over the period 2003 to 2012 to 16.2 per 10,000 population in 2012. From 2003 to 2012, the mortality rate in the city fell by 3.2 deaths per 10,000 population. Mortality rates are unevenly distributed across the city, with the South West consistently recording the highest mortality rate and the lowest mortality rate typically in Plympton.

3.37 Predicting future demand

Since 2003 following the 'Mackay vision' Plymouth has aspired to grow to a city in excess of 300,000 population by 2026.

The Office for National Statistics (ONS)[11] projects the total population of Plymouth to reach 271,800 by 2021. This trajectory would not result in Plymouth reaching its target of 300,000 residents by 2026.

To support this ambition the city's Adopted Core Strategy 2007 identifies a housing target of 17,250 new dwellings over the period 2006-21 and a further 7,250 dwellings in the period 2021-26. Much of this development is focused on new housing developments at Plymstock Quarry; the Northern Corridor and regeneration in areas of high deprivation. Sherford New Town will also provide dwellings as the town becomes established.

By 2021 ONS projects growth in the 0-9 age group of 15.1% and continued growth in the 20-29 age group. The 65 years and over age group will grow by 14.7% and will account for 18.0% of Plymouth's total population. An aging population will put pressure on Plymouth's public services, supported housing, and adult social care in particular.[12] In particular the over 75's age-group is predicted to rise from 20,472 in 2013 to 24,731 in 2021.[13]

In line with an increasing population we will also expect to see an increase in the City's BME population. There is a wide diversity to the current BME population and if this profile continues it will also provide challenges in ensuring that access to our services are fair and equitable.

There will clearly be an increase in pressure on health and wellbeing services required by an increasing population and whilst these developments will be linked to increased income generation for the city intelligent, 'smart' use of resources will need to be applied to ensure positive outcomes and efficient services.

3.38 Consultation feedback

During 2013 the Plymouth Fairness Commission set up the 'Summer of Listening'. This was a process whereby local people and other stakeholders were able to tell the Commission what issues they thought were fair and unfair in Plymouth. The following reflect feedback on areas seen as unfair and relevant to this strategy:

- low wages in Plymouth compared to the high cost of living
- personal impact of unemployment and benefit cuts
- lack of affordable homes to buy
- high rents and a lack of suitable social housing
- lack of support for those with a mental health condition
- access to mental health and rehabilitation services
- vulnerability of some older people
- high cost of public transport in the city
- access to healthcare and dentistry
- affordable healthy food
- leisure activities for disabled people and certain ethnic groups
- alcohol and drug-related abusive and anti-social behaviour
- racism and discrimination
- barriers to involvement in community activities
- limited opportunities for community engagement

11 ONS Subnational Population Projections, Interim 2011-based
12 ONS Subnational Population Projections, Interim 2011-based
13 Interim 2011-based subnational population projections, persons by single year of age for local authorities in England (ZIP 3964Kb)
http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections

- lack of clear routes for participation in local matters and decision making
- health inequalities
- obesity

The following reflect relevant areas recognised as doing well - fair:

- the opportunity to access adult learning with good support for individuals
- social housing allocation system and the investment in new build properties to tackle the problems of poor quality housing
- good healthcare provision
- availability and affordability of public transport schemes
- the breadth of volunteering and citizen engagement opportunities
- community improvement programmes
- abusive and anti-social behaviour, a number of respondents felt that issues are dealt with promptly
- positive response to abusive and anti-social behaviour

The feedback from stakeholders including local people and local groups bring into focus issues of fairness of access to services and support. They also reflect some of the challenges to peoples resilience and hence issues that can affect a person's wellbeing e.g. mental health, racism and discrimination, impact of unemployment etc. The feedback also reinforces the need for involvement in and the importance of community based activity, effective community engagement and participation in local decision making / issues. Assets linked to volunteering and citizen engagement are noted as are community improvement programmes and support available for those in adult learning.

In response to identifying commissioning intentions as part of the NEW Devon CCG Transforming Community Services programme the key issues identified by local people were written as 'I' statements:

- "I want the services I value now to be strengthened"
- "I want no barriers to care caused by geographic, regulatory or any other kind of boundary."
- "I want services that support me to manage my situation in life not just my condition"
- "I want the information I need to make healthy choices and stay healthy"
- "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"
- "I want to be able to get to my community services at times that are convenient for me"
- "I want to be able to have services provided in lots of different places not just health centres"
- "I want to be able to talk to healthcare providers when I need to."
- "I want to tell my story once - share my information with colleagues"
- "I want to be able to use new technology to help me manage my own health"
- "I want to continue to get the services I value that are provided by the voluntary sector"
- "I want to be able to get to the services in my community"

These statements support the need for people to be enabled to have choice and control over their lives across all of their lives stages including end of life. They reflect the need to have high quality advice and information available; accessible services and support that is local and centred on meeting a person's holistic needs. In developing a 'Wellbeing Strategy' with a strong prevention focus these

statements also support the need for co-design of services and building community capacity through the voluntary and community sector.

3.6 Needs Assessment Summary

The health of people in Plymouth is generally worse than the England average. In the city there are higher than average levels of deprivation, with more than 50% of residents being in the 2 most deprived socio-economic quintiles. The inequality in health that is driven by social inequalities and is demonstrated in the fact that there is a 7.9 year gap in life expectancy in men and a 5.8 year gap in life expectancy of women in Plymouth between the least and the most deprived groups.

Poor health behaviours cluster in the more deprived socio-economic groups and this also drives health inequalities. In Plymouth there are higher than average numbers of people who smoke and hence higher proportion of smoking related deaths. There are higher levels of alcohol-related ill health, higher levels of drug misuse.

Health in Plymouth is significantly worse than England as measured on 17/32 health indicators in the annual Health Profile. In relation to the 11 Regional Centre comparator areas, Plymouth is 5th= with Southampton in terms of health profile indicators. Mental health in Plymouth is also poor, demonstrated by the fact that common mental health problems are estimated to be 20% higher than would be expected for the demographic and economic make up of the City.

In Plymouth the population is broadly similar to national average, although there are considerably more young adults in age 20-29, attributable largely to the student population in the city. There is a small but rapidly growing black and minority ethnic population in the city and in the last 10 years there has been significant growth in the very young 0-4 years. Overall our population is an ageing one and growth in 65+ age groups is broadly in line with national average. These are the main population characteristics relevant to impact on health and wellbeing needs.

The levels of deprivation that exist in Plymouth drive the on-going challenge to tackling the resulting health and social inequalities and represent a major challenge to improving the health of the population as a whole. The new approach to health inequalities proposed in the city (4-4-54) will work over the next 10 years to address this by focusing on the 4 behaviours that drive health inequalities in the city – poor diet, lack of exercise, tobacco use and excess alcohol consumption.

Table 9

Demographic	• Increasing population size • Increasing older population over 75 • Increasing number and diversity of BME population
Deprivation	• Plymouth is ranked 72 out of 326 in terms of deprivation (1=most deprived; 326=least deprived) • There are higher levels of long term health problems or disability when compared nationally; there are lower levels of reported good or very good health when compared nationally
Determinants	• Clear social gradient in health which shows life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Plymouth than in the least deprived areas • Housing conditions in Plymouth are worst in the private rented sector with 37.2% categorised as non-decent • Under-employment' is comparatively high in Plymouth.

Need: Areas where we are reported as being significantly higher than England in the Health Summary for Plymouth	• Under 18 conceptions • Alcohol and drug misuse • Adults smoking • Sexually transmitted infections • Incidence of malignant melanoma • Early deaths from cancer • Violent crime - of which local data reports 31% of which linked to domestic abuse
Need - Additional	• Mental health need estimated as being 20% higher than what would be expected for a city with our population • Increase in the rate of hospital admissions for self-harm • Increase in the rate of hospital admissions for circulatory diseases • Increase in hospital admissions for falls in adults aged 65 and over • Increase in dementia in the over 69s by 2020

4.0 STRATEGIC CONTEXT

4.1 National

Health and Social Care Act 2012

Sets out the legislative framework to enable integrated health and social care delivery

Healthy Lives Healthy People 2010

The Governments strategy for public health in England stated, 'We need a new approach that empowers individuals to make healthy choices and gives communities the tools to address their own, particular needs'.

Fair Society, Healthy Lives[14]

Sir Michael Marmot's report sets out a life course framework for tackling the wider social determinants of health. The approach aims to build people's self-esteem, confidence and resilience right from infancy – with stronger support for early years.

A Call to Action: Commissioning for Prevention'[15]

NHS England and Public Health England state, "Commissioning for prevention is one potentially transformative change that CCGs can make, together with Health and Wellbeing Boards and their other local partners. Implemented systematically, the evidence suggests prevention programmes can be important enablers for reducing acute activity and capacity over the medium term".

The Five Year Forward View[16]

Sets out how the NHS needs to change. The authors state, 'The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.'

14 Marmot, M. (2010) Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010, www.marmotreview.org
15 NHS England & Public Health England (2013) A Call to Action: Commissioning for Prevention
16 NHS England; Public Health England; Health Education England; Trust Development Authority; Care Quality Commission; Monitor (2014) Five Year Forward View

4.2 Local

Creating the Conditions for Fairness (2014): The Plymouth Fairness Commission Final Report

This report sets out recommendations focused at both the national and local level that will create a fairer Plymouth. The Fairness Commission asked all local organisations named in the report to provide their response and commitment to delivery of attributed recommendations and initial estimates of timetables by the end of June 2014. In responding to this challenge the Health and Wellbeing Board stated that they will now 'ensure that the Commissioning Strategies from NEW Devon CCG, Plymouth City Council and other agencies are integrated, budgets are pooled and the Fairness Commission recommendations are addressed in the strategies developed and implemented'.

Health and Wellbeing Strategy (2014) Plymouth Health and Wellbeing Board

The Joint Health and Wellbeing Strategy is intended to inform commissioning decisions across local services such that they are focused on the needs of service users and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. Underpinned by the Marmot review the Strategy recognises that health and wellbeing must be addressed across the whole life course. In line with the Marmot review the Strategy aims to:

- Give every child the best start to life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy sustainable places and communities
- Strengthen the role and impact of ill health protection

The Plymouth Plan – How Plymouth Will be a Healthy City (in development)

The Plymouth Plan is a single holistic plan setting out the direction for the City up to 2031. It brings together all the key strategies and plans for the city into one coherent document. It does so because the interdependencies of these strategies and plans are key to transforming the City. The section on health recognises that over the course of the Plymouth Plan period demographic changes and increasing complexity of need will continue to put pressure on all vital front-line services. The challenge for the public sector is to meet the volume and complexity of demand with decreasing resource. A focus on prevention is evidenced to reduce the burden of disease and consequently reduce demand on front-line services. The Plymouth Plan will show how partners and services from across the city can achieve this aspiration.

PCC Corporate Plan – The Brilliant Co-operative Council

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

Thrive Plymouth (4-4-54): Framework for addressing health inequalities

Cabinet approved this framework and the supporting action plan to address health inequalities in the city in November 2014. Thrive Plymouth (4-4-54) will be delivered through a new Plymouth Health and Wellbeing Collaborative of multiple partner organisations in the city. In summary, poor diet, lack

of physical activity, tobacco use and excess alcohol consumption are risk factors for coronary heart disease, stroke, cancers and respiratory problems which together contribute to 54% of deaths in Plymouth. Changing these four behaviours would help prevent these four diseases and reduce the number of deaths due to those chronic diseases.

NHS Futures: Prevention - Outline Business Case

This strand of the NHS Futures Programme aims to reduce the overall demand on the health system by promoting healthier lifestyles straight away and commissioning for prevention starting in 2015/16. The recommended option for the Prevention Plymouth strand of the Programme was Option1.This was to achieve a reduction in the overall demand on the health system by increasing the health of the Plymouth population focusing on three workstreams (a) being born; (b) living and (c) ageing. Key to the delivery of this would be the 4-4-54 construct (see page 30)

Transforming Care in Devon and Plymouth: Five Year Strategic Plan, (2014) CF01 NEW Devon CCG

This Strategic Plan states that, 'By 2019, healthy people will be living healthy lives in healthy communities. Services will be joined up and delivered in a flexible way. Resources will follow need. More care will be provided in the community'. Healthy living and wellbeing is cited as one of the key elements to the model of care recognising that interventions 'focus on preventing ill health and social factors such as isolation in the first place, focused on those most at risk – where the returns are greatest in terms of quality benefits for patients and service users and the reduction in demand (and cost) along the care pathway'.

In this framework NEW Devon CCG state they 'will work with its partners to commission services that contribute to the delivery of the Joint Health and Wellbeing Strategy'. The framework sets out the key CCG intentions.

Integrated, personal and sustainable: Community Services for the 21st Century; A strategic framework (2014) NEW Devon CCG

The strategic framework sets out to design future services to meet people's needs whilst continuing to improve quality, efficiency and effectiveness of community services and to build on the many skills and talents of staff delivering them. It also sets out to achieve this change through co-production. That is working with partners, providers and communities to transform these services together.

The strategic intentions of the Western Locality are underpinned by:

- coordination and integration
- a pathway approach
- personalisation and self-management
- shifting care to a home based setting wherever possible
- prevention of ill health
- the key role of carers

For patients, Integrated Health and Social Care provision promotes:

- Greater choice and control over the care and support received
- Timely support in a crisis and support to recover
- Care provided closer to home and in communities
- Reduced health inequalities, high quality services and safe from abuse.

- The right care, in the right place at the right time

Examples of current Plymouth Strategies, Commissioning Plans and other key documents supporting the scope of this Commissioning Strategy:

- Addressing health inequalities in Plymouth: 4-4-54 Action Plan
- Carers Strategy 2014-18
- Charter for Older People (2012)
- Dementia Strategy 2014-15,
- Domestic Abuse Commissioning Plan 2012-2019,
- Healthy people living healthy lives in healthy communities CF01 NEW Devon CCG Commissioning Framework 2014 – 2016
- Housing Plan 2012-2017 Plymouth City Council
- How do we make Plymouth a healthier city? (2014) Plymouth Plan Topic Paper Health and Wellbeing
- Our (Plymouth City Council) Commitment to Equality and Diversity (2014)
- A Mental Health Commissioning Strategy for Devon, Plymouth and Torbay 2014-2017
- Plymouth Aquatics Strategy 2010 -2020
- Plymouth's Healthy Lives for Healthy Weight Action Plan (in development)
- Plymouth Mental Health Network Strategy – Whole Life Whole Systems
- Plymouth Mental Health and Wellbeing Promotion Action Plan strategy
- Plymouth Suicide Prevention Action Plan (in development)
- Promote Responsibility, Minimise Harm. A Strategic Alcohol Plan for Plymouth 2013-18
- Transforming Community Services: Proposed Commissioning Intentions for the Western Locality Your Health, Your Future, Your Say (2014) NEW Devon CCG

4.3 Key legislation

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 Act 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 Social Value Act (2012)

Requires all public bodies to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the community. 'Social value' involves looking beyond the price of the individual contract and considering the social impact on the community when the contract is awarded.

Care Act 2014

The Care Act 2014 creates a single modern piece of law for adult care and support in England. The reforms introduce significant new duties on Local Authorities and consequently will involve significant change to finances, processes and people.

The Act rebalances the focus of care and support and makes explicit the need to promote wellbeing and prevention rather than intervening only at points of crisis. Fundamental to these new duties will be the role of communities and social networks. There is a requirement that local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person.

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

Duties also include additional responsibility for assessment. This includes:

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

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

The Act states that 'local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person'. In this context the Act describes wellbeing as relating to the following areas:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society

This 'wellbeing principle' applies in all cases where a local authority is carrying out a care and support function, or making a decision in respect of the person. In this context the promotion of wellbeing is also central to the commissioning strategies covering community care and complex care and this can be seen to be complementary to the activity in scope of this Strategy. In this way wellbeing will be promoted at a population and sub-population level through this strategy and also promoted when an individual is in need of a service providing care and support including at end of life through the complementary strategies. The principle also applies to those caring for an individual.

4.4 Evidence based / good practice

4,4,1 This strategy will incorporate good practice and build on an evidence base to improve the health and social care outcomes of people in Plymouth. The following good practice resources, research and data can be accessed by health and social care professionals and commissioners:

- Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/
- National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/
- The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/
- NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/

- Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/
- Care Quality Commission (CQC) - http://www.cqc.org.uk/
- Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/
- Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm

4.4.2 THRIVE

Oxford Health Alliance (OxHA) developed the concept of 3 four 50 in response to global concerns about chronic diseases. This construct reflects the observation that there are three risk factors to health that together contribute to four chronic diseases which, in turn, contribute to more than 50% of preventable deaths worldwide. These diseases are:

- Cancer
- Coronory Heart disease
- Stroke
- Chronic obstructive pulmonary disease (COPD)

This focus on chronic diseases is appropriate as they are now the major cause of death and disability worldwide, having surpassed infectious diseases and injuries. By focusing on changing behaviours that can lead to the development of these diseases there is likely to be a reduction in the number of people who experience them with consequent benefit to the individual, family, community and public purse. Using this construct with the Plymouth data leads to the 4-4-54 numbers.

4.4.3Think Local Act Personal and Public Health England published a framework for Health and Wellbeing Boards in 2014 entitled, Developing the Power of Strong, Inclusive Communities. Evidence cited reflected a growing evidence base that shows:

- Low levels of social integration and loneliness significantly increase mortality whilst people with stronger networks are healthier and happier
- Social networks are consistently and positively associated with reduced illness and death rates
- The most significant difference between people with mental ill health and people without mental ill health is social participation. Social relationships can also reduce the risk of depression.
- Areas with poor social capital experience higher rates of cardiovascular disease in general and recurrence of acute coronary syndrome, in particular among lower level income individuals
- For older people, volunteering is associated with 'more positive effect and more meaning in life'
- Areas with stronger social networks experience less crime and delinquency
- Neighbourhood watch can reduce crime by 16-26%
- The time credits organisation Spice documented a 17% reduction in crime following the introduction of a timebank scheme in local youth groups

5.0 CURRENT PROVISION

5.1 Strategic overview

There has, up to now, not been a wellbeing system defined. A wide range of provision reflects services that have been commissioned in line with strategies, commissioning plans and business cases focusing on specific priorities that include a universal or preventative offer supporting wellbeing.

The existing approach has meant that differing commissioners utilising different budgets and commissioning processes have created 'artificial' structures that can mean unnecessary duplication can take place; service users have to repeat their story to access services; and service users on pathways linking differing services often do not experience this as seamless and timely. Importantly no coherent evidence based approach to population level prevention has been strategically agreed and delivered by all the key stakeholders across the city.

Outcomes in this context for the person have too often been shaped by more of a' silo' approach to service and system design which does not place the service user at the centre of the range of services they require and the outcomes they are needing.

There has always been ambition to design services that work better together within and across systems and progress has been made. However the current categories that we've commissioned against (see table 9) has not enabled us to maximise the potential to create a coherent system for wellbeing.

Currently, investment in universal and preventative services has been primarily met by the local authority.

5.2 Existing service provision

Currently there is a wide range of services that have been identified as supporting wellbeing. These services include the following:

Table 10

Current Categories	Examples
Universal / Social Capital	Advice and information ; Time-banking; Advocacy Services; Healthwatch; Carers Support; Learning, Physical and Sensory Disability Support, Counselling; Health Improvement Services; Primary Care Enhanced Services; Health Checks; GPs with Special Interest; Sexual health and prevention and promotion services; Community Contraception Services; GUM Services; Library Services; Stop Smoking Service; Community Gyms; Life Centre/ Brickfields/LIDO/Mount Wise Pools/ Plympton Pool; Community Health in Keyham;
Enabling and Floating Support	Home from Hospital; Telecare Alarm Monitoring; Dementia Support; Floating Support; Befriending; Carers Support; domestic abuse; homeless information, advice and support; mental health support;
Sheltered Housing	Information, advice and support; provision of sheltered housing;

These services are delivered by over 60 providers (not including Primary Health Practices and Pharmacies) with around 40 coming from the independent, voluntary and community sector.

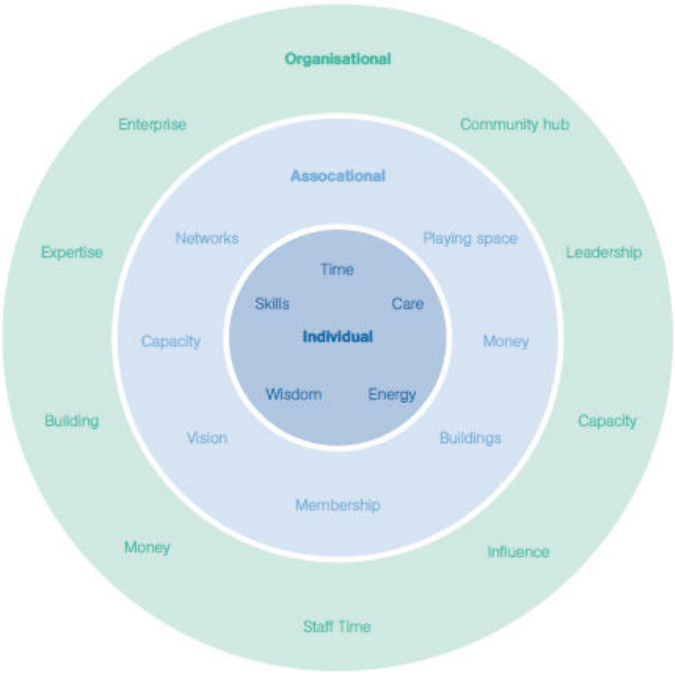
Services generally perform well against the measures in their contracts but this service performance is not always reflected in improvements in key outcomes for the city or in reducing inequality across the city.

Whilst there has been some investment in developing social capital this has been limited. Current commissioning practices have not facilitated a strategic approach to developing social capital and community self-help to support wellbeing.

5.3 Community asset mapping

Asset mapping will be utilised to determine existing informal provision, assets and resources that people have access to in the community. A co-production approach will improve the understanding of local needs and assets and will be part of the wider needs assessment work carried out across the four strategies. The asset maps would then support the formally procured services as part of the long-term commissioning strategies (Adapted from *Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014*). An example of the wide range of assets that could be included in the mapping exercise is presented in figure 1 below.

Figure 6 Asset Mapping



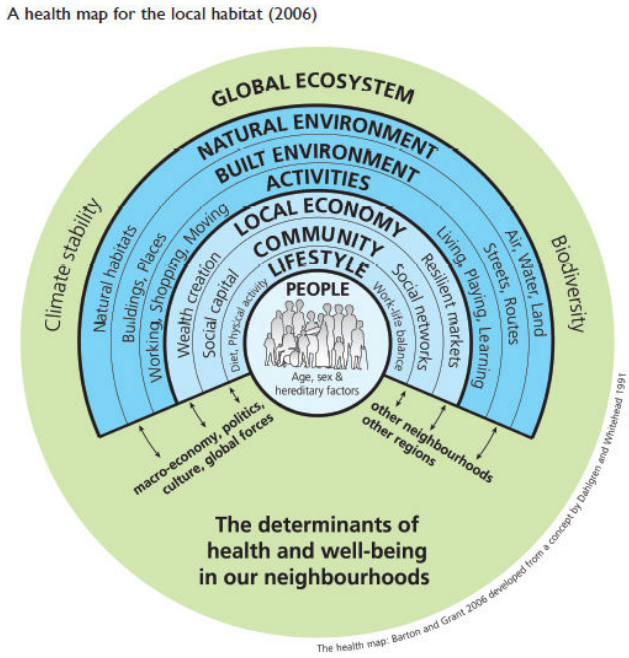
Source: Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014. Adapted from Foot, J. and Hopkins T. (2012). The Collaborative. (n.d.) Our Vision. The Collaborative: London. Retrieved from http://lembethcollaborative.org.uk/about/our-vision.

6.0 THE FUTURE 'WELLBEING' SYSTEM MODEL

6.1 Health Map and the Wellbeing System

Work by the Kings Fund identified that health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. The Health Map illustrated below details how many different factors influence people's health. Most experts agree that these 'broad determinates of health' are more important than health care in ensuring a healthy population.

Figure 7 Health Map



The Health Map places services in scope of this strategy within this wider system. These services focus on the people, lifestyle and community domains. Ensuring a strategic approach to improving wellbeing will create an environment within which decisions focusing on the wider determinants of health and wellbeing will be made with the aim of supporting the impact of the services in scope of this commissioning strategy and so maximise outcomes for individuals, families, communities and the city as a whole.

The approach must therefore ensure that improving wellbeing is integrated into strategic objectives and policies in respect of each of the domains set out: Natural Environment, Built Environment, Activities (such as shopping, transport and employment), Local Economy, Community, Lifestyle and People. Therefore the Health Map sets out our 'wellbeing system'.

The services in scope of this strategy will provide a universal and preventative offer and be designed to (1) target those issues that have the biggest impact on well-being across the city and (2) build capacity within communities (social capital) with the aim of supporting the development of healthy and happy communities in Plymouth, and reduce the pressure on the wider health and social care system.

The services that will be commissioned directly through this strategy will sit alongside a range of other key stakeholder contributions who also commission prevention services that support wellbeing. For example:

- NHS England commission Primary Health Care that plays a key role in preventing ill health and detecting ill health
- NHS England commission a range of immunisation and screening programmes that prevent ill health
- The Police Crime Commissioner PoCC invests in activity (much of which will sit alongside activity described in the Community Strategy) that includes some prevention work. This investment is used to support the commissioning intentions of Safer Plymouth.
- Plymouth City Council and NEW CCG through the accompanying Integrated Strategies have a duty under the Care Act to promote wellbeing of the people these Strategies are intended

to reach (through the wellbeing principle). In doing so 'promoting wellbeing' will not just be something 'siloed' within this Strategy but an offer that is integrated across the whole system of health and social care. For example the promotion of wellbeing for people at the 'end of life' and their carers will be a core offer. This Strategy will focus on delivering whole or targeted population level interventions.

- The Children and Young Peoples Commissioning Strategy will also include activity that supports the wellbeing of children, young people and families e.g. Health Visitors, Family Support.

For services and support that are not currently commissioned by the local authority, CCG, NHS England and the Police Crime Commissioner:

- Schools contribute significantly to the City's wellbeing through prevention activity that supports the wellbeing of their school population
- Business' contribute significantly to the City's wellbeing through running programmes to help improve the wellbeing of their employees
- The University's contribute significantly to the City's wellbeing through prevention activity that supports the wellbeing of their University population

Finally, the voluntary and community sector deliver commissioned services or services and support that is funded through charitable grant making bodies or services and support that is truly voluntarily based.

- The voluntary and community sector provide a wealth of services and support, that reflects local (neighbourhood) need and is a key enabler of local social capital and community self-help

6.2 Wellbeing Interdependencies
Maximising the relationship between stakeholders and their interdependencies to have an effective 'wellbeing system'

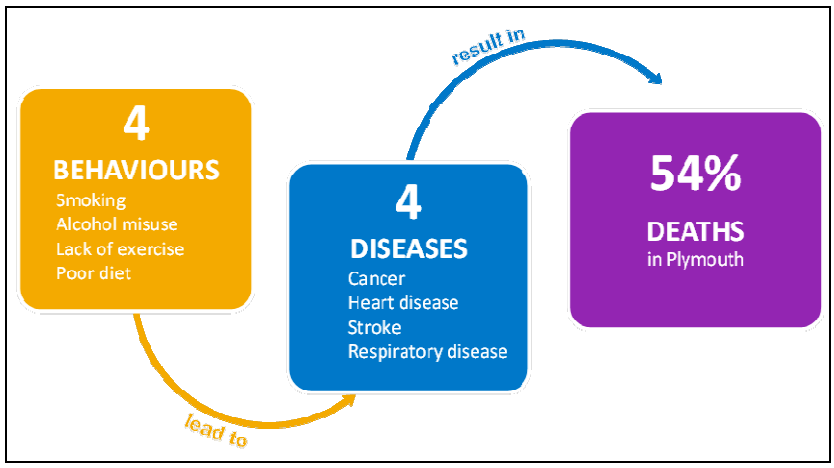
It is vital that at both a strategic level and on a service design and delivery level effective links are made with the appropriate stakeholders noted above. Opportunities to work in partnership, co-commission and joint work must be taken forward to maximise the use of resources and impact. Pathways described or that will be developed in support of the accompanying Strategies should where appropriate link to the activity that is developed through this Strategy enabling universal and preventative interventions to be accessible to anyone at any point within the system.

Central in this approach should be the strong emphasis given to building social capital and community self-help, and engaging in co-design activities with local communities. This will ensure a co-produced system that will maximise investment and local assets.

6.3 Thrive

The Strategy will drive forward a population level prevention programme through Thrive Plymouth (4-4-54) to tackle the four key behaviours that impact on four key diseases and contribute to 54% of all deaths in Plymouth.

Figure 8 Thrive Plymouth; 4-4-54



Thrive is not based on the delivery of commissioned services alone but through enabling social change through for example influencing key stakeholders, providing accessible advice and information to populations to change behaviours and supporting patient activation to help them achieve choice and control.

Commissioned services will deliver a range of high quality, evidence based interventions and include an enhanced focus on the key behaviours that contribute to risk factors for coronary heart disease, stroke, cancers and respiratory problems. These behaviours are poor diet, lack of exercise, tobacco use and excess alcohol consumption. Changing these four behaviours would help prevent these four diseases and reduce the number of deaths due to those chronic diseases.

6.4 Integrated Commissioning Model – Wellbeing

Currently there is a high spend on specialist care and in comparison a limited focus (and relatively limited resourcing) of preventative services. Over the lifetime of this and the accompanying strategies there will be a shift in the amount of investment and proportion of investment toward improving and promoting wellbeing and community based support.

Prevention is recognised through a range of evidence and policy drivers as key in reducing pressure at the complex and intensive end of provision as well supporting savings across the whole system.

Over time the system should not see a decrease in the proportion of investment supporting wellbeing through prevention activity as a proportion of investment across the whole system. Indeed the proportion of investment spent on prevention as a percentage of the total spend on health and social care should increase over the five years of the Integrated Commissioning Strategies. There is a good evidence base for the impact or preventative approaches. For example NHS England cites the following:

- 42% of the mortality decrease from Coronary Heart Disease between 1981 and 2000 was attributable to medical and surgical treatments, whilst about 58% was attributable to the

change in risk factors—showing that preventative interventions can have a significant impact over the medium term[17]

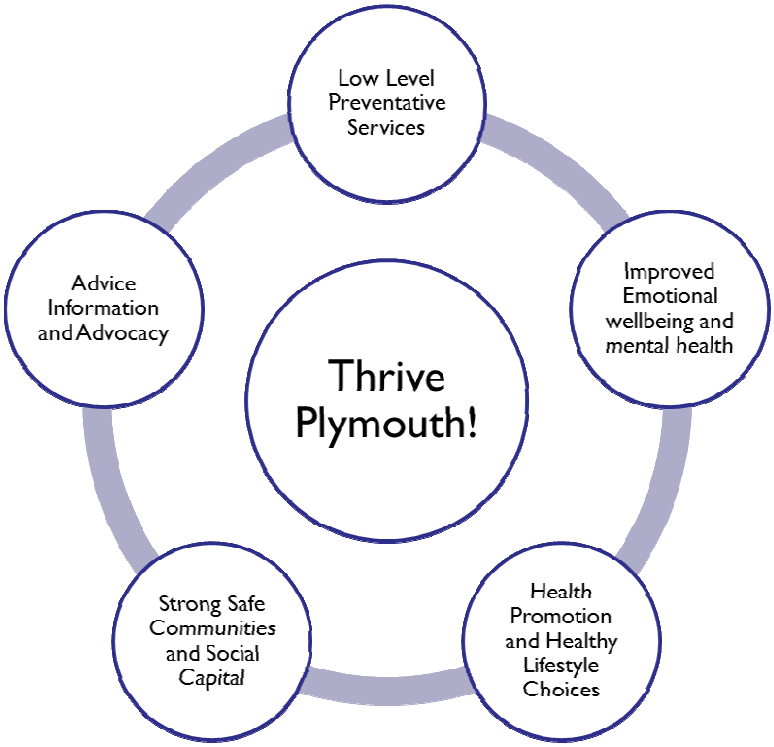
- For every £1 spent on preventative action £8 can be saved with families with conduct disorder[18]
- For every £1 spent on preventative action £18 can be saved on psychosis[19]
- For every £1 spent on preventative action £12can be saved with primary care[20]

Increasing the proportion of funding for wellbeing as a percentage of the whole of the Health and Wellbeing system and then investing this in evidence base interventions should save potential future spend.

This should be further supported through building social capital and self-help.

Commissioning framework for Wellbeing

Figure 9



Thrive is the central population focused approach to reducing health inequality in the city that will reduce preventable deaths, improve lifestyle behaviour and in time reduce the overall spend in the system. All the additional elements of the commissioning framework contribute to Thrive but require a specific focus in line with the City's Strategic ambition and the needs identified.

17 Kelly, M.P. and Capewell, S. (2004) Briefing paper: Relative contributions of changes in risk factors and treatmentto the reduction in coronary heart disease mortality. Health Development Agency

18 Campbell, C.A., Hahn, R.A., Elder, R., Brewer, R., Chattopadhyay, S., Fielding, J., Naimi, T.S., Toomey, T., Lawrence, B. and Cook Middleton, J. (2009) The Effectiveness of Limiting Alcohol Outlet Density as a means of reducing excessive alcohol intake. American Jounral of Preventative Medicine 37 (6) pp. 556 -569

19 Jebb, S.A., Ahern, A.L., Olson, A.D., Aston, L.M., Holzapfel, C., Stoll, J., Amann-Gassner, U., Simpson, A.E., Fuller, N.R., Pearson, S., Lau, N.S., Mander, A.P., Hauner, H. and Caterson, I.D. (2011) Primary care referral to a commercial provider for weight loss- treatment versus standard care: a randomised controlled trial. The Lancet 378 (98) pp.1485-1492

20 Jolly, K., Lewis, A., Beach, J., Denley, J., Adab, P., Deeks, J.J., Daley, A. and Aveyard, P. (2011) Comparison of range
of commercial or primary care led weight reduction programmes with minimal intervention control for weight lossin obesity: Lighten up randomised control unit. British Medical Journal 3 (343)

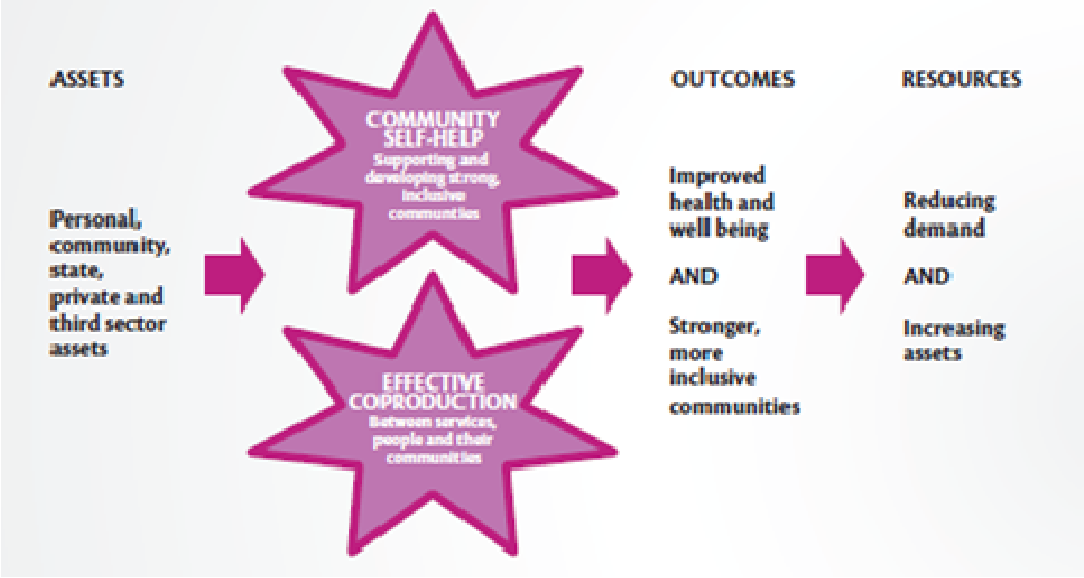
Key elements identified to support the wellbeing system in scope of this strategy:

6.4.1 Strong safe communities and social capital

In his report, Fair Society Healthy Lives, Michael Marmot states 'The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes. It is vital to build social capital at a local level to ensure that policies are both owned by those most affected and are shaped by their experiences.'

Building social capital and community self-help will be a key strand to the Strategy. Supporting community development approaches will enable local communities to build social capital and also design services with key stakeholders. The Strategy needs to raise the profile of this area and will require improved understanding of community based assets in place and more detailed work on the investment requirements to facilitate building on our current level to achieve a step-change in community engagement and participation.

Figure 10



Think Local Act Personal & Public Health England 2014

6.4.2 Advice, Information and Advocacy

High quality, accessible advice, information and advocacy, to support choice and control by individuals, families and communities. This also supports patient activation and will ensure that individuals and populations have access to independent support to ensure people know their rights or how they can challenge or clarify decisions made which affect their wellbeing. These are key building blocks to ensuring that people are enabled and empowered to be make decisions to improve their wellbeing and their health.

6.4.3 Health Promotion and Healthy Lifestyle Choices

Health promotion enables people and communities to be healthier. Delivered through a range of services and settings these activities can include screening and active engagement with people to develop improved lifestyle choices. Provision of evidence based information and knowledge along

with access to a range of activities or an offer that supports improved health e.g. community gymnasium.

6.4.4 Improved emotional well-being and mental health

Helping people build the resilience to challenges they face is critical. This is not just about what services there are available but what social capital can offer. Taken together more resilient people are able to cope better with life including those with many forms of mental illness . Improving the emotional wellbeing and mental health of individuals, families and communities is also recognised as a key cross cutting component to all aspects of improving wellbeing.

6.4.5 Low level preventative services

The needs data identified the following as areas that need a specific focus:

- Sexually transmitted diseases
- Violent crime and domestic abuse
- Falls by older people

These areas will require a specific focus at both a whole population level and targeted population level.

Some of the services and the offer developed will also work with people with multiple need and complexity. Access to wellbeing strategy commissioned services from community and complex commissioned services as well as services designed for children and young people will ensure wellbeing is addressed at all levels of need across the City and across the whole life course.

6.5 Available Resources

The current approximate commissioning budget against each service element is described in the table below.

Table 11

System element	Approximate current budget
Advice information and advocacy	£3,070,828
Low level preventative services	£3,773,422
Improved emotional wellbeing and mental health	£106,858
Health promotion and health lifestyle choices	£12,425,383
Strong safe communities and social capital	£1,375,744
Total	£20,752,235

An additional £40 million of prescribing spend is currently being linked to the Wellbeing Strategy but further discussions need to take place to determine the best place to hold this budget and the implications in doing so

6.6 Measuring Future System Performance

The following outcome performance indicators have been identified as key to measuring how this strategy contributes to improvements across the whole health, wellbeing and social care system in Plymouth. These will form part of a comprehensive performance dashboard that will be used to monitor an overview of the system.

Table 12

Indicator	National	Plymouth	Impact on system – why is this a measure?	Trajectory
PHOF 2.12 Excess weight adults	63.8%	60%	Measures against THRIVE - People lead healthier lives for longer delaying need for care and support service in the 'community' and 'complex' strategies	
PHOF 2.13ii Adults classed as inactive	28.9%	34%		
PHOF 2.14 Smoking prevalence in adults	18.4%	24.5%		
Social isolation: % of adult carers who have as much social contact as they would like	41.3%	36.5%		
Wellbeing Indicator	TBC	TBC	Key measure for wellbeing for the city. Further discussion to take place on using ONS measure and / or local wellbeing measure based on the Plymouth Wellbeing Survey	

7.0 COMMISSIONING INTENTIONS

DRAFT Initial Implementation timetable 2015/16

Table 14

System element	Commissioning Activity	Key Outcome	Lead Commissioner	Timeframe
THRIVE	Delivery of 4-4-54 Action Plan to address health inequality in the city	Reduce the number of preventable deaths	PCC / CCG	Annual Review
Comprehensive advice, information and advocacy offer	Advice and Information *Commission Advice and Information provision in response to the Care Act and Welfare Reform and in support of patient self-management (including financial information and advice and financial inclusion work)*	Improved wellbeing through exercising choice and control Improved wellbeing through patient activation Improved wellbeing for Carers	PCC / CCG	September 2015
	Advocacy Services *Implementation of new Advocacy Services contract for the City*	New contract commences safely and effectively	PCC / CCG	Review September 2015
Strong, Safe Communities and Social Capital	Building social capital and community self help *Develop a strategic approach to how PCC/CCG will actively support the building of social capital and community self-help through community development approaches and then deliver approach*	Improve the wider determinants of health Maximise volunteering for health and wellbeing Joint Strategic Needs and Assets Assessment Improved support networks Improved trust and neighbourliness Being active and having influence Living together and respect	PCC / CCG	Benchmark outcomes by March 2016 and then Annual review to monitor

	Strategic review of services supporting Safer Plymouth objectives and in scope of wellbeing to support maximising outcomes *Review to be undertaken to (1) ensure flexibility in system to commission in response to emerging or fast moving issues; and (2) to explore how to maximise outcomes through links across wellbeing system e.g. violent crime and domestic abuse Findings to be incorporated onto planning and commissioning decisions*	System has capability to support targeted prevention that aim to mitigate fast moving, new or emerging challenges Reduce crime	PCC / CCG (note link to Police Crime Commissioner)	December 2016
	Improve the poor condition and management of private sector housing that affects the health of residents, and results in higher health and care costs *Build on the work underway to enhance the approach*	• Reduction in the % of private rented accommodation that is classified as non-decent • Reduction in the % of private rented accommodation that is classified as having a category 1 hazard • Reduction in the % of private rented accommodation that is classified as being in disrepair • Improve in the % of private rented accommodation with regard to their thermal comfort rating • Reduction in the % of private rented accommodation that is classified as having a high level of fuel poverty	PCC / CCG	
	Implement Dementia Friendly City Action Plan 2015/16	Increased diagnosis rates People live well with Dementia	PCC	March 2016

Health promotion & healthy lifestyle choices	Develop Primary Care co-commissioning with Area Team *Review any current co-commissioning with Area Team and agree scope and scale of possible future co-commissioning to support well being*	Co-commissioning framework agreed to maximise health promotion and healthy lifestyle choices	CCG / PCC (NHS England)	December 2015
	Develop Physical Activity Commissioning Plan	Services commissioned in line with Plan	PCC / CCG	March 2016
	Build on existing offer to commission an older persons falls prevention programme	Reduction in number of older people presenting to Hospital following (1)an initial fall (2) a subsequent fall	PCC / CCG	March 2016
Low level preventative support	Strategic review of low level preventative services to ensure a sustained impact on improving wellbeing and reducing pressure on the wider health and social care system *Review of range of services currently commissioned to determine alignment with Strategic priorities and impact on improving wellbeing including mental health. Inform commissioning intentions for 2016 +*	Reduce or delay the need for care and support Review of range of services currently commissioned to determine alignment with Strategic priorities and impact on improving wellbeing	PCC / CCG	December 2015
	Undertake comprehensive sexual health needs assessment to inform future commissioning and system design	Reduction in rate of sexually transmitted infections Under under conceptions	PCC / CCG	March 2016
Improved emotional wellbeing and mental health	Build community / neighbourhood capability and capacity to support people with mental health needs	More people with mental health needs participate in their local community	PCC / CCG	March 2016
	Promote awareness of mental health need across system with a strong emphasis on tackling stigma			

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COMMISSIONING STRATEGY FOR COMPLEX CARE DRAFT

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Part: I

DOCUMENT CONTROL

Version	Date	Author	Change Ref	Pages Affected
1	13/10/14	Rachel Silcock	Whole document	
2	14/10/14	Clare Cotter	Review of whole document	5,6,7,19, 23,27,31
3	4/11/14	Nikki Bray	Review of sections on Individual Patient Placements	6, 14, 28, 31, 33, 34, 35
4	4/11/14	Caroline Paterson and Hannah Shaw	Review of sections on care home placements	26, 27
5	05/12/14 15/12/14 15/12/14 15/12/14	Clare Cotter Nikki Bray Caroline Paterson Susan Benjamin	Review of whole document	Various
6	18/12/14	Carol Green Rachel Silcock	Review of whole document	Various
7	21/01/15	Rachel Silcock	Review of whole document	7, 18,
8	11/02/15	Rachel Silcock Caroline Paterson	Review of whole document	Various
9	12/02/15	Hannah Shaw Caroline Paterson Lynne Kilner Susan Benjamin	Commissioning Intentions Commissioning Plan End of Life sections	38 – 41 Various
10	16/02/15	Craig McArdle	Review of Whole Document	Various
FINAL DRAFT	17/02/15	Katy Shorten Rachel Silcock	Review of whole document	Various

QUALITY REVIEWERS: (General QA and accuracy)

Name	Position	Signature	Date

FINANCE SIGN OFF:

Name	Position	Date

CONSULTATION PATHWAY:

NAME

Table of Contents **Page Number**

1.0 EXECUTIVE SUMMARY

The Complex Care system will consist of quality specialist health and care services that promote choice, independence, dignity and respect.

The provision that supports people with complex needs is mainly delivered in an acute hospital, residential, nursing home or hospice setting but also includes some people with complex needs supported at home.

The aim of this strategy is to develop an integrated, streamlined system to meet the needs of people with complex health and social care needs. Through an integrated assessment process people will have equity of access and provision that promotes a good quality of life right up to the end of life.

We will achieve this by:

- Providing pro-active care co-ordinated by GPs to ensure the most vulnerable frail older people are kept safe and as well as possible
- Commission an effective dementia care and support system that aims to keep people living well with dementia
- Developing an integrated assessment, referral and placement process for care homes across health and social care
- Undertaking a market review of the care home sector to ensure consistent quality and fee rates
- Reviewing and redesigning local pathways and provision in order to prevent and reduce out of area Individual Patient Placements
- Develop a commissioning plan for end of life care that aims for people being able to die in their preferred place of care

All designed with a system aim of reducing acute provision and acute episodes of care

2. INTRODUCTION

2.1 Background – Strategic Challenge

Public Sector organisations across the country are facing unprecedented challenges and pressures due to rising demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities. Until recently the complexity and scale of our system-wide challenge has been difficult to understand and local organisations have, as a result, focussed mainly on meeting their own challenges. A lot of this work has been successful and this has delivered much that is good right across our system. However we know that this existing good practice will not be enough to meet the current challenge. This means a new imperative for joint and collaborative working across all the organisations that commission and deliver health and wellbeing in our area.

Recognising these challenges and within the context of a system's leadership approach Plymouth Health and Wellbeing Board has agreed a vision that by 2016 we will have developed an integrated whole system of health and care based around the following elements:

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

Integrated Health and Care Services: Focus on developing an integrated provider function stretching across health and social care providing the right care at the right time in the right place;

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

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

2.2 An Integrated Commissioning Response

In order to meet the challenges facing Plymouth New Devon CCG and Plymouth City Council have agreed to develop a single commissioning function working towards jointly approved commissioning strategies and pooled budgets.

The primary driver of this is to streamline service delivery and provision with the aim of improving outcomes for individuals and value for money. Integrated commissioning must deliver integrated wellbeing.

To support this strategic aim 4 commissioning strategies have been developed that stretch across the spectrum of early years, health, social care, and wellbeing need in Plymouth.

These co-dependent Commissioning Strategies aim to move the balance of care towards prevention in order to improve life chances, manage demand and improve health outcomes. Specific aims of this system's approach includes;

- Provide and enable brilliant services that strive to exceed customer expectations
- People will receive the right care, at the right time in the right place.
- Improve pathways and transitions
- Help people take control of their lives and communities.
- Children, young people and adults are safe and confident in their communities.
- People are treated with dignity and respect.
- Prioritise prevention
- Sustainable Health and Wellbeing System
- Improve System Performance

2.3 Purpose of the Strategy

Each strategy describes the current and projected need in Plymouth, as well as the local and national strategic context that the future system will need to address / respond to. They also describe current provision how the existing system is performing.

This then builds into a vision of Plymouth's future system over a 5 year period, and details of how commissioners in Plymouth will achieve this through a series of annual implementation plans setting out and signalling to the market commissioning priorities, and how the impact of these will be measured across the system.

2.4 Implementation and Action

System Design Groups against each strategy will drive the implementation of the identified commissioning priorities within each strategy.

2.5 Finance

Table 1 provides an overview of how the current commissioning budgets in scope for integration are currently spread across the system.

Full detail on the existing resources allocated within each strategy area is provided in the 'current provision' section.

Table1: Current health and social care commissioning budgets

Strategy Area	Approximate total spend	% of spend in each Strategy area
Children and Young People	£27,150,102	6.72%
Wellbeing	£60,752,235*	15.03%
Community Care	£119,742,637	29.62%
Complex Care	£196,616,072	48.64%
TOTAL	**£404,261,046**	

*Includes approximately £40 million of prescribing spend

2.6 Definition of Complex Care

These are services that support people with complex needs, who need specialised care which is mainly delivered in an acute hospital, residential, nursing home or hospice setting but also includes some people with complex needs supported at home. This includes care homes for both working age adults and those over 65s. Support at home will mostly relate to end of life care as other nursing or specialist domiciliary care at home will be covered in the Community Strategy. Individual Patient Placements are a placement or treatment commissioned on an individual basis for people with complex mental health needs, learning disabilities, acquired brain injury and other complex needs that cannot be met locally. These are often out of area, high cost but small volume.

Supporting the complex system is a Clinical Effectiveness and Medicines Optimisation Framework which has the following mission:

"Our mission is to achieve the best possible care and outcomes for patients through ensuring the safest and most effective use of medication and other treatments while delivering value for money

for the NHS. We will achieve this by working closely with doctors, nurses, pharmacists, the public we serve, and other stakeholders in the health and social care community."

2.7 Scope

2.7.1 Care Homes

The majority of people choose to move into a care home due to their own personal circumstances and preferences. Following an assessment process described further on in this strategy, health and social care services will agree to fund placements where a person's health and care needs are too complex to be met cost effectively in their own home. This may also be subject to a financial assessment to determine if the person has to contribute to their care home fees. Many people pay for their own care.

Care homes offer accommodation and personal care for people who may not be able to live independently. Some homes also offer care from qualified nurses or specialise in caring for particular groups such as younger adults with learning disabilities. A care home is a place where personal care and accommodation are provided together and are integral to the health and care system in Plymouth; providing additional choices in respect to where people live and receive care to meet their needs.

Care homes can be residential or nursing or a combination, nursing homes include nursing homes, convalescent home with nursing, respite care with nursing, mental health crisis house with nursing and care home services without nursing. Residential homes include: residential home, rest home, convalescent home, respite care, mental health crisis house and therapeutic communities

The key reasons for bed use:

- A person's home
- Intermediate Care (Reablement and other services may make temporary placements in care homes as a 'step down' from hospital or 'step up' to avoid hospital admission. Reablement is described in the Community Strategy. There are also some beds used by people who have had serious physical injuries and are recovering which may be for several months)
- Respite care
- Long term care due to frailty
- Long term care due to complex health needs

2.7.2 Individual Patient Placements (IPPs)

Individual Patient placements are generally specialist hospital placements for individuals who have been detained under the Mental Health Act (MHA). S117 aftercare is care that is commissioned to meet an individual's mental health and care needs following an admission under Section 3 MHA.

Currently ways of offering care in or as close to individuals' homes as possible are being explored. Where individuals are placed out of area, there is a need to assure the quality of these placements and that they are not 'out of sight and out of mind'.

Individual Patient Placements include the commissioning of some highly specialist assessments, individual placements, and packages of care for:

a) adults with complex mental health problems 18 to 64 years

b) older adults over 65 years - these are more often related to functional mental health problems and sometimes clients will have had a forensic history. There is also a small minority of clients with dementia whose needs cannot be met by existing older people's inpatient units that require placement elsewhere
c) adults less than 65 years with early onset dementia
d) people with a learning disability and complex needs
e) physical disability requiring rehabilitation who do not currently meet the criteria for CHC. eg people with a Brain Injury requiring neuro rehabilitation or who have challenging behaviour or people with a complex mix of physical and mental health problems.
f) health funded components of s117 aftercare packages. This is aftercare for individuals who have been detained under certain sections of the Mental Health Act
g) health component of s17 leave for 1 month. This is leave from a hospital placement when an individual has been detained under the mental health act as part of a discharge process
h) Psychiatric Intensive Care Units (PICU)

2.7.3 End of Life

This is a range of services to provide palliative care, night time and day time nursing care, personal care and beds across the community. This includes bed based care such as that at St Lukes, care in hospital settings, care homes and services that take place in individuals homes, as well as that provided by other charitable service provision. Increasingly this is orientated towards provision of end of life care that would take place in a setting of an individual's choosing. Services need to develop to reflect this changing landscape.

3.0 NEEDS ASSESSMENT

3.1 Local demographics

For generic population information see Appendix 2 below. The following information gives an assessment of current need that has an impact on the complex care system.

3.2 Prevalence

3.2.1 Frailty[1]

An increased risk of adverse health outcomes can be predicted by early identification of frailty, and adverse outcomes prevented by appropriate multidisciplinary interventions.

Frailty in older people negatively impacts on their quality of life and causes ill-health and premature mortality. Older people who are frail have an increased risk of falls, disability, long-term care and death.

There is also a significant cost associated with the frail older population. Over half of gross local authority spending on adult social care and two thirds of the primary care prescribing budget is spent on people over 65 years of age.

Frailty is defined as having three or more symptoms from weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, and weak grip strength. It is estimated that of the 65 and over population approximately 11% are frail whilst about 42% have one or two of these symptoms and

[1] Better Care Fund planning template, Plymouth City Council and NEW Devon CCG, September 2014

are thus categorised as 'pre-frail'. This equates to 1.9% (4,782 people) of the Plymouth population who are frail and 7.0% (18,086 people) who are "pre-frail".

Table 2: Older people frailty estimates, Plymouth. (Source: 2012 mid-year estimates of usual resident population - ONS)

Age-group (years)	Reported frailty rate (%)	Reported pre-frailty rate (%)	Population	Estimated frail population	Estimated pre-frail population
65 and over	11.0	41.6	43,475	4,782	18,086
65 to 69	4.0	-	13,540	542	-
70 to 74	7.0	-	9,827	688	-
75 to 79	9.0	-	8,219	740	-
80 to 84	15.7	-	6,190	972	-
85 and over	26.1	-	5,699	1,487	-

3.2.2 Dementia

Approximately 60 people aged 30-64 years in Plymouth are estimated to have early-onset dementia in 2014.[2]

Over 3,130 over-65s are predicted to have a dementia in 2014. The number of cases of dementia in the over-65s is projected to increase over time, reaching around 4,850 by 2030[3].

The following are also useful statistics that impact on complex care:

- 70% of people living in care homes are thought to have a dementia
- 25% of people in hospital beds are thought to have a dementia
- 72% of people with dementia have at least one other long-term condition[4]

Table 3: People aged 65 and over predicted to have dementia, by age and gender, projected to 2030 (Source: Projecting Older People's Population Information - POPPI)

Ages	2014	2015	2016	2017	2018	2020	2025	2030
65 – 69	177	177	174	166	160	154	174	188
70 – 74	288	296	312	340	355	358	316	359
75 – 79	499	504	504	504	526	561	690	615
80 – 84	768	778	791	801	815	848	963	1,201
85 – 89	744	744	783	822	861	900	1,017	1,189
90 and over	659	687	687	714	745	804	1,038	1,303
Totals	**3,134**	**3,185**	**3,251**	**3,348**	**3,462**	**3,624**	**4,197**	**4,855**

[2] http://www.poppi.org.uk/ Viewed October 31st 2014
[3] http://www.poppi.org.uk/ Viewed October 31st 2014

[4] Care Home Residents Health Needs Assessment, Public Health Devon, April 2014
http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/

Figure 1: Care Home Population Pyramid for Plymouth as at 31st December 2013 (Source: Care Home Needs Assessment, April 2014 Public Health Devon)

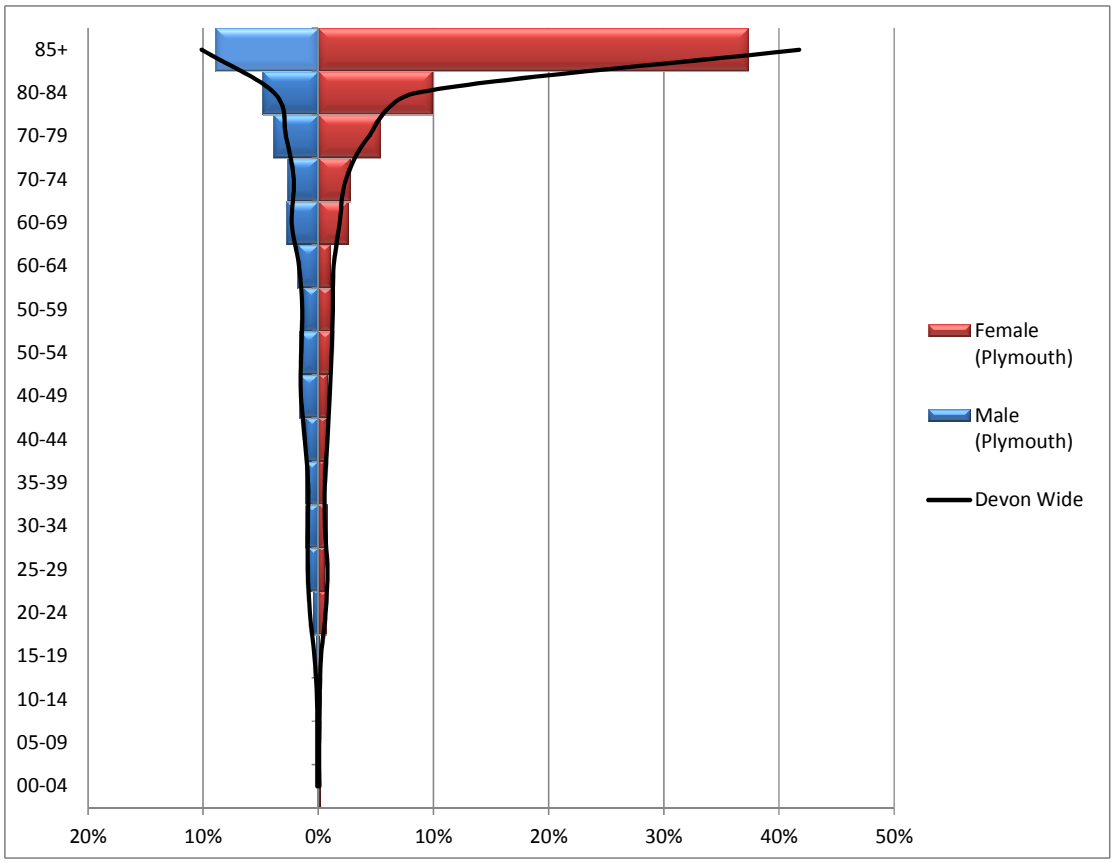
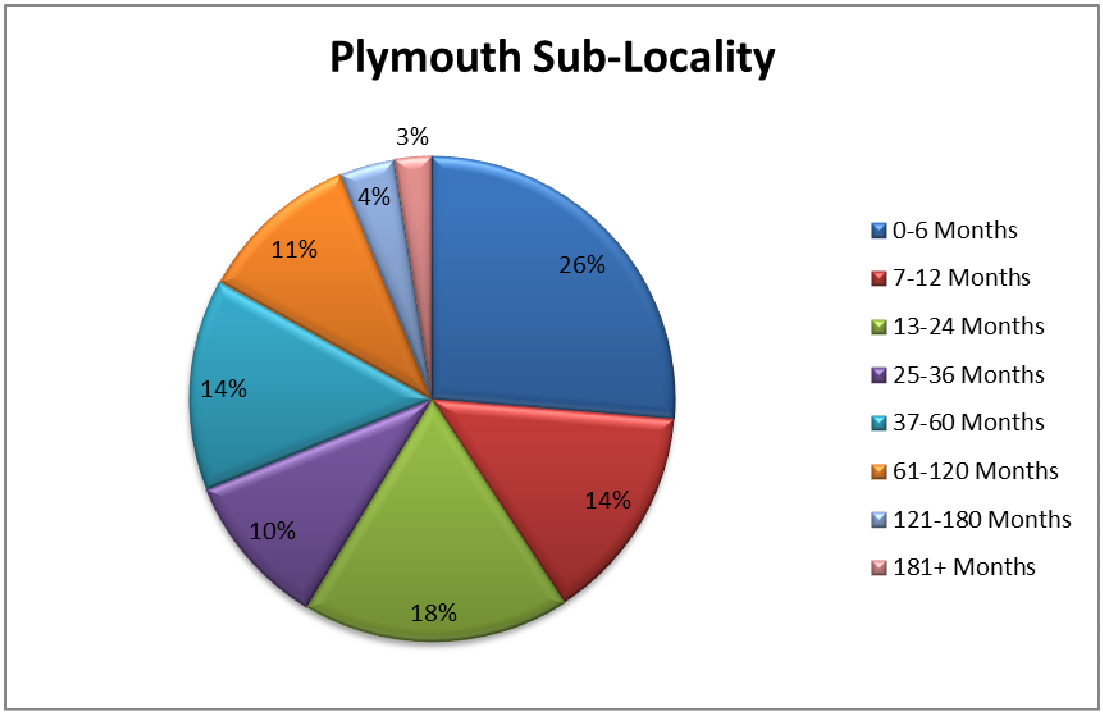


Figure 2: Care Home Length of Stay for Plymouth, February 2014 Source: Care Home Residents Health Needs Assessment, Care Quality Commission 2013



This demonstrates that 42% are in a care home for over 2 years, with 26% in a care home for less than 6 months. This is a very similar pattern to the rest of Devon.

Some of the people who will be in a care home for 0 – 6 months could be there because they are in respite or recovery as a 'step down' from hospital. Further work with providers will be needed to find out if they needed to be admitted to a care home at all or could have been discharged to their home.

3.2.3 Care Home to Hospital Admissions

The Care Quality Commission 'State of Care Report' (2013) looked at avoidable care home admissions and categorised them as bone fractures, dehydration, pneumonia and respiratory infections. In Devon (including Plymouth) there has been considerable interest in avoiding admissions from care homes due to the volume and cost of admissions. More older people are being admitted to hospital in an emergency with conditions that are generally avoidable**.** This is increasing faster than the growth in the older population. Among people living in care homes, hospital admissions for avoidable conditions were 30% higher for those who had dementia compared to those without dementia.

Avoidable admissions to hospital

Residents of care and nursing homes account for about 30% of all patients with hip fractures admitted to hospital. About one-fifth of people with a hip fracture die within one month and one-third within 12 months mostly due to associated conditions. Falls prevention is an essential intervention to improve the health and wellbeing of care homes residents. In Devon (including Plymouth) fractures and predominantly fractured neck of femur account for a large number of care homes admissions to hospital and the highest cost of any single cause. It is important to prevent falls but the principle of responding to the first fracture and preventing the second is also important[5].

Table 4: Number and Types of Admissions from Plymouth Care Homes (1stApril to 31 December 2013) (Data includes emergency and non-elective admission case types only) Source: Care Home Needs Assessment, April 2014, Public Health Devon

Fall	Pressure Sore	Diabetic Complication	Flu / Pneumonia	COPD	Constipation	Dehydration
423	162	49	183	266	130	248

Table 5: Types of Admissions per 100,000 Bed Days in Plymouth (Over the previous 24 months as at 31 December 2013) (Data includes emergency and non-elective admission case types only) Source: Care Home Needs Assessment, April 2014, Public Health Devon

No. Falls per 100,000 Care Home Bed days	No. Pressure Sores per 100,000 Care Home Bed days	No. Diabetic Complications per 100,000 Care Home Bed days	No. Flu / Pheumonia per 100,000 Care Home Bed days	No. COPD per 100,000 Care Home Bed days	No. Constipation per 100,000 Care Home Bed days	No. Dehydration per 100,000 Care Home Bed days
24.8	9.5	2.9	10.7	15.6	7.6	14.5

[5] Care Home Residents Health Needs Assessment, Public Health Devon, April 2014 http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/

Table 6: Cost of Admissions to Hospital from Plymouth Care Homes (Data includes day case elective, emergency, inpatient elective, inpatient non-elective and day attender admissions) Source: Care Home Needs Assessment, April 2014, Public Health Devon

Period	Total No. of Admissions	Total Cost (£s)	Total Admissions per 100,000 Care Home Bed Days
Last 12 months	1380	£3,420,261	168.41
12 – 24 months	1491	£3,312,868	
24 – 36 months	1594	£3,750,626	

Ambulatory Care Sensitive (ACS) conditions are a group of conditions including angina, Coronary Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), asthma and diabetes where admissions to hospital can be avoided through effective case management in primary and community care.

The Care Quality Commission 'State of Care Report' (2013) recommends three ways that providers and commissioners can respond to reduce rates of Ambulatory Care Sensitive admissions:

- Develop a local understanding of the rate and trend of admissions for each Ambulatory Care Sensitive condition in their area as markers of local performance. Where admission rates for a particular condition in their area appear atypical (that is, usually higher than expected) when compared with similar areas, undertake further local analysis to explore why this is the case.
- Where proven interventions or quality standards exist for a condition, ensure that these are in place across their own area.
- Consider the extent to which broader strategies for reducing the need for emergency admission are being successful. In particular, focus on changes in key patient groups, especially care for frail older patients. The need is not only to prevent hospital admission, but also to prevent the distress and deterioration of the patient that leads to hospital admission

3.2.4 Limiting Long Term Illness[6]

Between 2014 and 2030 it is expected that the number of people in Plymouth aged over 65 with a limiting long term illness will rise from 23,739 to 31,950. By 2030 16,538 people will be severely limited in their day to day activities. This may have an impact on the demand for complex care services including care homes and IPPs.

Table 7: Illnesses, conditions or disabilities which may impact on the complex care system in Plymouth (Source: Care Home Residents Health Needs Assessment, April 2014, Public Health Devon)

Illness/ Condition/disability (total population 65 and over)	2014	2015	2016	2017	2018	2020	2025	2030
Limiting long term illness severely limiting day-to-day activities	12,041	12,269	12,434	12,643	12,875	13,368	14,980	16,538
Longstanding health condition caused by a heart attack	2,222	2,256	2,290	2,321	2,362	2,416	2,672	2,931
Longstanding health condition caused by a stroke	1,045	1,064	1,079	1,097	1,119	1,149	1,284	1,407

[6] http://www.poppi.org.uk/ Viewed February 17th 2015

Longstanding health condition caused by bronchitis and emphysema	766	778	790	801	815	831	914	1,004
Number admitted to hospital as a result of falls	935	953	965	985	1,010	1,065	1,228	1,343
Those with severe / profound sensory impairment – visual and hearing	1,876	1,909	1,942	1,969	1,987	2,001	2,076	2,316
Mobility – unable to manage at least one activity on their own	8,235	8,392	8,567	8,735	8,947	9,305	10,429	11,749
Obesity (BMI of 30 or more)	11,925	12,079	12,240	12,376	12,536	12,695	13,693	14,854
Diabetes (Type 1 or Type 2)	5,656	5,733	5,820	5,918	6,025	6,125	6,690	7,342
Moderate / Severe Learning Disability	128	130	132	134	135	137	147	160

3.2.5 Learning disability and challenging behaviour in Plymouth[7]

The number of people aged between 18 and 64 with a severe learning disability or with a learning disability who are likely to display challenging behaviour is likely to remain stable up to 2030. So this will not in itself create pressure on care homes or IPPs.

Table 8: People aged 18-64 predicted to have a severe learning disability, and hence likely to be in receipt of services, by age, projected to 2030

People aged 18-64 predicted to have a severe learning disability	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have a severe learning disability	73	74	71	70	78
People aged 25-34 predicted to have a severe learning disability	52	52	53	53	51
People aged 35-44 predicted to have a severe learning disability	50	49	49	51	52
People aged 45-54 predicted to have a severe learning disability	40	40	37	33	33
People aged 55-64 predicted to have a severe learning disability	33	33	36	37	36
Total population aged 18-64 predicted to have a severe learning disability	**249**	**249**	**246**	**245**	**250**

[7] http://www.pansi.org.uk/ Viewed February 17th 2015

Table 9: People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030

People aged 18-64 with a learning disability predicted to display challenging behaviour	2014	2015	2020	2025	2030
People aged 18-24 with a learning disability, predicted to display challenging behaviour	16	16	15	15	17
People aged 25-34 with a learning disability, predicted to display challenging behaviour	16	16	16	16	15
People aged 35-44 with a learning disability, predicted to display challenging behaviour	14	13	13	14	14
People aged 45-54 with a learning disability, predicted to display challenging behaviour	15	15	14	12	12
People aged 55-64 with a learning disability, predicted to display challenging behaviour	13	13	14	15	13
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	**74**	**74**	**73**	**72**	**72**

3.4 Predicting future demand

3.4.1 Care Homes

Demand for care home placements derives from 3 main sources: Plymouth City Council commissioned activity, NHS Continuing Health Care activity and people who pay privately (self-funders). There are a small number of other factors that influence demand for care home beds, such as other local authorities and charitable funding.

Projecting Older Peoples Population Information (POPPI) projects an increase in demand in over 65s care home places in Plymouth. The total population aged 65 and over living in care homes with or without nursing is predicted to rise from 1,524 in 2014 to 2,408 in 2030. This increase in provision will need to be met through an increase in bed capacity unless alternative models of care are developed.

An ageing profile of older people will mean increased prevalence of dementia and other long-term conditions with individuals often having multiple long-term conditions. Indeed the complexity of need of people living in care homes appears to be increasing

The number of physically frail elderly in nursing and residential care has fallen since 2005 whereas there has been an increase in NHS funded placements in care homes with nursing. There has also been a significant increase in the proportion of older people with mental health difficulties in care homes. These trends are expected to continue and reflect the desire and ability of physically frail older people to remain independent at home for longer, as well as the growth in the number of older people with dementia

Projecting Adult Needs and Service Information (PANSI) predicts that the number of people with a severe learning disability and those with LD who also have challenging behaviour is predicted to remain stable over the next 15 years. The number of care home places for people under 65 is predicted to fall as people with learning disabilities are better supported to remain in the community.

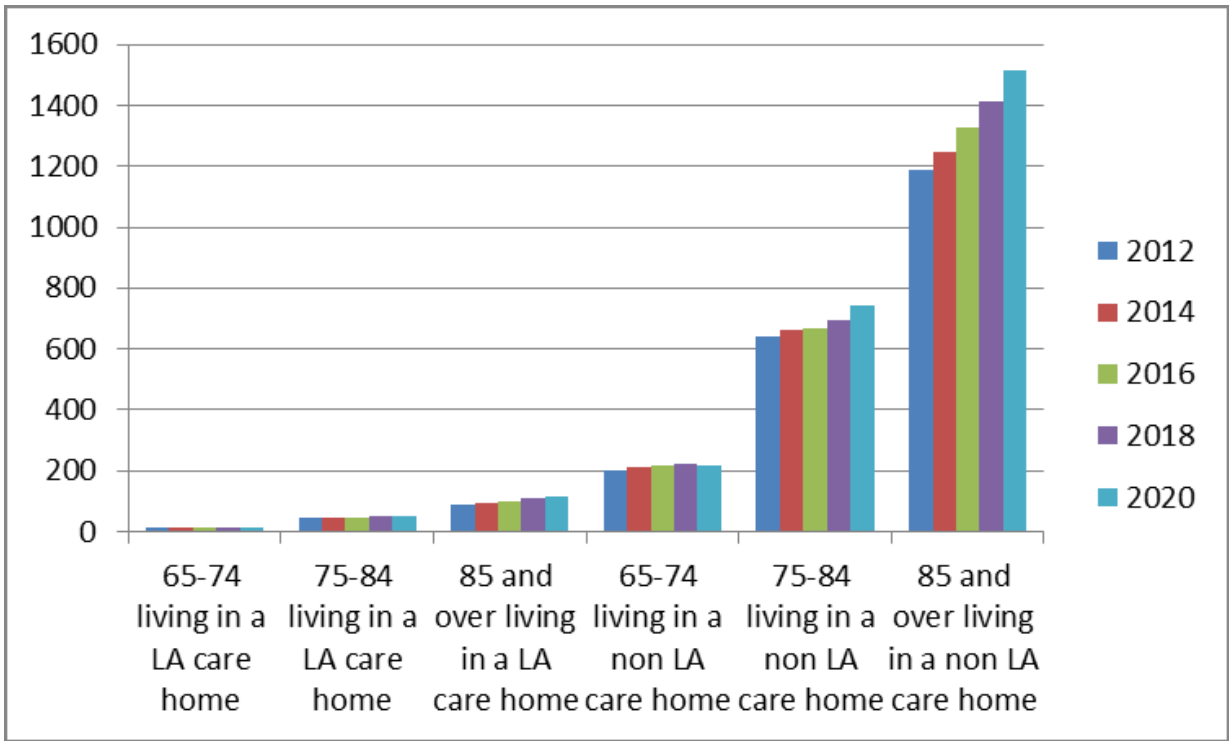
3.4.1.1 Ageing population and increasing complexity of need impact on residential and nursing care

Plymouth is expecting to see a rise in the number of older people in the City over the next 20 years. This, together with the predicted rise in those living with dementia and the projected increase in other illnesses leading to a longstanding health condition is likely to have an impact on the residential care services required in Plymouth. This can be addressed by commissioning priorities within the Community Strategy which aim to reduce length of stay, develop extra care, delay need for care and support whilst also ensuring a sufficient capacity in terms of care home placements where required.

Table 10: People aged 65 and over living in a care home with or without nursing, by age, projected to 2030 (POPPI)

	2014	2015	2016	2017	2018	2020	2025	2030
People aged 65 - 74	202	206	209	212	212	211	211	233
People aged 75 – 84	445	450	450	457	469	498	594	615
People aged 85 and over	877	907	937	966	996	1,071	1,278	1,560
Total population 65 and over living in a care home with or without nursing	**1,524**	**1,563**	**1,596**	**1,635**	**1,677**	**1,780**	**2,083**	**2,408**

Figure 3: Projected Increase in Residents in Plymouth Living in Care Homes With or Without Nursing (POPPI 2013)



3.4.1.2 Care Act 2014 impact on residential and nursing care

The Care Act will result in increased pressure on public funding and will potentially have an impact on the care home market.

The implementation of the Care Act could significantly extend the number of individuals receiving Local Authority contribution toward their residential care costs - in effect, a new class of 'self-funder top-ups'. Given individuals who become entitled to a Local Authority contribution to their residential care costs cannot be expected to move, these self-funder top-ups are therefore likely to be subject to existing rules on top-ups, which seek to protect local authorities, providers and families.

3.4.2. Individual Patient Placements

More information is needed about possible increasing numbers of young people with autism/mental health and very challenging behaviour. A rising number of older people with dementia are likely to mean that s117 packages for people with dementia and complex needs are likely to rise. The number of people with severe learning disability with challenging behaviour is predicted to remain stable. However, planned commissioner response to this should mean that demand for out of area placements are not in the main expected to rise.

3.4.3. End of Life

Medical advances allow us to keep people alive for longer and there will be a continuing increase in the number of people who are living with increasingly complex conditions. Whilst the number of people dying at home is gradually increasing, the public expectation to die at home will mean increasing resources in terms of the cost of nursing complex conditions. Indications are that when people are asked about "Preferred Place of Care" at the end of their lives, the majority of people would chose home. If their usual place of care is a care home, this should be supported although it has implications in terms of service provision to safely support complex packages of care

End of Life providers are able to fund a majority of the care they provide through their own fundraising and are thus able to influence how the market provides this care. However, statutory services provide a significant amount of input to the care provided in the community

3.5 Consultation feedback

NHS England through national consultation has developed the following 'I' statements in relation to the outcomes for patients from Continuing Health Care and Dementia Care:

The CHC 'I' statements are:

- I receive care and support that helps me live the best life I can and promotes my independence
- My care workers know me, understand me and do everything they can to help me
- My care workers have the right knowledge and skills to meet my needs
- I am supported to have choice and control wherever possible over my care and support
- The care and support I need is designed around my needs
- I know who to contact about my care arrangements

The Dementia Strategy 'I' Statements are:

- I have personal choice and control or influence over the decisions about me
- I know that services are designed around me and my needs
- I have support that helps me live my life
- I have the knowledge and know-how to get what I need
- I live in an enabling and supportive environment where I feel valued and understood
- I have a sense of belonging and of being a valued part of family, community and civic life
- I know there is research going on which delivers a better life for me now and hope for the future

The Devon, Plymouth and Torbay Care Home Quality Collaborative has developed the following 'I' statements in relation to what good medical care in care homes looks like:

- I will be able to register with a GP of my choice, and stay with my existing GP if this is possible
- I will be able to see or speak to my GP when I have a medical need; my needs and feelings will be the most important part of decisions about my medical care and treatment, whether I am able to discuss this or not. I may also want my family or other significant person to be included in these decisions
- I will be cared for by a team of people who are equally valued and able to meet my needs, and who treat me with dignity and respect
- I will have the same access to specialist care when I need it, provided in the most appropriate setting to my needs
- I (care home staff) will feel valued and respected as part of the team looking after our residents

3.6 Summary of Needs, Performance and Future Demand

- A significant proportion of the adult social care and primary and secondary health care budgets are associated with the elderly frail population
- Early identification of frailty and appropriate interventions can reduce adverse outcomes and save money
- Residents of care homes account for a significant proportion of avoidable admissions to hospital, falls being a major cause, and admission to hospital is more likely for people with dementia
- Lifestyle related diseases and multi-morbidities in future years are predicted to increase resulting in a larger number of residents who could be more dependent.
- An ageing profile of older people will mean increased prevalence of dementia and other long-term conditions; with individuals often having multiple long-term conditions. The complexity of need of people living in care homes is increasing. This will mean care home provision will need to be better at supporting people with complex needs particularly dementia and mental ill-health
- The changing demographics described above will result in increasing demand for care home placements and nursing care
- There is not likely to be an increase over time in the number of people with a severe learning disability or challenging behaviour so this is not an area that will put pressure on the need for more care home beds or IPPs
- Individual patient placements are often out of area and expensive
- There is pressure from national policy and the public to ensure that people can die in their preferred place of care
- The 'I' statements will be used to benchmark future performance

4.0 STRATEGIC CONTEXT

4.1 National

4.1.1 Winterbourne View and Frances Reports[8]

A number of serious cases have been identified nationally including reports of abuse and neglect exposed in the Winterbourne View review. The Frances report published on 24th February 2010 reviewed the failings of the Mid Staffordshire NHS Foundation Trust between the periods of 2005–09. The Francis report highlights 'a systematic failure of the provisions of good care'. To support all organisations to learn from and respond to the recommendations of the report, three further reports have been published to help embed effective governance and detect and prevent such serious failures occurring again. The themes of these are identifying early warning signs, assuring quality and providing governance to present such failings occurring.

4.1.2 NHS ENGLAND standards for Continuing Health Care

The right people are being identified and being assessed for NHS CHC using the national tools, and that the assessments accurately reflect individuals' care needs

The quality of the 'patient experience' fits with the aspirations in the 'I statements' (as described in paragraph 3.5 above)

The NHS CHC assessment process is adequately resourced to ensure that statutory responsibilities are met in a timely way

All levels of staff who are involved in the NHS CHC assessment process are appropriately trained – with an emphasis on partnership working across organisations and also workforce planning

Systems are in place to support and empower staff in working confidently with individuals, their families and their representatives, and also in raising any concerns around the level and quality of care provided

Accurate written and verbal information is given to individuals throughout the NHS CHC process, and the views of the individuals (and/or their representatives) are recorded and considered

4.1.3 National End of Life Strategy (Department of Health)

The key measure of progress against the End of Life Care Strategy is the preferred place of care this is usually the 'home' setting. If this figure continues to rise it suggests that more people are able to receive care and to die in the place of their choice. "At home" has always been a proxy for choice in end of life care. For many people in care homes, that itself becomes their home and they would no more wish to leave there at the end of their life than they would their own home.

The end of life care pathway continues to provide the framework for a wide range of activity from identifying the right people who need end of life care through to supporting bereaved families and carers. It is essential that service redesign continues – in particular, to make sure that the right services are in place to support people at home and in care homes. The End of Life Care Strategy emphasizes the importance of providing care where people would prefer to be. Very often this means providing care away from the acute hospital setting. However, there will always be people who choose to die in hospital, and others for whom hospital is the only realistic option so it is important that care there improves too.

While the end of life care pathway itself is generic, different types of condition need more tailored approaches. Cancers, for example, while themselves a heterogeneous group, are a different proposition from dementia. It will not be possible or necessary to devise specific pathways for every single disease but it will be helpful to have a range applicable to the broad groupings

[8] (Transforming care: A national response to Winterbourne View Hospital *Department of Health Review: Final Report 2012)* and http://www.midstaffspublicinquiry.com/

4.1.4 Integrated Personalised Commissioning and Personal Health Budgets

Integrated Personal Commissioning is a new voluntary approach recently launched by NHS England to help to join up health and social care for people with complex needs. This proposal makes a triple offer to service users, local commissioners and the voluntary sector to bring health and social care spend together at the level of the individual. People will be offered power and improved support to shape care that is meaningful to them. Local authorities and NHS commissioners, and providers will be offered dedicated technical support, coupled with regulatory and financial flexibilities to enable integration. The voluntary sector will be a key partner in designing effective approaches, supporting individuals and driving cultural change. Plymouth City Council and NEW Devon CCG are jointly participating in this work and will be collaborating with NHS England and partners across the South West. This is an opportunity to bring together resource and expertise, share good practice and collectively overcome barriers to implementation.

Personal health budgets are a key strand of the government's drive to personalise public services. The Personal Health Budget Programme was launched in 2009 after the publication of the Next Stage Review. An independent evaluation was commissioned alongside the programme which revealed that personal health budgets led to a better quality experience for service users and helped them to become less reliant on conventional health services.

From October 2014 people receiving NHS Continuing Health Care (CHC) were given the 'right to have' a personal health budget. It is now a priority for Plymouth City Council and the NEW Devon CCG to integrate health and social care services to ensure that people who choose to have a personal health budget are properly supported and can maximise the opportunities that this can bring, to take more control over their care and support and achieve a greater level of independence.

Our ambition for personal health budgets locally is to use the concept as a spring board to foster person-centred care and deliver services in a more integrated fashion. Implementation will help commissioners to support people with health and social care needs, particularly those in receipt of Continuing Healthcare (CHC) funding, to live more independently, remaining in their own communities and staying in their own homes for longer.

4.2 Local

4.2.1 Our Plan: The Brilliant Cooperative Council

The Strategy will support the achievement of the following Council objectives and outcomes:

- Pioneering Plymouth: A Council that uses its resources wisely
- Growing Plymouth: More decent homes to support the population
- Caring Plymouth: People are treated with dignity and respect
- Confident Plymouth: Government and other agencies have confidence in the Council and partners: Plymouth's voice matters.

4.2.2 The Plymouth Plan – How Plymouth Will be a Healthy City (in development)

The Plymouth Plan is a single holistic plan setting out the direction for the City up to 2031. It brings together all the key strategies and plans for the city into one coherent document. It does so because the interdependencies of these strategies and plans are key to transforming the City. The section on health recognises that over the course of the Plymouth Plan period demographic changes and increasing complexity of need will continue to put pressure on all vital front-line services. The challenge for the public sector is to meet the volume and complexity of demand with decreasing resource. A focus on prevention is evidenced to reduce the burden of disease and consequently reduce demand on front-line services. The Plymouth Plan will show how partners and services from across the city can achieve this aspiration.

4.2.3 Health and Wellbeing Strategy (2014) (Plymouth Health and Wellbeing Board)

The Joint Health and Wellbeing Strategy is intended to inform commissioning decisions across local services, such that they are focused on the needs of people and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. Underpinned by the Marmot review the Strategy recognises that health and wellbeing must be addressed across the whole life course.

4.2.4 Joint Dementia Strategy (2014 – 16) (Plymouth City Council and NEW Devon CCG)

The Strategy sets out our commitment to improving outcomes for people with dementia and their carers, recognising the imperative of working together to achieve this. Dementia is a condition that needs to be understood not only by health and social care organisations but by the whole of society as well, making dementia 'everybody's business'.

The strategy gives the following commitments by the CCG and Plymouth City Council:

- To continue to promote the benefits of healthy lifestyles and health checks
- To recognise that the stigma still felt by some people with dementia discourages them from seeking the help and support they need and exacerbates feelings of loneliness and isolation.
- To ensure that people experience care and support that is personalised and coordinated, delivered in the right place at the right time and to continue to work in partnership to achieve this.
- To measure and report progress on delivering better outcomes and to oversee our planning and activity through a clear governance structure.
- To respond to the new duties for Local Authorities laid out in The Care Act, recognising its importance in reforming care and support and prioritising wellbeing.

Key specific aims in the strategy that relate to complex care include supporting continuous quality improvements in hospital and care home settings and ensuring carers are supported and involved in decision making. The levers for achieving this are the Dementia Quality Mark for care homes, the Hospital CQUIN targets that relate to dementia and carers and the Joint Carers Strategy.

4.2.5 NEW Devon CCG 5-Year Strategic Plan Summary 2014-2019 and 5 pillars

This plan provides the basis for moving forward with a whole-system strategy for health and social care, setting out how we will work together as a system to tackle the challenges we face and move forward to deliver changes in the way we meet the needs of people who use our services. The vision has 5 key aims to improve a patient's experience of local health services.

1. Partnerships to deliver improved health outcomes
    - Informed users of healthcare through improved lifestyle advice, support and preventative services, to be healthy and reduce the need for treatment
    - Services designed & delivered in a targeted way to reduce health outcome inequalities
    - Organisations and businesses across local communities supporting schemes to improve health and wellbeing with greater local co-ordination
2. Personalisation and integration
    - Greater access to personal health and social care budgets supporting and empowering those in most need
    - Personalise community health and social care services
    - More services for individuals will be coordinated by a single agency
    - Improved services will see people stay safe, well and at home for longer
    -

3. At scale general practice registered populations as the organising units of care
    - Improved access to wider primary care teams for longer hours over 7 days with a range of different locations to visit for urgent care
    - Registered GP lists ensure regular contact with the same professional for long-term care
    - Enhanced range of services delivered around a GP practice with more care organised by the wider practice team; more flexible access for minor conditions

4. A regulated system of elective care that delivers efficient and effective care for patients
    - More one-stop treatment will be the norm for elective services personalised for patients, some provided in bigger centres, but with less visits
    - More support to self-manage conditions and reduce the need for surgery or specialist care in the first instance
    - More care provided in the GP practice with support to find the right place when specialist input is required

5. A safe and efficient urgent care system
    - Supported to self-manage and stay safe, well and at home for longer
    - A single organisation to organise all care needs and respond to personal requests
    - A single number making it easy to seek advice, navigate urgent and emergency care and access the right local services the same day
    - Most specialist care available in the CCG with some further afield.

4.2.6 Integrated, personal and sustainable community services for the 21st century: A Strategic Vision for Transforming Community Services, NEW Devon CCG, Aug 2014

Five year local outcome ambitions relating to Complex Care include:

- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the proportion of older people living independently at home following discharge from hospital

4.2.7 Transforming Community Services: Western Locality Commissions Intentions, proposal document, Sept 2014

This document has been published as a consultation document by the CCG. The general proposition is that there must be a greater focus on health promotion and ill health prevention, where resources are moved from traditional acute services to modern, efficient community services.

The vision of the Clinical Commissioning Group is 'Healthy People, Living Healthy Lives in Healthy Communities'. This is reflected in the six strategic priorities for delivery of Community Services.

The following strategic priorities impact on Complex Care:

- Co-ordinate pathways

  We are reviewing pathways of care for individuals from prevention of illness, planned care, urgent care, response to crises and rehabilitation to ensure they are effective, bringing about good outcomes for individuals and populations and they represent good value for money.

- Think carer, think family

  Many people rely on carers to help them with day to day living; many people are carers who have their own needs to support their own health and wellbeing. We will actively consider carers and families when designing services such that they are offered in a way that is

conducive to people having excellent experience of their care and their care bringing about good health and wellbeing outcomes

- Home as the first choice

  We are exploring ways of offering care in or as close to individuals' homes as possible, ensuring quality, safety and cost effectiveness. There will always be a need for in-patient beds in the community. Effective and strategic use of beds will particularly help to avoid admission when care could safely and effectively be delivered elsewhere. Greater use of modern technologies, advance planning and ensuring that services are provided with individuals taking informed choices is key.

One aim of Transforming Community Services is to review pathways for people with complex needs.

It is estimated that 20 – 30% of emergency admissions to hospital could have been avoided if appropriate alternative forms of care had been available or if care had been managed better in the period leading up to admission. It is proposed to commission joined up care that follows patient flows within a natural geography – that is the path patients take through local services – in order to maximise shifts in care from acute to community settings and design the system for out of hospital care. The influence of this pathway approach is that specialist elderly care physicians and primary care expertise would be at the heart of the community services

The commissioning intentions for people with complex needs are to create pathways which will:

- support natural patient flows and geography (e.g. primary to community to acute)
- support improving patient pathways to enable more care at home or closer to home
- support the achievement of ambition through collaboration and transformation as the norm between commissioner and provider

Service providers will provide a health and social care system that:

a) Chooses to admit only those frail older people who have evidence of underlying life-threatening illness or need for surgery

b) Provides early access to an old age acute care specialist, ideally within the first 24 hours, to set up the right management plan

c) Discharges to assess as soon as the acute episode is complete, in order to plan post-acute care in the person's own home

d) Provides comprehensive assessment and reablement following acute care, to determine and reduce long term care needs.

These principles can also be applied to other people such as those with respiratory conditions.

Wherever possible the 'home as the centre' of care, built firmly around the GP as a care co-ordinator, enabling individuals to take greater responsibility for their health and wellbeing, with the support of carers and families.

4.2.8 Commissioning Framework - The Top 6 Commissioner Priorities 2014 – 16 (NEW Devon CCG)

The following priorities apply to Complex Care:

-The general thrust of commissioning for non-elective care is to move from a bed based model of reactive care to a model of care that is closer to home and places prevention and well-being at its heart. It is the intention to use funding released from bed based care to increase the capacity of community teams and the total volume of care that is available for people living in Plymouth and ensure that all people living with a dementia and/or cognitive impairment are identified.

- Individual Patient Placements. As part of their experience of learning disability, mental health and social care support and treatment services, considerable numbers of people, both adults and children, are placed in facilities in the public, independent and third sectors for support. In many but not all cases, services are local to families, friends and services. For some, services may be at a considerable distance from their usual support networks. The Winterbourne View action plan contained clear expectations regarding the reduction in out of area placement for people with a learning disability. This plan focused on overcoming the negative consequences of out of area placement and the learning from individuals' experiences of Winterbourne View can be applied to all patient groups

- The focus will be on the prevention of out of area placements through the provision of alternatives to hospital admission and the redesign of pathways for individuals requiring step down from higher levels of secure care. Consideration will be given to utilising a risk stratification tool to identify those individuals most at risk of repeated admissions or an out of area placement and target resources to support these individuals appropriately.

4.2.9 Care Home Quality Collaborative Vision (2014)

- People living in care homes will have the same opportunities to live a good quality, healthy life as part of their community
- People will feel at home and have a voice
- People will be able to have fun and enjoy life
- People will have a care and support plan that describes their needs and those needs are met by someone who understands them and is able to meet them
- People working in care homes will feel valued as part of the whole health and social care system

4.2.10 Better Care Fund Submission 2014 (NEW Devon CCG and Plymouth City Council)

To use the Better Care Fund to support our wider strategic aims for integration across our population. These aims are to:

- Strategically join the key actions we know will make a difference.
- Consistently commission great services that deliver to defined outcomes.
- Positively shift resources to parts of the system where there is most benefit.
- Adopt an asset based approach to help communities to help themselves.
- Target our attention to impacting on inequalities and services for the most vulnerable.
- Bring a new model of out of hospital care.
- To put in place schemes and arrangements to progress towards the national conditions of the BCF and achieve our desired outcomes. The national conditions include protecting social care services, seven day working, data sharing, and ensuring joint assessment and accountability for individuals at high risk of hospital admission.
- To improve performance outcomes. This will include the national outcomes set by the BCF, but also the additional local outcomes that will enable us to achieve our aims. The national outcomes for performance improvement include: delayed transfers of care, avoidable admissions, effectiveness of reablement and patient / user experience.
- To fully embrace the opportunity presented by the BCF to change the nature of commissioning and the speed and scale of integration. To work closely with our local authority partners and providers to make this happen.
- To integrate our commissioning, services delivery and health and wellbeing.

- To fully embrace the opportunity presented by the BCF to change the nature of commissioning and the speed and scale of integration.

4.3 Key legislation

4.3.1 Health and Social Care Act 2012

The Health and Social Care Act 2012 provides the basis for better collaboration, partnership working and integration across local government and the National Health Service (NHS) at all levels. The act also identifies 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, with an emphasis that care is integrated around the needs of the person.

4.3.2. Care Act 2014

The proposals for integration are supported by the provisions of The Care Act 2014, which has been 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*.

4.3.3 The Social Value Act (2012)

Requires all public bodies to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the community. 'Social value' involves looking beyond the price of the individual contract and considering the social impact on the community when the contract is awarded.

4.4 Evidence based / good practice

4.4.1 Summary

This strategy will incorporate good practice and build on an evidence base to improve the health and social care outcomes of people in Plymouth. The following good practice resources, research and data can be accessed by health and social care professionals and commissioners:

- Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/
- National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/
- The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/
- NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/
- Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/
- Care Quality Commission (CQC) - http://www.cqc.org.uk/
- Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/
- Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm
- The Devon, Plymouth and Torbay Care Homes Health needs assessment www.devonhealthandwellbieing.gov.uk

More detailed descriptions of the resources listed above can be found in appendix 1.

4.4.2 Dementia Care[9]:

There is good evidence that providing pro-active case management within primary care to people with dementia improves their mental health which should prolong their ability to remain living at home.

- Cognitive Stimulation Therapy was found to benefit people with mild to moderate dementia in relation to cognitive function, quality of life and well-being.
- Information provision was found to improve quality of life.
- Improved environments within care homes was found to improve patient engagement and reduce violence, aggressive behaviour, falls and staff morale;
- Reminiscence therapy was found to improve mood between 4 – 6 weeks;
- Exercise was found to improve cognitive functioning;

4.4.3 Care Homes[10]

There is limited evidence to support the assumption that the care of people with dementia in special care units is superior to care in traditional nursing units and quality standards for dementia should be met regardless of setting – NICE 2013

There is some evidence that exercise is important to preventing falls and to delaying the onset of dementia. Social interaction and activity is important to quality of life.

One of the major problems identified was that older people in care homes do not have access to enough activities or ways to occupy their time. It has also been reported that many care home residents have problems accessing NHS primary and secondary healthcare services. A lack of activity and limited access to essential healthcare services can have a detrimental impact on a person's mental wellbeing.

'Transforming our Health and Care System' (Kings Fund 2013) includes ten high impact changes for commissioners including care co-ordination through integrated health and social care teams.

'Co-ordinated Care for People with Complex Needs' (Kings Fund 2013) highlights that programmes should be localised so that they address the priorities of specific communities. Models of care co-ordination are likely to be more effective when operating as 'fully-integrated' provider teams with some operational autonomy. The paper raises some principles that are applicable to integrated care for care home residents.

A systematic review (Davies 2011) on integration between health services and care homes yielded inconclusive results and despite evidence about what inhibits and facilitates integrated working there was limited evidence about what the outcomes of different approaches to integrated care between health service and care homes might be. The review identified a need for more research to understand how integrated working is achieved and to test the effect of different approaches on cost, staff satisfaction and resident outcomes.

No conclusive research exists to suggest that any nursing model or skill-mix model would be effective at improving patient or staff wellbeing in a residential aged-care facility.

Evans undertook an evaluation that adopted a mixed methods approach, combining quantitative performance data with semi-structured stakeholder interviews and emergency bed use costings. The

[9] Llewellyn, D. Dr; Lang, I. Dr.Current evidence on dementia prevention, treatment, and care, *University of Exeter Medical School and Devon County Council. 2014*

[10] Care Home Residents Health Needs Assessment, Public Health Devon, April 2014 http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/

evaluation suggested that the project made significant steps towards integrating care homes with the health and social care community and demonstrated cost savings through reduced hospital bed use. Health and social care interventions aimed at upskilling care home staff can increase standards of care and quality of life for residents; they are also likely to highlight unmet needs. The project demonstrated the need for better integration of health and social care services with care homes in order to improve quality of life for residents. (Evans 2013)

The Better Care Fund has been developed to support integration of local health and care services. The integration work needs to demonstrate a reduced demand through a reduction of permanent admissions to care homes and reduce potentially avoidable hospital admissions both rely on integrated effective local services

4.4.4 Reducing Harm and Hospital Admissions from Care Homes

Brownhill (2013)[11] undertook an observational study looking at training in care homes to reduce avoidable harm. This study investigated the effectiveness of using workshop-based education and service-improvement models in care homes. The models were designed around both threshold and predictive modelling and were intended to raise awareness of the symptoms that may result from a fall, pressure ulcers or urinary tract infections. The project exceeded targets. Preventive assessments, care planning and timely referrals resulted in a reduction in avoidable hospital admissions and district nurse and GP visits.

Each home was set the following reduction targets:

- Falls-40%
- Recurrent falls - 60%
- Care home-acquired grade 2 pressure ulcers - 75%
- Care home-acquired grade 3 and 4 pressure ulcers - 95%
- Urinary and catheter-acquired infections - 40%
- Hospital admissions - 60%
- District Nurse visits - 40%
- GP visits - 40%

Once the targets had been reached, the study aimed to sustain the levels through continuing to work with the care homes. Through a robust training package and tailored support, the study reported a reduction the number of avoidable hospital admissions from participating care homes by 51%. By raising awareness of symptoms and encouraging early risk assessment and care planning, the study reported that the level of care delivered to vulnerable patients was raised. It reported a significant link between falls and urinary tract infections. Early assessment by care staff, including recognition of symptoms and urine dip test results, reduced the number of recurrent falls in care homes.

5.0 CURRENT PROVISION

5.1 The Care Home system

There are three routes into a care home;

- Following an Adult Social Care assessment
- Following a health assessment (Continuing Healthcare or Funded Nursing Care)
- People choosing to move into a home who are not eligible for public funding and who pay for themselves (referred to as ‘self-funders)

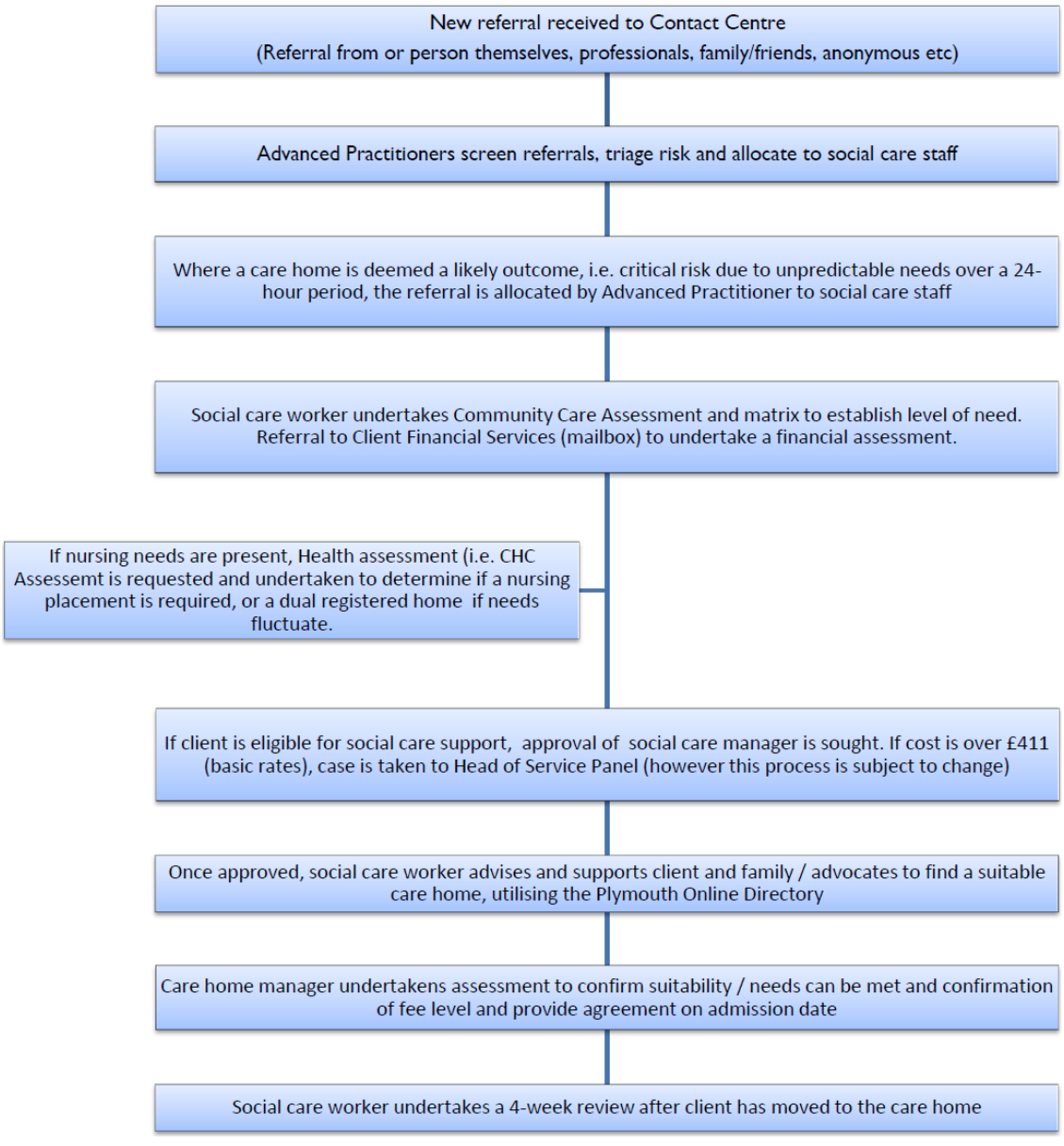
[11] As quoted in Care Home Needs Assessment Final, April 2014, Public Health Devon

Often a move into a care home is suggested because of an illness or a fall - but it is not always the only reason. It is also possible to have a short stay in a care home for a trial period or get respite care to give the service user or carers a break. When choosing a home, it is important to make sure that the one chosen is the right one. To help with this, a person should get advice and information from their social worker or care manager, a district nurse, a health visitor or their family doctor.

Care homes have to make it very clear what level of care they provide and how they will meet each resident's needs. If a resident is unable to leave the bed, or has a medical condition or illness that requires frequent medical attention, they may possibly need to look for a care home that provides nursing care. This type of home should have a qualified nurse on duty 24 hours a day.

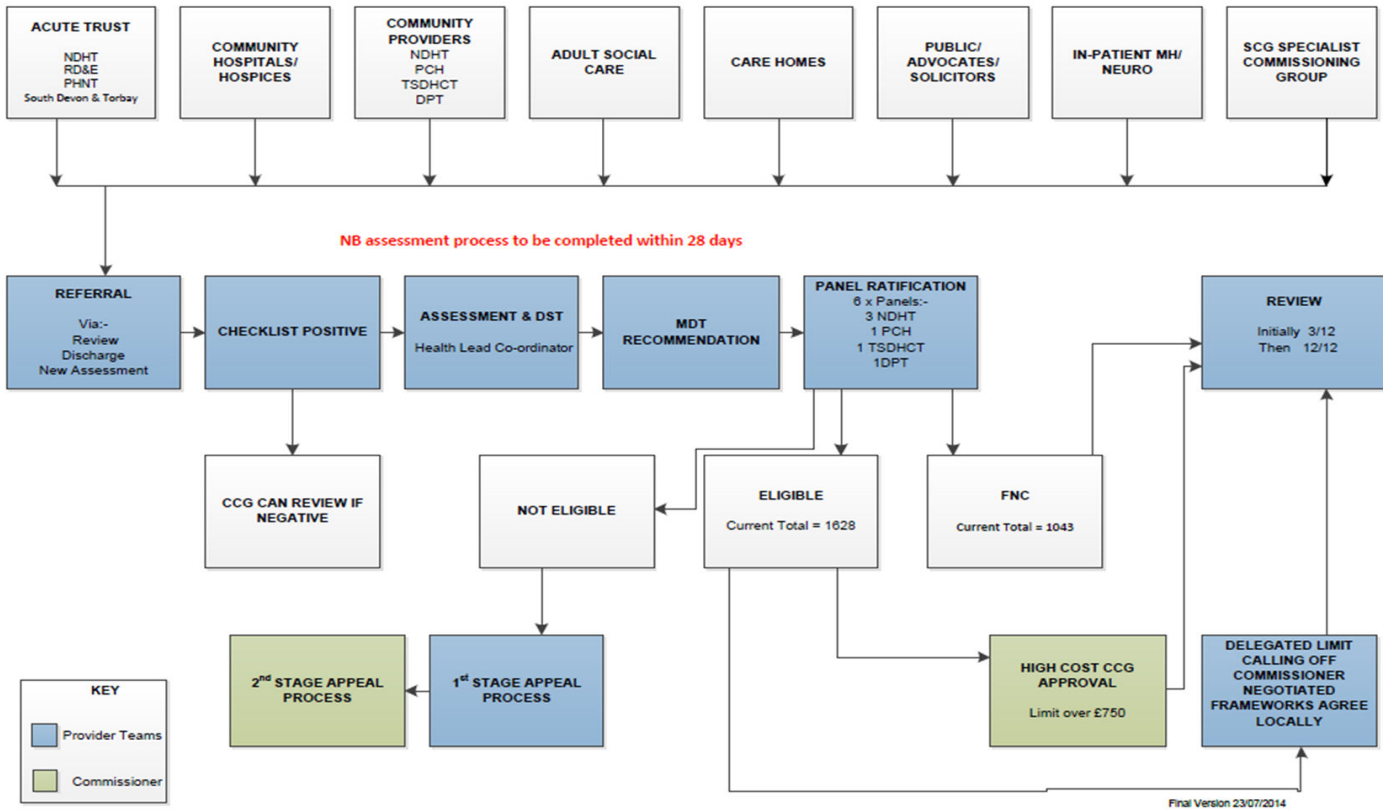
5.1.1 The process for assessing people for Adult Social Care funding

If a person is thinking of moving to a care home or has been paying for their own care in a care home and want to see if the local authority can help with the fees, they must first have their needs assessed by the Council to see if they are eligible for adult social care support. After the social care needs have been assessed, and if the person is eligible for social care support, the local authority will conduct a financial assessment. This will decide whether or not the person has sufficient money to pay towards some or all of the cost of the support they need. If a person has capital or savings worth over £23,250 they will have to pay the full cost of care.



5.1.2 Continuing Health Care and Funded Nursing Care process

The diagram below describes the complexity of ensuring the statutory obligations for assessing and awarding eligibility for CHC funding across the NEW Devon CCG footprint. An assurance programme is underway to ensure all responsibilities are discharged lawfully, ensuring people are assessed against the National Framework.



Currently there is no central point for referral and collation of the activity so whilst we know who we have assessed and who is eligible and when the review is due, we don't know how many people have not yet been assessed who should be. Risks associated with non-assessment at appropriate time equate to those surrounding inappropriate care packages, missed opportunity for recovery or improvement, safeguarding issues not being picked up, poor outcomes therefore poor value for money.

As can be evidenced from the above two diagrams, both the social care and health processes for accessing funding are complex, with clear opportunities for future join up.

5.1.3 Quality in Care Homes

There is an established Quality Assurance & Improvement Team (QAIT) within the PCC's Co-operative Commissioning Team. It was developed to have a structured and proactive approach to monitoring and supporting the improvement of the quality of care in the care home sector. The team includes care home practitioners who undertake quality reviews based on a risk assessment framework. The quality reviews take place in the care home, in collaboration with the registered manager, over a period of 2 days. The care home practitioners review documentation within the home, including various audits, staff files and care plans. The review also involves speaking to various staff members and, where possible, residents, to gain their feedback on the running of the home. Since the team was established in July 2012, a total of 95 full Quality Reviews have been undertaken, which represents 89% of the Plymouth care homes.

The Quality Assurance & Improvement Team has developed a quality assurance framework, and are encouraging care homes to develop their own framework to support continuous service improvement.

QAIT Quality Framework

Plymouth established a Dignity in Care Forum in February 2009 which is now led and facilitated by the Quality Assurance & Improvement Team. The purpose of the forum is to look at operational issues around training, help and advice with improving quality of commissioned services. It also aims to improve dignity standards in care home settings and raise awareness of current local and national initiatives in the sector. The Forum is focused around the 8 key themes of the My Home Life programme. Every third forum is dedicated the topic of 'Celebrating Excellence' and sharing best practice. The forum will also deliver best practice sessions on themes identified through local CQC compliance, hospital admissions and safeguarding. The Forum supports a multi-agency approach and is attended by colleagues in Plymouth Hospitals NHS Trust, the Medicines Optimisation Team, NEW Devon CCG and the voluntary sector.

Plymouth City Council's Older Person's Charter: Adult Social Care have been working with partners and groups of older people in the City to develop a charter made up of a series of 11 pledges which outline the standards and approaches to service delivery that older people should enjoy. The Quality Assurance & Improvement Team will encourage care providers to sign up and embed the pledges from the Charter, through the Dignity Forum and the quality assurance framework.

The Dementia Quality Mark model was created in 2010 by David Francis and was established in Plymouth in 2011. The Dementia Quality Mark was established to:

- Establish a local accreditation system
- Improve person-centred care
- Improve the quality of commissioned services
- Reduce admissions into acute settings
- Reduce substantiated safeguarding alerts
- Improve discharge pathways into good quality services

36 care homes have been awarded the Dementia Quality Mark and further applications are in progress.

Plymouth has established a Leadership Programme for registered care home managers.

"The Government's White Paper, *Caring for our Future: Reforming Care & Support*, emphasises the importance of leadership at all levels from strategic leaders to practice leaders. And leadership is important for the future of social care: the sector needs to develop a pipeline of new talent, comfortable with working across traditional boundaries and capable of inspiring the workforce of the future." (*Norman Lamb MP, Minister of State for Care and Support*).

The Leadership Programme is intended to:

- Embed the principles of the Leadership Qualities Framework
- Provide individuals and organisations with a benchmark against which to measure their current leadership capabilities
- By quality and innovative training, it will improve the public and professional awareness and understanding of leadership
- It will maintain and support the quality framework for care homes
- Good leadership is crucial towards delivering excellent social care and will make a significant difference to the lives of people who use the service

The Quality Assurance & Improvement Team also offer support and advice to providers and professionals across the City and endeavour to build relationships with key stakeholders, such as Healthwatch Plymouth, Public Health and health professionals.

The Care Home Quality Collaborative is a collaboration of people from across the health, social, independent and voluntary sector from Devon, Plymouth and Torbay. This is a strategic group managing a programme of work that supports the work undertaken in local fora. For example:

- Implementing a reporting and learning system for serious incidents requiring investigation in care homes with nursing
- Working with the independent sector to provide an analysis of emergency admissions and work together to reduce inappropriate admissions
- Defining what good looks like across a number of key strategic priorities: medical and community care, medicines management, falls prevention, mental health and wellbeing
- Reducing the prevalence of key harms (pressure ulcers, catheter acquired infection, fall) through whole system working

5.1.4 Supply of Care Homes (Source: Plymouth City Council and CCG data)

There are currently 65 care homes in Plymouth providing care for people over 65. There are 99 care homes in total including those for the under 65s.

At December 2014 the total numbers of residents in care homes break down is:

- 800+ over 65 years are funded by Plymouth City Council
- 250+ adults under 65 are funded by Plymouth City Council
- 582 are funded by Health which breaks down as (a snapshot taken at the end November 2014) :

  402 – Continuing Health Care

  180 – Funded Nursing Care

This does not include placements by the Care Co-ordination teams or Reablement

- 103 self-funders – i.e. full cost payers where Plymouth City Council contract for their care and they are charged the full amount. Many of these will have a deferred payment arrangement based on the capital value of their own home which will be sold when the person dies or no longer requires long term social care either because they become eligible for funding by Continuing Health Care or they go into hospital at end of life.
- 577 private residents – i.e. those who admit themselves and fund all of their care

At a snapshot taken in July 2014 there were 101 vacant beds across the care home sector in Plymouth (not including Learning Disability). At the end of January 2015 there were 67 vacancies in nursing & residential (not including LD). This is lower due to the development of 39 step down beds in response to pressure on the urgent care system.

There are 99 care homes in Plymouth, which are provided by private sector providers and 1 care home which is a Local Authority service.

Approximately 85% of these met all CQC standards when inspected, 14% did not meet all standards with minor improvements required, and 1% has enforcement action due to major non-compliance.

Only 2 homes in Plymouth have had CQC reports published in the new inspection process which started in October 2014 and both have been classified as 'Good'. Whilst several homes have been inspected, the outcome has to go through a panel system for adjudication and the report can take 2 – 3 months to be published.

The fees currently paid by Plymouth City Council are as follows:

Nursing – older frail £437

Nursing – dementia £463 not including FNC

Residential – older frail £411 or £431

Residential – dementia £431 or £453 if a Dementia Quality Mark home

At the time of writing the CCG rates had not yet been agreed.

We currently place in 90 care homes which are out of the Local Authority area, accounting for approximately 138 placements.

5.1.5 Care Home Performance

Table 11

Performance Indicator	National	Local
PHOF 2.24i Injuries due to falls	2011	2032
Local Proxy - Avoidable hospital admissions (2013/14)	1898.3	2187
Social care related quality of life	19.0	19.3
Satisfaction rates amongst social care clients	64.9%	67.8%

5.2 The Adult Individual Patient Placements system

Individual Patient Placements generally refer to locked rehabilitation and locked and open specialist mental health placements that fall outside of the service specification for forensic secure services (low, medium and high secure) for adults 18 years plus with mental health difficulties as follows:

- Planned mental health hospital placements and planned independent sector supported placements required due to the assessed **primary** mental health needs of the individual, including individuals with other diagnoses and conditions such as Huntington's disease, Acquired Brain Injury, Physical Disability, Learning Disability where the assessed primary need is mental health.
- The client's needs cannot be met through contracted services.
- Specialist Mental Health Assessments
- Health funded contribution for adult mental health placements on Section 17 leave. This would normally be for a maximum of 1 month.
- Full or part (jointly) funded adult mental health placements in accordance with agreed local section 117/17 aftercare policy
- Mother and Baby specialist individual support packages as an alternative to hospital care.
- People aged up to 65 years old with the diagnosis of early onset dementia.
- Psychiatric Intensive Care Units
- Clients accessing locked placements will usually be subject to detention under the mental health act. In exceptional circumstances, clients who have an informal mental health act status may require a diagnostic assessment for complex needs but treatment needs of informal clients should be met locally.

It also includes physical disability requiring neuro rehabilitation with specific therapy outcomes. eg people with a Brain Injury requiring neuro rehabilitation or who have challenging behaviour or people with a complex mix of physical and mental health problems. S117 aftercare describes the duty of Local Authorities and CCG's to arrange or provide after care for individuals who have been previously detained under Section 3 of the Mental Health Act. Individuals often have a combination of both health and social care needs.

5.2.1 Commissioning of Individual Patient Placements

This is commissioned mainly by the Clinical Commissioning Group. The following functions are required in order to commission safe and high quality care through individual placements:

- **Quality Assurance:** Winterbourne View brought the importance of quality assurance of out of area providers into stark relief**.** Quality Assurance nurses reside within the Individuals Commissioning team
- **Care Coordination** including monitoring of care against treatments outcomes, review and discharge planning. This is currently provided through the Plymouth Community Healthcare

mental health and Learning Disability teams. There is no clear arrangement for people with physical difficulties or a complex mix of physical and mental health problems. There are also a number of clients who are in secure accommodation commissioned by NHS England. There remains some disclarity about roles and responsibilities with NHSE Care Managers and care coordinator roles for clients in secure settings outside the IPP budget.

- **Process Control**. There is no current IPP panel (for the consideration of applications for out of area placements and care reviews), established in Plymouth although there has been a panel in the past. Control processes could be improved with the greater inclusion of both clinical staff and commissioners in decision making processes and it is the intention to develop this.

5.2.2 Supply of Individual Patient Placements

This provision is provided by a wide number of providers on a spot purchase basis. Most of the providers of hospital placements are currently provided out of area.

There is very little national benchmarking data available to be able to compare our performance with other areas.

Currently there are approximately 60 people who are registered with a Plymouth GP who have a s117 aftercare package with a health funded component. (PCC will need to provide the number of people solely funded by LA).

There are currently 23 people in an IPP placement of which 15 are placed outside of Devon

5.3 The End of Life system

This provision is commissioned mainly by the Clinical Commissioning Group

The hospice provider is St Lukes and 70% of their funding is from their own sources, providing specialist intervention. However, hospital and palliative care is also provided by statutory community teams. Other end of life provision is provided by Marie Curie nurses**.**

Table 12: Performance - Place of death[12]

Place of Death	Plymouth Score %	England Average %
Hospital	45	54.5
Own Home	20.7	20.3
Hospice	7.2	5.2
Care Home	24.5	17.8

At December 2014 there are 402 people who have continuing health care funding for domiciliary care at home and 180 who have Funded Nursing Care

5.4 Community asset mapping

Asset mapping will be utilised to determine existing informal provision, assets and resources that care homes, other providers and individuals have access to in the community. A co-production approach working with providers and service users will improve the understanding of local needs and assets and will be part of the wider needs assessment work carried out across the four strategies. The asset maps would then support the formally procured services as part of the long-term commissioning strategies (Adapted from *Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014*).

[12] http://www.endoflifecare-intelligence.org.uk/home Viewed October 31st 2014

6.0 THE FUTURE 'COMPLEX CARE' SYSTEM MODEL

The Complex Care system will consist of quality specialist health and care delivered close to home that promotes choice, independence, dignity and respect.

Figure 4: The future model for each element of the system is described below:

<table>
<tr><th colspan="5">Complex Care - System Overview</th></tr>
<tr><td colspan="5">"Quality specialist health and care delivered close to home that promotes choice, independence, dignity and respect"</td></tr>
<tr><td>Individual Placements
"Care provided at home or as close to home as possible in the least restrictive environment"</td><td colspan="2">Residential and Nursing Care
"Meeting the needs of people with dementia or multiple long term needs and avoiding unnecessary hospital admissions"</td><td>End of Life
"People supported to die with dignity in the settings they chose"</td><td>Acute
"Admissions only when necessary and discharge to appropriate settings"</td></tr>
<tr><th colspan="5">System Enablers</th></tr>
<tr><td>Prevention and Wellbeing</td><td>Pro-active
Primary Care</td><td>Seamless Integrated Care Pathways</td><td>Skilled professionals, supported by Clinical Effectiveness and Medicines Optimisation</td><td>Excellent preventative services and services that can support complex needs</td></tr>
<tr><th colspan="5">System Outcome</th></tr>
<tr><td colspan="5">Reducing Reliance on Acute Provision and Acute Episodes of Care</td></tr>
</table>

6.1 Care Homes

A good care home system will be one that meets the needs of people with dementia or multiple long term need, avoiding unnecessary hospital admissions.

<u>What will Success Look like?</u>

- ✓ Well defined, transparent and fair assessment and placement process
- ✓ Consistent oversight of the market across health and social care
- ✓ Quality health and care placements to meet individual need that promotes choice, independence, dignity and respect
- ✓ People are supported to die with dignity in settings they choose
- ✓ Reducing demand on health system by promoting healthier lifestyles
- ✓ Good advice and Information around financial planning and paying for care
- ✓ Reduction in length of stay in care homes whenever possible

- ✓ Admissions to hospital only when necessary

6.2 Individual Patient Placements

The aim is to provide care at home or as close to home as possible in the least restrictive environment. Reduction in IPP, particularly out of area placements, is a clinical as well as a financial necessity. This will be achieved and sustained in the long term by developing the ability of local services to work with greater levels of complexity and risk - supported by specialised services where necessary.

This will be achieved through 6 broad strategic aims:

- Ensuring effective quality assurance of placements
- Improved process control
- Greater focus on prevention and early intervention strategies
- Better commissioning to meet more needs locally
- Improved community services including access to psychological therapy and crisis response
- Improved systems flow – making best use of existing commissioned local services

<u>What Will Success Look Like?</u>

- ✓ Less people will be placed out of area and more people cared for closer to home
- ✓ Reduced Length Of Stay
- ✓ Better monitoring against treatment outcomes
- ✓ Improved patient experience
- ✓ More people cared for closer to home
- ✓ Decreased acute admissions
- ✓ Improved transition processes
- ✓ Improved community services for Personality Disorder
- ✓ Improved access to therapy
- ✓ Less spend out of city and greater investment in local services

6.3 End of Life

Medical advances allow us to keep people alive for longer and there will be a continuing increase in the number of people who are living with increasingly complex conditions. Whilst the number of people dying at home is gradually increasing, the public expectation to die at home will mean increasing resources in terms of the cost of nursing complex conditions. A future system will need to respond to these expectations whilst recognising that this will not always be possible. There will be opportunities to support this, for example by enabling all parts of the system to understand the importance of recognising when someone is approaching End Of Life, referring the right people for the appropriate conversations and supporting people to die well across all settings. This will include staff enabled to have difficult conversations and to discuss advanced care plans.

<u>What will success look like?</u>

- ✓ Increasing numbers of people dying at home
- ✓ Care provided closer to home where possible

- ✓ Carers supported in the care they provide at End of Life
- ✓ Consistent and joined up assessment of needs at End of Life
- ✓ Preventing avoidable hospital admissions
- ✓ Fewer delayed transfers of care from hospital to the community for EOL care
- ✓ Good quality End of Life Care across all providers

6.4 Available Resources

The current approximate commissioning budget against each service element is described in the table below.

Table 13: Current Complex Care budgets

System Element	Approximate current budget
Individual patient placements	£7,622,129
Residential and nursing	£30,592,245
End of life	£4,378,084
Acute	£154,023,614
Total	£196,616,072

6.5 System Performance – Current and Future

The following outcome performance indicators have been identified as key to measuring how this strategy contributes to improvements across the whole health, wellbeing and social care system in Plymouth. These will form part of a comprehensive performance dashboard that will be used to monitor an overview of the system.

Table 14: Performance dashboard

Indicator	National	Plymouth	Impact on system – why is this a measure?	Trajectory
PHOF 2.24i Injuries due to falls	2011	2032	Falls are preventable and increase pressure on the urgent care system with some evidence that they advance onset of other health conditions e.g. Dementia	
Local Proxy - Avoidable hospital admissions (2013/14)	1898.3	2187	BCF has set a target to reduce non-elective by 3.5%	
Local Proxy - Non-elective admissions (2013/14)	N/A	26,423	Waiting times in A&E is a proxy for effective working of the urgent care system	25,498
PHNT - 4hr wait in A&E (2014/15 ytd)	90.8%	91.6%		95%
PHOF 4.16 Estimated diagnosis rates for Dementia (December 2014)	57.4%	52.3%	A diagnosis of dementia is key to ensuring an appropriate service response is available	66.7%

Local proxy - % of people dying at preferred place of care	TBC	TBC		
Local proxy - Number of out of area IPP's	TBC	TBC		

7.0 FIVE YEAR COMMISSIONING INTENTIONS

7.1 Care Homes

- To develop the integrated commissioning of care home placements to ensure consistency, transparency and quality including assessment processes, review processes, care planning and case management
- To ensure there is sufficient local market provision of placements to meet need
- To ensure the commissioning model allows for the effective management of the market and in particular manage market failure
- To develop an integrated commissioning approach to quality assurance and safeguarding that challenges poor practice including an integrated Quality Assurance and Improvement Team
- To further develop the Quality Assurance and Improvement framework to ensure that care home staff are able to implement preventative assessments, care planning and make appropriate referrals to reduce the risk and impact of falls, secondary fractures, pressure ulcers, urinary tract infections, dehydration and COPD
- To develop excellent care-coordination for frail older people with support for the most complex patients from geriatricians, community pharmacies, the voluntary sector and older persons mental health services.
- To commission an effective Dementia Pathway that includes prevention, early diagnosis, carer support and case management and co-ordination to best support people to live well for as long as possible and ensure they are not admitted to hospital unnecessarily. *Early diagnosis will often take place when the person is living in their home and the full commissioning intentions for dementia will straddle the Wellbeing, Community and Complex Care strategies*
- To ensure that people living in care homes will be able to access the same level of healthcare as anyone living elsewhere in the community:
    - In assessment, review and treatment by their GP and Consultant Gerontologist and Consultant Psychiatrist
    - The specialist knowledge of community nurses, tissue viability, continence, nutrition and end of life practitioners should be equally accessible to people living in care homes with nursing
    - Dentist, Optometrists and Pharmacists, Allied Health Professionals
- To reduce the length of stay of people in care homes by ensuring that there are excellent delivery mechanisms to reduce long-term placements including reablement, respite support at home and end of life support at home

7.2 Individual Patient Placements

The aim is to provide care at home or as close to home as possible in the least restrictive environment. This will be achieved and sustained in the long term by developing the ability of local services to work with greater levels of complexity and risk, supported by specialist services where necessary.

The CCG has developed commissioning intentions to devolve responsibility for IPP commissioning for Plymouth GP registered individuals to Plymouth Community Healthcare as the main local provider of specialist mental health services in Plymouth. This would strengthen clinical decision making in the process of making an individual patient placement out of area. It would also allow the provider to be more creative in the utilisation of resources to offer alternatives to admission in the community.

Improving quality and reducing the usage of out of area placements requires the implementation of a range of both transactional and transformational strategies:

- Quality control and improvement of processes such as referral for IPP and clinical and placement reviews. This will also include improved exacerbation and contingency planning, blue light policies etc. A greater focus on information about clinical outcomes related to placements.
- Excellent provider assurance processes
- Improved system flow including through local recovery services
- Detailed needs assessment
- A strategic commissioning approach, with local services better commissioned to meet the needs of all but people with the most specialised needs
- Market management - the potential development of new providers within the market
- Improving processes for assessment and spend of Section 117 money
- Continued commissioning of cost effective enhanced community support packages
- New ways of working within existing providers for example the strengthening of integrated approaches to dual diagnosis and personality disorder and more staff trained in therapeutic approaches such as DBT
- Improved transition processes for young people with complex needs in community services or out of area
- An increased focus on effective packages of support for complex young adults 16 to 25 years
- Primary preventative approaches such as Families With a Future
- The potential role of risk stratification in identifying people at risk of out of area placement and complex individuals who would benefit from integrated personalised packages of care and/or integrated case management
- Identification of timely repatriation plans for services uses placed out of Devon.

7.3 End of Life

The aim is to have coo-ordinated care through good communication with individuals and professionals across the wider health and social care system.

We will achieve this by:

- Working with providers to make sure that the right services are in place to support people at home and in care homes and provide support for carers.
- Continuing to improve the quality of care in hospital for those at the end of life
- Continue to develop good quality care across all providers
- Joined up assessments through integrated services
- Continuing to develop bereavement services for families

8. COMMISSIONING PLAN 2015/16

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
Residential and Nursing Care	To develop care co-ordination for frail older people with GP practices	Better access to primary care for care home residents Reduced admission to hospitals from care homes	**CCG**	**By March 2016**
	To review the current Dementia Pathway and to develop a commissioning plan	Better management of complex people in care homes Reduced admission to hospital for people with dementia	**JOINT CCG and PCC**	**By March 2016**
	QAIT to develop a pilot project based on the Brownhill study 2013 to develop reduction targets in relation to falls, pressure ulcers, UTIs and overall hospital admissions QAIT to identify the Top 10 care homes with emergency admissions to hospital and action planning with those homes	Better trained and skilled care home staff Reduced admission to hospital from care homes Improved CQC Quality Ratings and User satisfaction	**PCC**	**By March 2016**
	To start the process towards the integrated commissioning of care home placements	Pooled budget with full joint contracts in place	**JOINT CCG and PCC**	**By April 2016**
	Continue to raise the quality of care homes through- ➢ QAIT Reviews ➢ Roll out best practice through Dignity Forum	Improved CQC Quality Ratings and User satisfaction	**PCC**	**By March 2016**
	Complete Market Needs Assessment to determine capability and capacity of market to meet future demand	Completed Market Needs Assessment	**JOINT PCC and CCG**	**By April 2016**
	Develop and implement a fair fee model for Care Homes	Fair Fee Model Implemented Improved CQC Quality Ratings and User satisfaction	**JOINT PCC and CCG**	**By March 2016**

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
Individual Patient Placements	Review and redesign local pathways and provision in order to prevent and reduce out of area IPP's	Reduction of placements	**CCG**	**By March 2016**
	Potential devolvement of IPP budget to main mental health service provider	Improved operational processes in place	**CCG**	**By April 2015**
	Develop market including new local providers	Market assessment completed		**By end of 2015**
	Develop Clinical Quality and Innovation Payment Schemes for all main healthcare providers which identifies children likely to transition to adult services and improves transition care.	Improved transition from children's services to adult care	**CCG**	**By March 2016**
	Implement Winterbourne View Action Plan and Concordat Agree repatriation trajectories with providers	Reduction of placements	**CCG**	**2015**
End of Life	Develop a commissioning plan for end of life care	Publication of EOL Plan	**CCG**	**June 2015**
	Develop the health and social care workforce to support people to die at their preferred place of care (usually the home setting)	Training needs assessment completed	**CCG**	**2016**
	Deliver CQUIN target	CQUIN achieved	**CCG**	**April 2016**
	To continue to develop bereavement services for families	Increased access to bereavement services	**CCG**	**March 2016**

APPENDIX 1 Resources for Evidence base and good practice

Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/

The SCIE aims to improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy

National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. There are also the following NICE Standards and Indicators areas:

1. *NICE Quality Standards* are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health or care and are derived from the latest evidence and best practice. The NICE Quality Standards are divided into 3 categories:
    a. *Quality standards for health* focus on the treatment and prevention of different diseases and conditions. Topics are referred to NICE by NHS England. They are reflected in the new Clinical Commissioning Group Outcome Indicator Set (CCGOIS) and will inform payment mechanisms and incentive schemes such as the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) Payment Framework.
    b. *Quality standards for social care* focus on the services and interventions to support the social care needs of service users. Topics include supporting people to live well with dementia, looked-after children and young people, autism and the mental wellbeing of older people in care homes. Topics are referred by the Department of Health and Department for Education.
    c. Quality standards for public health will support Public Health England, local authorities and the wider public health community. Topics include reducing tobacco use in the community, preventing harmful alcohol use, and strategies to prevent obesity in adults and children. Topics are referred by the Department of Health.
2. *Quality and Outcomes Framework (QOF)* is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. NICE's role focuses on the clinical and public health domains in the QOF, which include a number of areas such as coronary heart disease and hypertension.
3. *CCG OIS* is to support and enable Clinical Commissioning Groups (CCGs) and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of services commissioned by CCGs. It is also intended to provide clear, comparative information for patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes. All indicators are evidence based and draw on NICE quality standards, NICE guidance or NICE accredited guidance.

The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/

HSCIC is the national provider of information, data and IT systems for health and social care. The Health and Social Care Act 2012 sets out HSCIC responsibilities, which include:

- Collecting, analysing and presenting national health and social care data
- Setting up and managing national IT systems for transferring, collecting and analysing information.
- Publishing a Code of Practice to set out how the personal confidential information of patients should be handled and managed by health and care staff and organisations
- Building a library of 'indicators' that can be used to measure the quality of health and care services provided to the public
- Acting to reduce how much paperwork doctors, nurses and care workers have to complete by ensuring that only essential data is collected, and avoid collecting the same information twice
- Helping health and care organisations improve the quality of the data they collect and send to us by setting standards and guidelines to help them assess how well they are doing
- Creating a register of all the information that we collect and produce, and publishing that information in a range of different formats so that it will be useful to as many people as possible while safeguarding the personal confidential data of individuals.

NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/

NHS IQ is working to improve health outcomes for people by providing improvement and change expertise across the NHS in England. NHS IQ utilises good practice and builds improvement capacity and capability and to help develop knowledge and skills across the whole health and care system. They work to the five domains of the NHS Outcomes Framework:

1. Living longer lives
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/

Ofsted independently inspect and regulate services which care for children and young people, and those providing education and skills for learners of all ages. Ofsted will work with providers which are not yet good to promote their improvement, monitoring their progress and sharing with best practice.

Care Quality Commission (CQC) - http://www.cqc.org.uk/

CQC is the independent health and adult social care regulator. CQC monitor, inspect and regulate services to make sure they meet fundamental standards of whether the service is safe, effective, caring, responsive to people's needs and well-led. CQC will publish findings, including performance ratings to help people choose care. Regulated services include:

- Hospitals
- Dentists
- Care Homes
- Community Based Services
- GPs and Doctors
- Clinics

- Home Care Services
- Mental Health Services

Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/

HCPC are a regulator who keep a Register of health and care professionals who meet our standards for their training, professional skills, behaviour and health.

Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm

The HSE's work covers a varied range of activities; from shaping and reviewing regulations, producing research and statistics and enforcing the law.

There are also a wide range of regulators for health staff, such as the General Medical Council (GMC) for registered doctors in the UK, their good practice guidance will be considered wherever applicable.

APPENDIX 2

Demographics

Population

Plymouth currently has a population of 258,000 (Office of National Statistics (ONS) 2012 mid-year population estimates).

Overall 50.5% of Plymouth's population are female; this reflects the national figure of 50.8%.

Population growth and change since 2001 (Draft 'Plymouth Report 2014', Rob Sowden)

Population change occurs as a result of two factors:
- 'natural change', the difference between the number of births and the number of deaths,
- 'net migration', the difference between the number of people migrating into an area and the number migrating out of the area.

These components combined affect whether the population increases or decreases over the course of a year.

In Plymouth live births are increasing whilst deaths are decreasing resulting in an increase in the population due to natural change. From 2001 to 2012 Plymouth's population increased by 6,600 people due to natural change alone. This accounts for 38.4% of all change in Plymouth over that time.

Plymouth's population has increased by 17,100 (7.1%) since 2001. This is below the growth rate in both the South West region (8.0%) and England (8.2%).

People aged 65 years and over account for 16.8% of Plymouth's total population. This is comparable to that found nationally (16.9%).

An aging population will put pressure on Plymouth's public services, supported housing, and adult social care in particular. For example it is expected that those aged over 65 years with a limiting long-term illness will rise from 21,682 in 2013 to 24,061 in 2020, while those in this age group with dementia are predicted to rise from 3,107 to 3,667. The number of people aged 85 and over will increase from 5900 to 10,400 by 2030.

Current and Projected Population of Plymouth (18 – 64)

Ages	2014	2015	2016	2017	2018	2020	2025	2030
18 – 24	35,600	35,900	36,000	35,900	35,500	34,200	33,600	37,300

25 – 34	34,900	34,900	34,900	34,900	35,100	35,300	35,600	34,200
35 – 44	30,200	29,700	29,300	29,200	29,200	29,600	30,600	31,100
45 – 54	34,400	34,300	34,100	33,700	33,200	31,500	27,700	27,600
55 – 64	28,500	28,800	29,300	29,700	30,200	31,500	32,300	29,900
Total population 18 – 64	163,600	163,600	163,600	163,400	163,200	162,100	159,800	160,100
Total population all ages	260,400	261,300	262,300	263,100	264,000	265,300	269,300	274,500

Source: PANSI – Projecting Adult Needs Service Information website, Oxford Brookes

Current and Projected Population of Plymouth (65 and over)

Ages	2014	2015	2016	2017	2018	2020	2025	2030
65 – 69	14,200	14,200	14,000	13,300	12,900	12,500	14,000	15,200
70 – 74	10,400	10,800	11,400	12,400	12,900	13,100	11,600	13,000
75 – 79	8,500	8,600	8,500	8,600	8,900	9,600	11,800	10,500
80 – 84	6,400	6,500	6,600	6,700	6,800	7,100	8,100	10,100
85 – 89	3,700	3,800	4,000	4,100	4,200	4,500	5,100	6,000
90 & over	2,200	2,300	2,300	2,400	2,500	2,700	3,500	4,400
Total population 65 and over	45,400	46,200	46,800	47,500	48,200	49,500	54,100	59,200
% of total population 65 and over	17.43%	17.68%	17.84%	18.05%	18.26%	18.66%	20.09%	21.57%
% of total population 85 and over	2.27%	2.33%	2.40%	2.47%	2.54%	2.71%	3.19%	3.83%

Source: POPPI – Projecting Older People's Population Information website, Oxford Brookes

Provision of unpaid care (Draft 'Plymouth Report 2014', Rob Sowden)

In the England and Wales, there are around 5.4 million people providing unpaid care for an ill, frail or disabled family member or friend. Using data from the 2011 Census revealed there were 27,247 of these carers in Plymouth. The majority (57.3%) provided 1-19 hours of care per week but nearly 30% (7,566 individuals) were committing over 50 hours.

Across the Plymouth neighbourhoods the total number of carers ranged from 212 in Mutley to 1,133 in Honicknowle. The same two neighbourhoods respectively had the lowest and highest numbers of individuals providing 50 hours or more care.

Estimated 2014 prevalence of mental health problems in 18-64 year olds in Plymouth

Common mental health problems, including depression, anxiety and obsessive-compulsive disorder, constitute the greatest proportion of the mental health burden in Plymouth. Drug and alcohol dependence; as well as psychiatric co-morbidity are also very significant. However, the need for

services is not necessarily proportionate to the numbers; for example a person with a psychosis may require repeated episodes of inpatient care and greater input from specialist services than a person suffering from a mild depressive illness.

In 2014 nearly 10,000 people in Plymouth aged 18-64 years, of which 7,204 are male, are predicted to be alcohol dependent; whilst over 5,500 are estimated to be dependent on drugs.

According to the 2014 health profiles almost a quarter of adults in Plymouth's alcohol consumption is 'increasing and higher risk'. Rates of hospital stays for alcohol related harm in Plymouth is higher than England average and Southampton, Sheffield and Portsmouth.

Personality disorders

Personality disorders are longstanding problematic personality features which cause a person to have difficulty functioning in addition to making and sustaining relationships. There are various types of personality disorders but two are particularly important in terms of need for health and other services:

(1) Borderline personality disorder is significant because this condition involves high levels of emotional instability, self-harm, and suicide. In 2014 more than 730 people in Plymouth aged 18-64 years are predicted to have borderline personality disorder.

(2) Antisocial personality disorder, characterised by an aggressive and irresponsible pattern of behaviour, also has a wider impact on society as it is linked with crime and violence. In 2012 almost 580 people aged 18-64 years in Plymouth are estimated to have antisocial personality disorder.

Psychosis

Psychosis is a term for disturbance of perception, thought, and insight. For example, people may experience hallucinations, or distorted sensations such as hearing things, that are not there in external reality. These experiences may be frightening and distressing. A lack of insight means that sufferers may not recognise that they are unwell or that they could benefit from treatment. Psychotic symptoms occur in illnesses such as schizophrenia, and can also accompany mood disorders such as bipolar affective disorder. In 2014 over 650 people aged 18-64 in Plymouth are estimated to have some type of psychotic disorder.

Psychiatric co-morbidity

It is quite common for people to meet the diagnostic criteria for two or more mental health problems and suffer from psychiatric comorbidity. This is an important issue as it is associated with greater disease severity, longer illness duration, greater functional disability, and an increased use of health services. Over 11,500 people in Plymouth aged 18-64 years are estimated to have more than one mental health problem.

COMMISSIONING STRATEGY FOR COMMUNITY BASED CARE DRAFT

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Part: I

DOCUMENT CONTROL

Version	Date	Author	Change Ref	Pages Affected

QUALITY REVIEWERS: (General QA and accuracy)

Name	Position	Signature	Date

FINANCE SIGN OFF:

Name	Position	Date

CONSULTATION PATHWAY:

NAME

Table of Contents **Page Number**

1.0 EXECUTIVE SUMMARY

The introduction of the Health and Social Care Act 2012 provided us with new and exciting opportunities to work together across health and social care and address the key issues that undermine the health and wellbeing of those people in the city of Plymouth.

Plymouth's Health and Wellbeing Board, established under the Health and Social Care Act 2012, provides a key partnership, where leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The Board's vision is for "Happy, Healthy, Aspiring Communities" and its core purpose is to encourage commissioners across the public sector to work in a more joined-up way.

This commissioning strategy sets out the approach for Health and Social Care Community based services commissioning intentions which includes an integrated Commissioning and Delivery approach for services putting the person at the centre with support services wrapped around them.

2. INTRODUCTION

2.1 Background – Strategic Challenge

Public Sector organisations across the country are facing unprecedented challenges and pressures due to rising demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities. Until recently the complexity and scale of our system-wide challenge has been difficult to understand and local organisations have, as a result, focussed mainly on meeting their own challenges. A lot of this work has been successful and this has delivered much that is good right across our system. However we know that this existing good practice will not be enough to meet the current challenge. This means a new imperative for joint and collaborative working across all the organisations that commission and deliver health and wellbeing in our area.

Recognising these challenges and within the context of a system's leadership approach Plymouth Health and Wellbeing Board has agreed a vision that by 2016 we will have developed an integrated whole system of health and care based around the following elements:

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

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

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

2.2 An Integrated Commissioning Response

In order to meet the challenges facing Plymouth New Devon CCG and Plymouth City Council have agreed to develop a single commissioning function working towards jointly approved commissioning strategies and pooled budgets.

The primary driver of this is to streamline service delivery and provision with the aim of improving outcomes for individuals and value for money. Integrated commissioning must deliver integrated wellbeing.

To support this strategic aim 4 commissioning strategies have been developed that stretch across the spectrum of early years, health, social care, and wellbeing need in Plymouth.

These co-dependent Commissioning Strategies aim to move the balance of care towards prevention in order to improve life chances, manage demand and improve health outcomes. Specific aims of this system's approach include;

- Provide and enable brilliant services that strive to exceed customer expectations
- People will receive the right care, at the right time in the right place.
- Improve pathways and transitions
- Help people take control of their lives and communities.
- Children, young people and adults are safe and confident in their communities.
- People are treated with dignity and respect.
- Prioritise prevention
- Sustainable Health and Wellbeing System
- Improve System Performance

2.3 Purpose of the Strategy

Each strategy describes the current and projected need in Plymouth, as well as the local and national strategic context that the future system will need to address / respond to. They also describe current provision how the existing system is performing.

This then builds into a vision of Plymouth's future system over a 5 year period, and details of how commissioners in Plymouth will achieve this through a series of annual implementation plans setting out and signalling to the market commissioning priorities, and how the impact of these will be measured across the system.

2.4 Implementation and Action

System Design Groups against each strategy will drive the implementation of the identified commissioning priorities within each strategy.

2.5 Finance

Table 1 provides an overview of how the current commissioning budgets in scope for integration are currently spread across the system.

Full detail on the existing resources allocated within each strategy area is provided in the 'current provision' section.

Table1

Strategy Area	Approximate total spend	% of spend in each Strategy area
Children and Young People	£27,150,102	6.72%
Wellbeing	£60,752,235*	15.03%
Community Care	£119,742,637	29.62%
Complex Care	£196,616,072	48.64%
TOTAL	£404,261,046	

*Includes approximately £40 million of prescribing spend

2.6 Definition & Scope of Community Based Care

Targeted services for people who need support in the community to maintain independence or those who may be at risk in the future of losing their independence. The services may be long term for those who need on-going personalised support or may respond to a crisis, providing a timely response, reablement and recovery.

The opportunity that the Integrated Health and Wellbeing Commissioning agenda presents is to undertake a whole system review of a wide range of service provision in order to consider what changes are needed to meet the needs of people who access health and social care services and deliver outcomes.

In scope of this strategy are services currently commissioned for the people of Plymouth by NEW Devon CCG and PCC. Examples of these include social care, community nursing, domiciliary care, day opportunities, reablement, community equipment, supported living for people with a learning disability, housing and homelessness support, substance misuse treatment, mental health services and Telecare.

3.0 NEEDS ASSESSMENT

Plymouth's population has grown by over 15,000 people (an increase of 6.4%) from 2002 to 2012 (mid-year population estimates shown in Table 1). All six ONS localities have increased in population size, with the largest percentage increase in the South West (12.1%) and South East (12.0%) localities. The smallest percentage increase occurred in Plymstock (1.9%).

Table 2: Mid-year population estimates (all ages) for Plymouth localities and Plymouth, 2002-2012

Year	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
2002	49,727	51,805	29,301	24,234	35,118	52,365	242,550
2004	49,699	51,841	29,438	24,235	35,850	52,974	244,037
2006	50,316	52,180	29,345	24,545	37,554	55,238	249,178
2008	50,864	52,307	29,656	24,698	38,426	56,537	252,488
2010	50,855	52,261	29,747	24,680	39,063	57,621	254,227
2012	51,488	53,779	30,029	24,687	39,342	58,701	258,026
% change	3.5%	3.8%	2.5%	1.9%	12.0%	12.1%	6.4%

Source: Office for National Statistics

It is estimated that Plymouth's population will increase by over 16,000 by 2030 (Table 2). The largest increase will be seen in 75+ year olds (54.6%), whilst it is estimated there will be a 5.2% reduction in the 30-64 year old population.

Table 3: Sub-national population projections by age group, 2012-2030

Age group	2012	2015	2020	2025	2030	% change
Under 18	50,912	51,482	53,645	55,241	55,102	8.2%
18-29	52,613	53,779	53,169	52,133	54,820	4.2%
30-64	111,026	109,880	109,002	107,814	105,247	-5.2%
65-74	23,367	24,964	25,584	25,569	28,205	20.7%
75+	20,108	21,210	23,904	28,511	31,091	54.6%
90+	2,119	2,296	2,700	3,475	4,432	109.2%
All ages	258,026	261,315	265,304	269,268	274,466	6.4%

Source: Office for National Statistics

Such a demographic profile is likely to put increasing pressure on a range of public services and especially those who may access community based services

3.1 People who may have Multiple Needs

This section relates to a cohort of people that have multiple needs and use services relating to homelessness, substance misuse, offending and mental health. Whilst neither issue on its own may trigger a statutory or secondary care service the combination of support needs create a complexity that requires a more specialist intervention in the community. For the purposes of this strategy we are using the Making Every Adult Matter (MEAM) definition which describes adults who experience

several problems at the same time that; impact on families and communities, have ineffective contact with services, and live chaotic lives (http://meam.org.uk/)

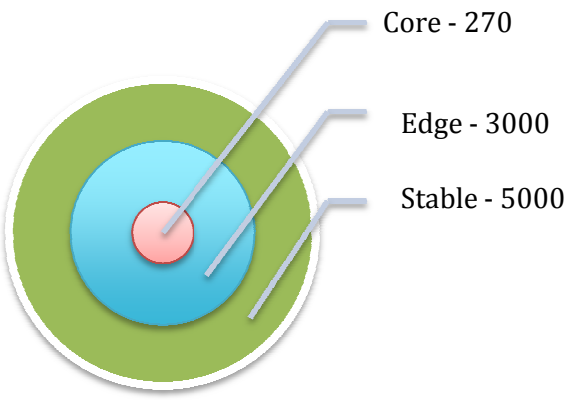
Comprehensive 'Needs Assessments' have been completed separately for alcohol, mental health, and substance misuse in Plymouth. Information from each of these has been extracted and brought together to try and understand the overlap and synergy across these different categories.

What we know - Prevalence

Client Group	Source	Number of people in Plymouth with need
Alcohol – Hazardous drinking	Alcohol Needs Assessment, 2011	25,300
Alcohol – Harmful drinking	Alcohol Needs Assessment, 2011	6,360
Homelessness – Statutory Applications	PIE Statistics 2013/14	523
Homelessness – Local Authority Prevention and Relief	PIE Statistics 2013/14	898
Drugs	Substance Misuse Atlas	5,600
Drugs – OCU	Public Health England	2372
Mental Health – common mental disorder (18-64)	PANSI	26,300
Offender		

Overlap of Need

Local information, combined with national modelling indicates that adults experience complex needs at different levels with a core group of approximately 270 requiring intense support for a number issues at the same time, approximately 3000 people that are not in immediate crisis but could trip into core without intervention, and approximately 5000 people who have complex needs but are stable and engaging with support.



There is significant overlap across the different categories of need within the MEAM definition that until now have been assessed, developed and commissioned for separately, high level summary information as follows:

Commissioned service area	% of current service users also have support needs around homelessness	% of current service users also have support needs around mental health	% of current service users also have support needs around substance misuse	% of current service users also have support needs around offending
Homeless	N/A	44%	46%	21%
Mental Health	tbc	tbc	tbc	tbc
Substance Misuse	24%	18%	N/A	tbc
Offending	27%	40%	46%	N/A

Prevalence of need across all categories is focussed within the same neighbourhoods indicating communities with multiple needs. These communities are generally high levels of deprivation.

General feedback from the sector reports:

- Younger and more complex cases which is changing the intensity and capacity of effective interventions.
- Poly drug use very common – alcohol, illegal drugs, New Psychoactive Substances (NPS) and prescribed drugs
- That moderate/common mental health problems are increasing
- Austerity is both increasing demand and making 'recovery' more difficult
- Increasing demand and pressure on the homelessness system

3.2 People in need of an Urgent Care response

This section covers the needs of people who are in crisis and need care and support to avoid admission to hospital or a care home and support to recover to regain maximum independence. They may need services such as rapid response home care, standard home care, mental health support services, reablement and/or community equipment.

Census data indicates the percentage of the Plymouth population identify health as bad or very bad, of have limited day to day activities. These figures are an indicator of potential need for domiciliary care or are at risk of needing urgent care if not supported to remain stable in their own homes.

- 6.5% identified their health as bad or very bad[1]
- 10% of people find their day-to-day activities are limited a lot[2]

We know that one of the most significant factors which are going to impact on further demand for community services is the growing numbers of older people.

[1] Summary 2011 Census Profile. Produced as part of the JSNA. Public Health, PCC. December 2013.

[2] Summary 2011 Census Profile. Produced as part of the JSNA. Public Health, PCC. December 2013.

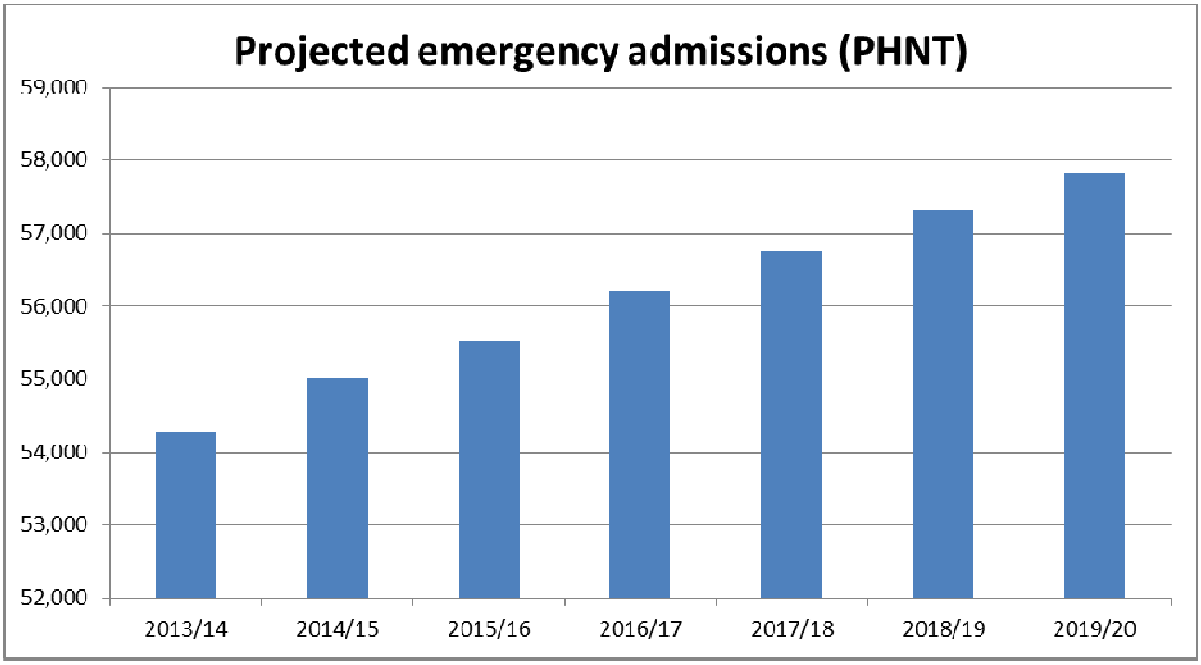
Age Group	2014	2015	2020	2025	2030
65-69	14,200	14,200	12,500	14,000	15,200
70-74	10,400	10,800	13,100	11,600	13,000
75-79	8,500	8,600	9,600	11,800	10,500
80-84	6,400	6,500	7,100	8,100	10,100
85-89	3,700	3,800	4,500	5,100	6,000
90 and over	2,200	2,300	2,700	3,500	4,400
Total	**45,400**	**46,200**	**49,500**	**54,100**	**59,200**
% Change		**1.73%**	**6.67%**	**8.50%**	**8.61%**

Source: Projecting Older People Population Information

What we know - Inappropriate and lengthy stays in hospital – & delayed transfers of care[3]

Demographic projections are showing that the number of emergency admissions to hospital is expected to rise by around 1.1% per year (see graph below). However, due to the aging population it is expected that this will increase the total number of emergency bed days by around 1.6% per year. It is also known that the prevalence of long-term conditions are rising which will place an additional demand pressure on the urgent care system.

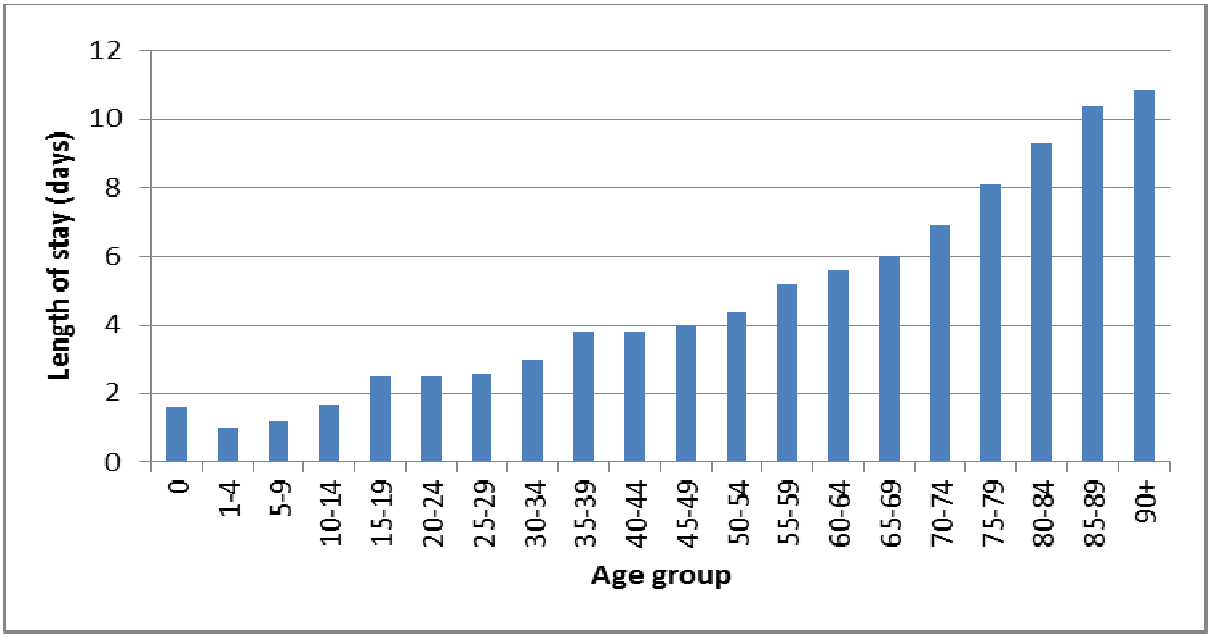
Chart 1: Projected increase in emergency admissions (PHNT)



The average length of stay in hospital varies significantly by age with an older person having, on average, a significantly longer length of stay (see graph below). This is a key reason why the aging population has such a dramatic effect on hospital capacity.

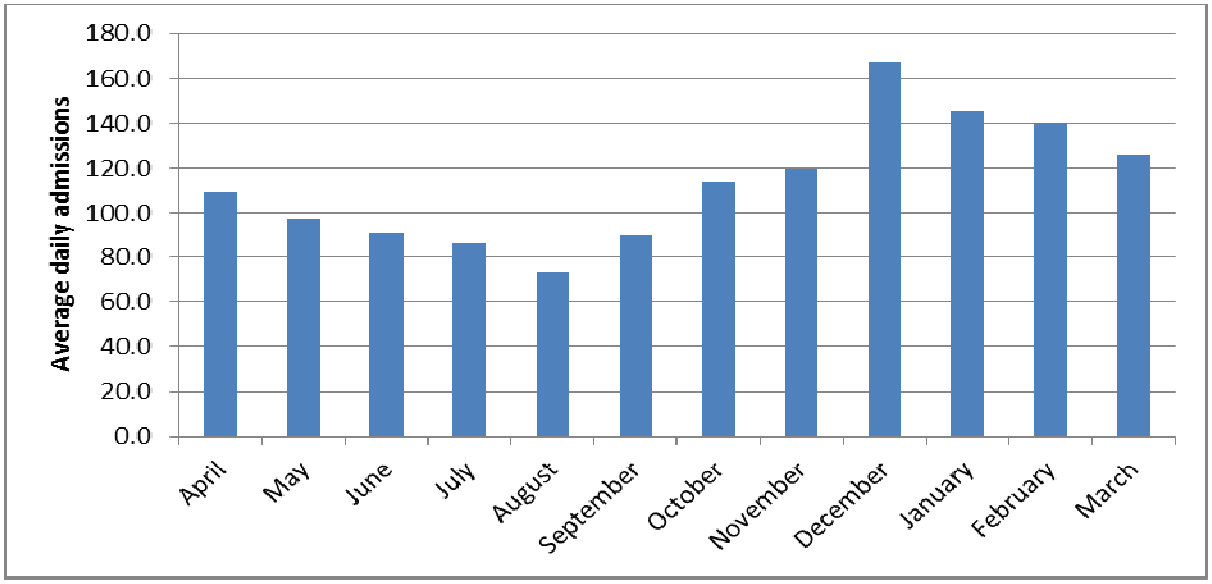
[3] Western Locality CCG, IPAM Reporting from PHNT April 2014

Chart 2. Average length of stay by age group for emergency admissions



Demand on the urgent care system is known to be seasonal. Older people are much more susceptible to the effects of the cold weather and as a consequence have higher rates of emergency admissions in the winter months. This combined with their longer length of stay creates a significant bed pressure on acute hospitals in the winter. Respiratory conditions are known to be the most seasonal of all conditions as shown in the graph below. Plymouth Hospitals NHS Trust will increase its bed base by around 60 extra beds in the winter months to accommodate this extra demand.

Chart 3: Monthly profile of respiratory admissions



Winter pressures are not restricted to acute hospitals and most health and adult social care service areas experience this increase in demand. Ensuring efficient patient flow through the whole urgent care system is a key element in ensuring high quality patient care.

What we know – Domiciliary Care

The Community Domiciliary Care market has continued to grow in terms of demand of people growing older and wanting to remain living independently for as long as possible in their own home. The table below demonstrates the Domiciliary Care service growth of hours per week that are commissioned by PCC and NEW Devon CCG.

	2012/13	**2013/14**	**2014/15**
PCC	12,928	12,552	13,391
CCG	4,354	5,383	6,710
Total	**17,282**	**17,935**	**20,101**
% change		**3.8%**	**12.1%**

This demonstrates a slight decrease in the number of hours commissioned for adult social care but an increase in health commissioned domiciliary care.

What we know - Reablement and Hospital Discharge

Reablement services provide intensive support to people for a time limited period to either prevent an escalation of need, or to promote speedy recovery.

- The capacity of the commissioned Reablement service - in January 2015 there were 165 people in the reablement service with 47 people awaiting review for discharge.
- Between 250-400 referrals are received per quarter.

The Home from Hospital and Community Support service provides a smooth transition from hospital to home for people which assists in the prevention of delayed discharge from hospital. Once home they support the person to regain confidence and live independently in the community and prevent any breakdowns in care and unnecessary hospital admissions. They also support carers and provide practical and emotional support.

- In 2013/14 the service received 563 referrals. 84% of referrals were for clients over the age of 65, with 40% of referrals for people aged between 80 and 89
- So far in 2014/15 (up to December 2014) the service has received 418 referrals. 86% of referrals were for clients over the age of 65, with 43% of referrals for people aged between 80 and 89.

3.3 People needing Long Term Support

This section covers the needs of people who have the need for on-going personalised support or those who may be at risk in the future of developing more complex needs. The aim is to support people to live as independently as possible within the community, for as long as possible. The type of services currently commissioned to respond to this need include Day Opportunities, Supported Living, Home Care, Housing Adaptations, and Telecare. In line with personalisation agenda an increasing number of people will direct their own care through Direct Payments and Personal Budgets. This group includes both older and younger people with disabilities.

What we know - Long term limiting illness

- In 2014 a total of 12,041 people over the age of 65 were predicted to have a long term limiting illness where their day to day activities are limited a lot
- Between 2014 and 2030 it is expected that the number of people aged over 65 with a limiting long term illness will rise from 12,042 to 16,538

People with a long term limiting illness whose day to day activities are limited a lot by age group	**2014**	**2015**	**2020**	**2025**	**2030**
65 - 74	4,801	4,880	4,997	4,997	5,504
75 - 84	4,657	4,719	5,219	6,219	6,438
85 +	2,583	2,670	3,152	3,764	4,596
Total	**12,041**	**12,269**	**13,368**	**14,980**	**16,538**
% change		**1.86%**	**8.22%**	**10.76%**	**9.42%**

Source: Projecting Older People Population Information

- In 2014 550 people were predicted to have a profound hearing impairment

People predicted to have a profound hearing impairment by age group	**2014**	**2015**	**2020**	**2025**	**2030**
18 - 24	0	0	0	0	0
25 - 34	0	0	0	0	0
35 - 44	0	0	0	0	0
45 - 54	16	16	15	13	13
55 - 64	36	36	39	40	37
65 – 74	151	153	157	156	172
75 – 84	94	95	104	123	128
85 +	253	262	306	363	437
Total	**550**	**561**	**621**	**696**	**787**
% change		**0.18%**	**9.66%**	**10.78%**	**11.56%**

Source: Projecting Older People Population Information

- The National Census indicates 27,247 informal carers living in Plymouth with 28% of them providing more than 50 hours of support a week.

Older people are the largest group in this population. Not all older people need support and the fitter and healthier we help them stay the less likely they are to need help from us. However some older people do need long term support. Older people falling into the following groups are more

likely to need long term support - frail older people, older people with dementia and hearing and/or sight loss.

What we know - Older people with dementia

- In 2014 3,134 people over the age of 65 were predicted to be living with dementia
- By 2030 it is expected that the number of people over 65 with dementia will be 4855.

People predicted to have dementia aged 65 and over by age group	**2014**	**2015**	**2016**	**2017**	**2018**	**2020**	**2025**	**2030**
65 – 69	177	177	174	166	160	154	174	188
70 – 74	288	296	312	340	355	358	316	359
75 – 79	499	504	504	504	526	561	690	615
80 – 84	768	778	791	801	815	848	963	1,201
85 – 89	744	744	783	822	861	900	1,017	1,189
90 and over	659	687	687	714	745	804	1,038	1,303
Totals	**3,134**	**3,185**	**3,251**	**3,348**	**3,462**	**3,624**	**4,197**	**4,855**
% change		**1.60%**	**2.03%**	**2.90%**	**3.29%**	**4.47%**	**13.65%**	**13.55%**

Source: Projecting Older People's Population Information

What we know - Frail older people

Frailty is defined as having three or more symptoms from weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, and weak grip strength.

Frailty in older people negatively impacts on their quality of life and causes ill-health and premature mortality. Older people who are frail have an increased risk of falls, disability, long-term care and death.

There is also a significant cost associated with the frail older population. Over half of gross local authority spending on adult social care and two thirds of the primary care prescribing budget is spent on people over 65 years of age.

It is estimated that approximately 11% of over 65 year olds are frail. About 42% of over 65 year olds have one or two of these symptoms and are categorised as pre-frail.

This equates to 1.9% (4,782 people) of the Plymouth population who are frail and 7.0% (18,086 people) who are "pre-frail".

An increased risk of adverse health outcomes can be predicted by early identification of frailty, and adverse outcomes prevented by appropriate multidisciplinary interventions.

Older people frailty estimates, Plymouth

Age-group	Reported frailty rate (%)	Reported pre-frailty rate (%)	Population	Est. frail population	Est. pre-frail population
65 and over	11.0	41.6	43,475	4,782	18,086
65 to 69	4.0	-	13,540	542	-
70 to 74	7.0	-	9,827	688	-
75 to 79	9.0	-	8,219	740	-
80 to 84	15.7	-	6,190	972	-
85 and over	26.1	-	5,699	1,487	-

Source: 2012 mid-year estimates of usual resident population (ONS) using rates stated in the Devon Better Care Fund application, 2013

What we know – Continuing Health Care

There are currently approximately 545 Continuing Health Care (CHC) eligible people within the Plymouth footprint, with 239 people living at home within the community or residential home. There are 307 living within care homes with nursing. In addition there are 182 people in receipt of Funded Nursing Care Contributions.

What we know – Mental Health

- In 2014 it was predicted that there were 26,295 people with a common mental health disorder
- Between 2014 and 2030 it is expected that this number will rise to 25,670.

People aged 18 – 64 predicted to have a/an:	2014	2015	2020	2025	2030
Common mental disorder	26,295	26,282	25,988	25,647	25,670
Borderline personality disorder	734	734	725	716	716
Antisocial personality disorder	577	577	574	566	569
Psychotic disorder	653	653	645	637	637
Two or more psychiatric disorders	11,781	11,774	11,656	11,505	11,524

Source: Projecting Adult Needs Service Information

What we know – Learning Disabilities

- GPs identified 1240 people (5.7 in 1000) as having a learning disability in Plymouth compared to the national average of 4.54 in every thousand. [4]
- Hate Crime - the number of reported hate crimes to the Council are rising every year from Year 2011/12 - 34 (17 related to learning disabilities), Year 2012/13 - 47 (27 related to learning disabilities, Year 2013/14 - 59 (41 related to learning disabilities).

[4] Learning Disabilities Profile for Plymouth 2013. Public Health England.

It is suggested the data reflected above only represents a small percentage of the actual incidents that take place in Plymouth across all groups of disabled people. The increase in hate crimes, year on year, specifically related to people with learning disabilities in Plymouth reflects the national picture around the difficulties that people with learning disabilities face on a daily basis living in their local communities

- Accommodation - 665 (68.21%) people with learning disabilities were living in settled accommodation in Plymouth (2011/12), 21.54% were living in non-settled accommodation and 10.26% had an unknown accommodation status to LA[5]. Devon Home Choice collects information about the number of people with specific disabilities who wish to be considered for social housing.
- 815.38 in 10000 population adults with learning disabilities (age 18-64) are receiving community services, above the national 749.71[6]
- 282.05 in 10000 population adults with learning disabilities (age 18-64) are using day services, below the national figure of 347.20.[7]

People predicted to have a learning disability by age group	**2014**	**2015**	**2020**	**2025**	**2030**
18 - 24	964	971	924	906	1,003
25 - 34	869	869	879	886	852
35 - 44	741	729	729	756	771
45 - 54	802	801	740	654	654
55 - 64	647	654	716	734	680
65 - 74	529	538	558	553	610
75 - 84	298	302	336	404	418
85 +	112	116	139	167	206
Total	**4,962**	**4,982**	**5,021**	**5,060**	**5,194**
% change		**0.40%**	**0.78%**	**0.77%**	**2.58%**

Source: Projecting Older People Population Information

[5] Learning Disabilities Profile for Plymouth 2013. Public Health England.

[6] Learning Disabilities Profile for Plymouth 2013. Public Health England.

[7] Learning Disabilities Profile for Plymouth 2013. Public Health England.

What we know – Autism

- In 2014 2,070 people were predicted to have an autism disorder
- Between 2014 and 2030 it is expected the number of people with an autism disorder will rise from 2,070 to 2,186.

People predicted to have autistic spectrum disorders by age group	2014	2015	2020	2025	2030
18 - 24	374	377	361	354	393
25 - 34	355	356	368	377	363
35 - 44	300	295	294	306	315
45 - 54	339	334	304	270	270
55 - 64	283	287	313	314	289
65 - 74	241	244	245	248	276
75 +	178	183	213	259	281
Total	**2,070**	**2,076**	**2,099**	**2,128**	**2,186**
% change		**0.29%**	**1.10%**	**1.36%**	**2.65%**

Source: Projecting Older People Population Information & Projecting Adult Needs Service Information

What we know – Physical Disabilities in young people

- In 2014 there were 3,520 people predicted to have a serious physical disability aged between 18 and 64
- Between 2014 and 2030 it is expected that this figure will rise to 3,443.

People predicted to have a serious physical disability by age group	2014	2015	2020	2025	2030
18 - 24	285	287	274	269	298
25 - 34	140	140	141	142	137
35 - 44	513	505	503	520	529
45 - 54	929	926	851	748	745
55 - 64	1,653	1,670	1,827	1,873	1,734
Total	**3,520**	**3,528**	**3,596**	**3,553**	**3,443**
% change		**0.23%**	**1.89%**	**-1.21%**	**-3.19%**

Source: Projecting Adult Needs Service Information

3.4 Consultation feedback

The ***Plymouth Fairness Commission Report*** March 2014, 'Creating the Conditions for Fairness', makes a series of recommendations for improving fairness and addressing inequalities within the city following a "*Summer of Listening"*. The report identified areas that would have the highest impact on fairness in Plymouth. These are:

- Strengthening Communities
- Improving individual and Family Wellbeing
- Improving services for young People and young Adults
- Reducing discrimination and social exclusion
- Assisting people to cope with the escalating cost of living
- Strengthening the Local Economy
- Improving housing
- Addressing the implications of an ageing population

The ***Strategic Vision for Transforming Community Services*** document has been developed by CCG. The document provides context around the issues surrounding community based services and provides a vision for the future of service delivery within the Community to address these issues.

The CCG developed a large stakeholder reference group at the start of the programme. The reference group provided feedback that enabled 10 commissioning principles to be developed. These principles form the basis of the case for change:

1. Integrated and seamless delivery
2. Clear pathways and access
3. Consistent outcomes
4. Evidence based foundations
5. Individuals and carers at the centre
6. Personalised and localised models
7. Honest and open relationships
8. Care that reflects health needs
9. Sustainable, agile and flexible responses
10. Shifts of resources and innovation

These principles were then turned into 'I statements' which will be used to guide planning and decision making on the strategy and delivery arrangements.

- "I want the services I value now to be strengthened"
- "I want no barriers to care caused by geographic, regulatory or any other kind of boundary."
- "I want services that support me to manage my situation in life not just my condition"
- "I want the information I need to make healthy choices and stay healthy"
- "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"
- "I want to be able to get to my community services at times that are convenient for me"

- "I want to be able to have services provided in lots of different places not just health centres"
- "I want to be able to talk to healthcare providers when I need to."
- "I want to tell my story once - share my information with colleagues"
- "I want to be able to use new technology to help me manage my own health"
- "I want to continue to get the services I value that are provided by the voluntary sector"
- "I want to be able to get to the services in my community".

4.0 STRATEGIC CONTEXT

4.1 National

Transforming the Delivery of Health and Social Care, The case for fundamental Change 2012

This policy sets out the major progress which has been made in improving the performance of the NHS in the past decade. Notwithstanding this progress, the current health and social care delivery system has failed to keep pace with the needs of an ageing population, the changing burden of disease, and rising patient and public expectations. Fundamental change to the delivery system is needed, with greater emphasis on:

- Preventing illness and tackling risk factors, such as obesity, to help people remain in good health
- Supporting people to live in their own homes and offering a wider range of housing options in the community
- Providing high standards of primary care in all practices to enable more services to be delivered in primary care, where appropriate
- Making more effective use of community health services and related social care, and ensuring these services are available 24/7 when needed
- Using acute hospitals and care homes only for those people who cannot be treated or cared for more appropriately in other settings
- Integrating care around the needs of people and populations.

Some of the key findings:

1. Services have struggled to keep pace with demographic pressures, the changing burden of disease, and rising patient and public expectations. Too much care is still provided in hospitals and care homes, and treatment services continue to receive higher priority than prevention
2. The traditional dividing lines between GPs and hospital-based specialists, hospital and community-based services, and mental and physical health services mean that care is often fragmented and integrated care is the exception rather than the rule
3. Current models of care appear to be out-dated at a time when society and technologies are evolving rapidly and are changing the way patients interact with service providers
4. Care still relies too heavily on individual expertise and expensive professional input although patients and users want to play a much more active role in their care and treatment
5. National and local leaders need to take a strategic view rather than focusing on short-term fixes designed to preserve existing services

6. Implementation of new models of care will involve: decommissioning out-dated models of care; supporting NHS organisations to innovate and adopt established best practices; recognising the potential of new providers as an important source of innovation; developing a culture that values peer support for learning and innovation; encouraging players at the local level to test new models of care.

NHS Five Year Forward View 2014

This sets out an agenda to further modernise NHS Services, ensuring there is a focus on tackling the causes of ill health, such as obesity, smoking and alcohol use, alongside creating more diverse and locally shaped service models, designed to meet local need.

Within this is a clear agenda to work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government

The Better Care Fund

The £3.8bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single integrated budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

It creates a substantial ring-fenced budget for investment in a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge.

Integrated Personalised Commissioning and Personal Health Budgets

Integrated Personal Commissioning is a new voluntary approach recently launched by NHS England to help to join up health and social care for people with complex needs. This proposal makes a triple offer to service users, local commissioners and the voluntary sector to bring health and social care spend together at the level of the individual. People will be offered power and improved support to shape care that is meaningful to them. Local authorities and NHS commissioners, and providers will be offered dedicated technical support, coupled with regulatory and financial flexibilities to enable integration. The voluntary sector will be a key partner in designing effective approaches, supporting individuals and driving cultural change. Plymouth City Council and NEW Devon CCG are jointly participating in this work and will be collaborating with NHS England and partners across the South West. This is an opportunity to bring together resource and expertise, share good practice and collectively overcome barriers to implementation.

Personal health budgets are a key strand of the government's drive to personalise public services. The Personal Health Budget Programme was launched in 2009 after the publication of the Next Stage Review. An independent evaluation was commissioned alongside the programme which revealed that personal health budgets led to a better quality experience for service users and helped them to become less reliant on conventional health services.

From October 2014 people receiving NHS Continuing Health Care (CHC) were given the 'right to have' a personal health budget. It is now a priority for Plymouth City Council and the NEW Devon CCG to integrate health and social care services to ensure that people who choose to have a personal health budget are properly supported and can maximise the opportunities that this can bring, to take more control over their care and support and achieve a greater level of independence.

Our ambition for personal health budgets locally is to use the concept as a spring board to foster person-centred care and deliver services in a more integrated fashion. Implementation will help

commissioners to support people with health and social care needs, particularly those in receipt of Continuing Healthcare (CHC) funding, to live more independently, remaining in their own communities and staying in their own homes for longer.

4.2 Local

Our Plan: The Brilliant Cooperative Council

The Strategy will support the achievement of the following Council objectives and outcomes:

- Pioneering Plymouth: A Council that uses its resources wisely
- Growing Plymouth: More decent homes to support the population
- Caring Plymouth: People are treated with dignity and respect
- Confident Plymouth: Government and other agencies have confidence in the Council and partners: Plymouth's voice matters.

The Plymouth Plan – How Plymouth Will be a Healthy City (in development)

The Plymouth Plan is a single holistic plan setting out the direction for the City up to 2031. It brings together all the key strategies and plans for the city into one coherent document. It does so because the interdependencies of these strategies and plans are key to transforming the City. The section on health recognises that over the course of the Plymouth Plan period demographic changes and increasing complexity of need will continue to put pressure on all vital front-line services. The challenge for the public sector is to meet the volume and complexity of demand with decreasing resource. A focus on prevention is evidenced to reduce the burden of disease and consequently reduce demand on front-line services. The Plymouth Plan will show how partners and services from across the city can achieve this aspiration.

Health and Wellbeing Strategy (2014) Plymouth Health and Wellbeing Board

The Joint Health and Wellbeing Strategy is intended to inform commissioning decisions across local services, such that they are focused on the needs of people and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. Underpinned by the Marmot review the Strategy recognises that health and wellbeing must be addressed across the whole life course.

Transforming Care in Devon and Plymouth: Five Year Strategic Plan, (2014) CF01 NEW Devon CCG

This Strategic Plan states that, 'By 2019, healthy people will be living healthy lives in healthy communities. Services will be joined up and delivered in a flexible way. Resources will follow need. More care will be provided in the community'. Healthy living and wellbeing is cited as one of the key elements to the model of care recognising that interventions 'focus on preventing ill health and social factors such as isolation in the first place, focused on those most at risk – where the returns are greatest in terms of quality benefits for patients and service users and the reduction in demand (and cost) along the care pathway'.

In this framework NEW Devon CCG state they 'will work with its partners to commission services that contribute to the delivery of the Joint Health and Wellbeing Strategy'. The framework sets out the key CCG intentions.

Transforming Community Services: Proposed Commissioning Intentions for the Western Locality

The Transforming Community Services programme with our local strapline of 'Your Health, Your Future, Your Say' has given an opportunity to review the community services NEW Devon CCG currently commission, engage with the community and look at what is wanted and needed for our future to ensure resources are used in the way that best meets the needs of the Western locality population.

The aim of this document is to share the commissioning intentions for services in the community in the future. The document has been informed by public health information to incorporate knowledge about local needs, how the population may change over forthcoming years, listened to individual and community views and taken into account evidence and national policy to inform how we plan for tomorrow, not just today.

In doing so a model has been described where community services work clearly and healthcare is closely integrated with social care in some areas. There must be a greater focus on health promotion and ill health prevention, where resources are moved for the benefit of individuals, the population and sustainability of the system from traditional acute services to modern, efficient community services.

Integrated Health & Wellbeing – Integrated Commissioning

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

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

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

Therefore by building on co-location and existing joint commissioning arrangements, the focus will be to establish a single commissioning function, the development of integrated commissioning strategies and pooling of budgets, through a section 75 agreement.

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

Integrated Health & Wellbeing – Integrated Delivery

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

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

With the customer requirements combined with key drivers such as the Better Care Fund, Care Closer to Home, NEW Devon CCG strategy and initiatives such as Admission Avoidance the

emphasis in setting up the integrated function requires a significant focus on services based in the Community.

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

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

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

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

Better Care Fund Submission 2014 (NEW Devon CCG and Plymouth City Council)

To use the Better Care Fund to support our wider strategic aims for integration across our population. These aims are to:

- Strategically join the key actions we know will make a difference.
- Consistently commission great services that deliver to defined outcomes.
- Positively shift resources to parts of the system where there is most benefit.
- Adopt an asset based approach to help communities to help themselves.
- Target our attention to impacting on inequalities and services for the most vulnerable.
- Bring a new model of out of hospital care.
- To put in place schemes and arrangements to progress towards the national conditions of the BCF and achieve our desired outcomes. The national conditions include protecting social care services, seven day working, data sharing, and ensuring joint assessment and accountability for individuals at high risk of hospital admission.
- To improve performance outcomes. This will include the national outcomes set by the BCF, but also the additional local outcomes that will enable us to achieve our aims. The national outcomes for performance improvement include: delayed transfers of care, avoidable admissions and effectiveness of reablement and patient / user experience.
- To fully embrace the opportunity presented by the BCF to change the nature of commissioning and the speed and scale of integration. To work closely with our local authority partners and providers to make this happen.
- To integrate our commissioning, services delivery and health and wellbeing.
- To fully embrace the opportunity presented by the BCF to change the nature of commissioning and the speed and scale of integration.

Examples of current Plymouth Strategies, Commissioning Plans and other key documents supporting the scope of this Commissioning Strategy:

- How do we make Plymouth a healthier city? (2014) Plymouth Plan Topic Paper Health and Wellbeing
- Community Domiciliary Care Business Case 2015-19
- Dementia Strategy 2014-15,
- Carers Strategy 2014-18,
- Strategic Alcohol Plan for Plymouth 2013-2018
- A Mental Health Commissioning Strategy for Devon, Plymouth and Torbay 2014-2017,
- Housing Plan 2012-2017 Plymouth City Council

4.3 Key legislation

Health & Social Care Act 2012

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

Care Act 2014

The Care Act 2014 creates a single modern piece of law for adult care and support in England. The reforms introduce significant new duties on Local Authorities and consequently will involve significant change to finances, processes and people.

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

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

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

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

The Social Value Act (2012)

Requires all public bodies to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the community. 'Social value' involves looking

beyond the price of the individual contract and considering the social impact on the community when the contract is awarded.

4.4 Evidence based / good practice

This strategy will incorporate good practice and build on an evidence base to improve the health and social care outcomes of people in Plymouth. The following good practice resources, research and data can be accessed by health and social care professionals and commissioners:

- Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/
- National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/
- The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/
- NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/
- Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/
- Care Quality Commission (CQC) - http://www.cqc.org.uk/
- Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/
- Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm

More detailed descriptions of the resources listed above can be found in appendix 1.

5.0 CURRENT PROVISION

5.1 Strategic overview

This section will describe the current 'Community Based Care' system in three parts:

- Multiple Needs Services
- Urgent Care Services
- Long Term Support Services

5.2 Existing service provision

<u>Multiple needs</u>

This area covers adults who experience several problems at the same time (e.g. mental health, substance misuse, homelessness, offending), that have significant impact on families and communities. Often people are living chaotic lives, and have ineffective contact with services

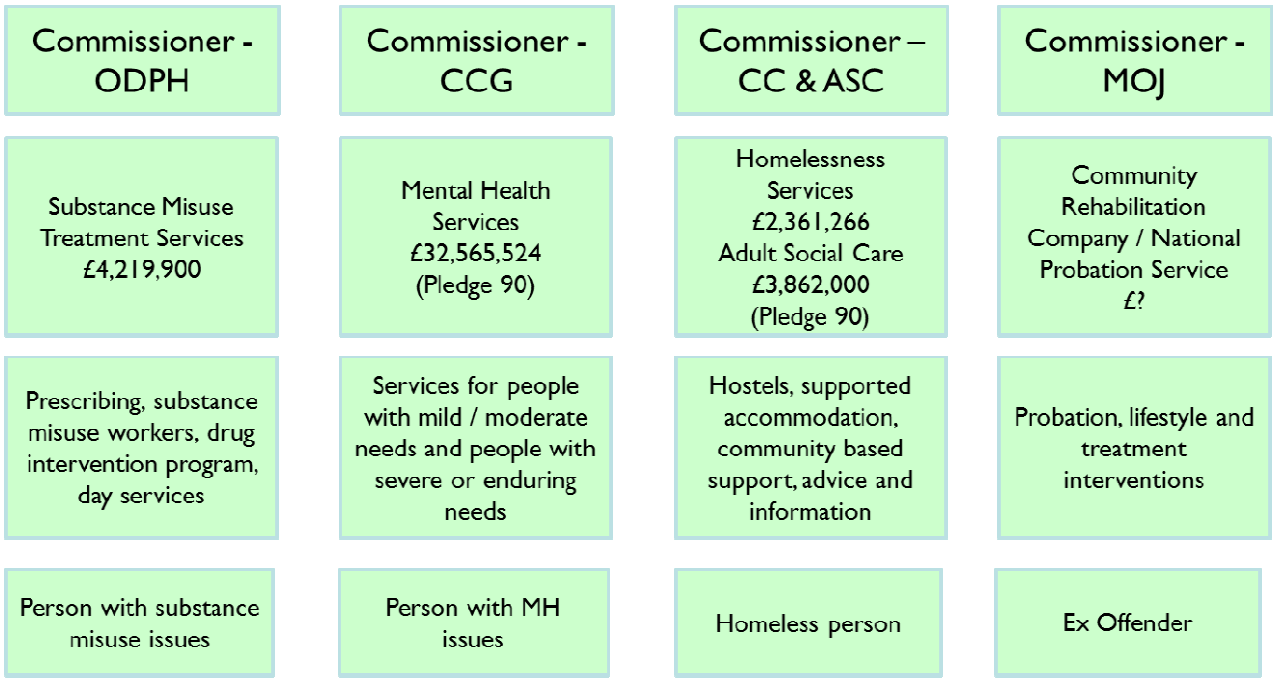
In Plymouth services to support adults with multiple needs are commissioned by different commissioners through service specific contracts that cover only on the issue they are commissioned to provide. Correspondingly the provider market has developed into specialist areas, although there are some good examples of joint working there is limited meaningful partnerships that respond to the range of needs an individual often presents with.

This can lead to duplication with the same clients often accessing a number of different services in an unpredictable manner and potentially, more worryingly, clients with complex health and social care needs, not being able to access any services due to lack of clarity as to "who does what".

The diagram below demonstrates the silo approach to commissioned services, albeit a range of services are delivered in a more integrated manner. The diagram raises the following questions:

- Where does a client go with a combination of problems?

- What happens if the client is homeless and has a mental health problem and some form of addiction?
- Does the information about the client who presents to one commissioned service go with them or get shared with another service with whom the client engages?
- Does the system chaos adversely impact on people whose lives, by the very nature of their health and social care issues, are often chaotic?



Services are also performance monitored separately. There is a general sense of the following performance across each individual element of the system

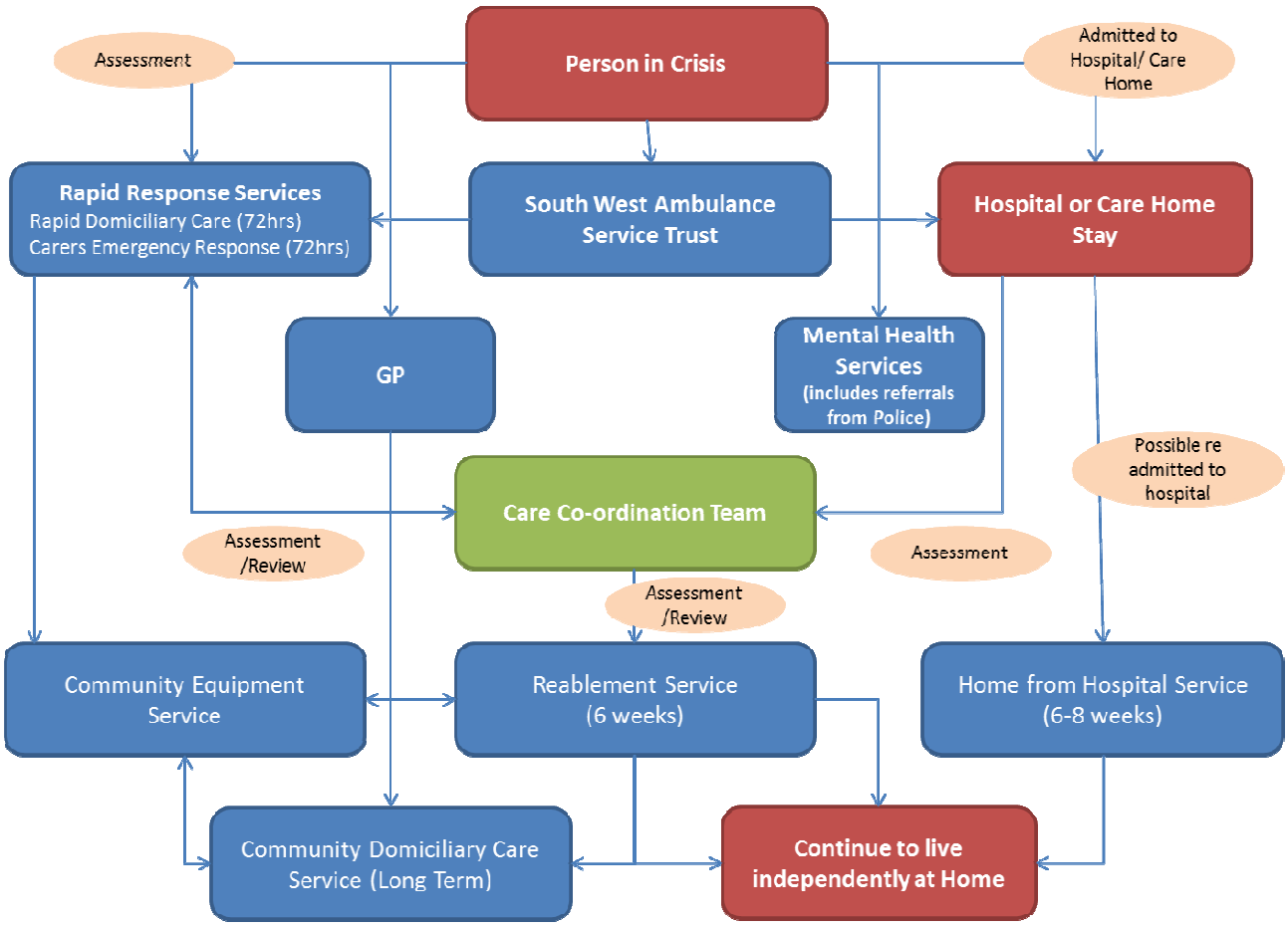
- Homelessness – well utilised services with high planned move on to independent tenancies
- Substance misuse – trajectory of improving levels of successful completions
- Mental health – some specific concerns around referral to treatment, service capacities, and outcomes (e.g. Plymouth Options).

It remains difficult to gauge a comprehensive picture across the whole system. The national outcomes frameworks provide an indication of how Plymouth is performing overall compared to other areas

Public Health Outcome Framework (PHOF) Indicator	England	Plymouth
1.06ii Secondary MH in stable & appropriate accommodation	58.5	53
1.08ii Gap in employment rate between MH and overall	62.3	63
1.13ii Reoffending levels	26.9	27.5
1.15i Statutory Homelessness	2.3	2.5
2.15i Successful completions (opiate)	7.8	7.2
2.18 Alcohol related hospital admissions	637	708
2.23iv Self reported wellbeing (high anxiety)	21	24.1

Urgent Care

The purpose of the existing provision of Urgent Care Services is to support people and their carers in crisis, to avoid admission to hospital or care and to promote recovery and reablement as quickly and effectively as possible. There is a variety of services within this area however the system is difficult to navigate with the increasing pressures due to demand and complexity.



There are a significant number of pressure points within this system.

The system does not currently prevent people from going into a crisis and too many people are admitted to hospital in an emergency. At any point in time, in the region of 30% of people are admitted to hospital when, in fact, their needs could be met elsewhere. Once people, particularly the frail elderly are admitted, there is the very real risk that they will recover slowly, potentially become more unwell, be isolated from their usual support networks and more dependent. This results in long lengths of stay (delayed transfers of care) and admissions to care homes (nursing and residential), and not providing a seamless and speedy recovery journey.

This winter (2014/15) has been one of the most difficult for the health and social care system, with Plymouth Hospitals NHS Trust having spent over 6 weeks at "black escalation" as a consequence of this.

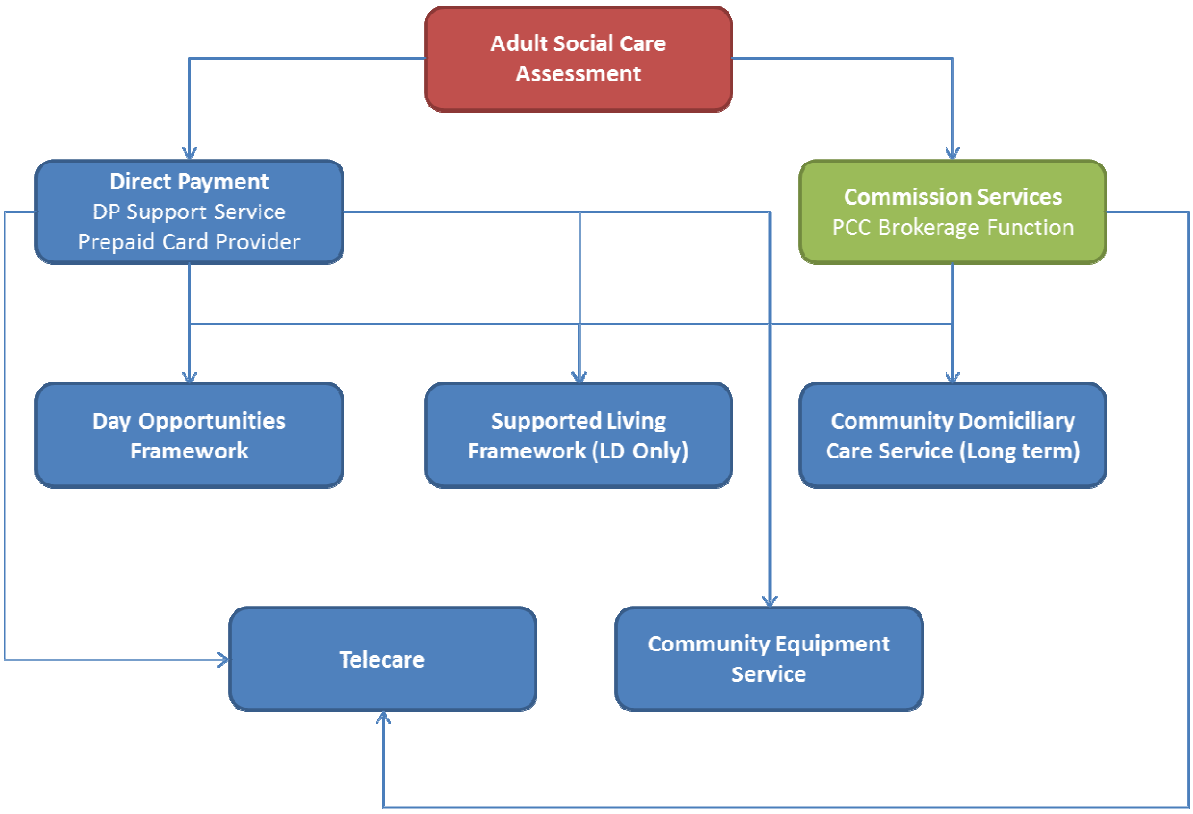
There are significant pressures within the capacity of our Domiciliary Care Providers in the City at the moment and with people needing to be discharged from hospital quickly the demand is only likely to increase as describe within the needs assessment.

Other performance indicators that can be used to indicate how well the urgent care system are described below.

Performance Indicator	National	Plymouth
Local Proxy - Avoidable hospital admissions (2013/14)	1898.3	2187
Local BCF - Delayed transfers of care (days delayed) from hospital per 100,000 population (aged 18+)	887.9 (Q2 13/14)	1514.7 (Q3 14/15)
ASCOF 2A Permanent admissions to residential and nursing care homes (aged 65+)	650.6	649.7
ASCOF 3A Percentage of adults using services who are satisfied with the care and support they receive	64.8% (2013/14)	67.8% (2013/14)
ASCOF 2B Proportion of older people still at home 91 days after discharge	82.5% (2013/14)	80.8 (2013/14)

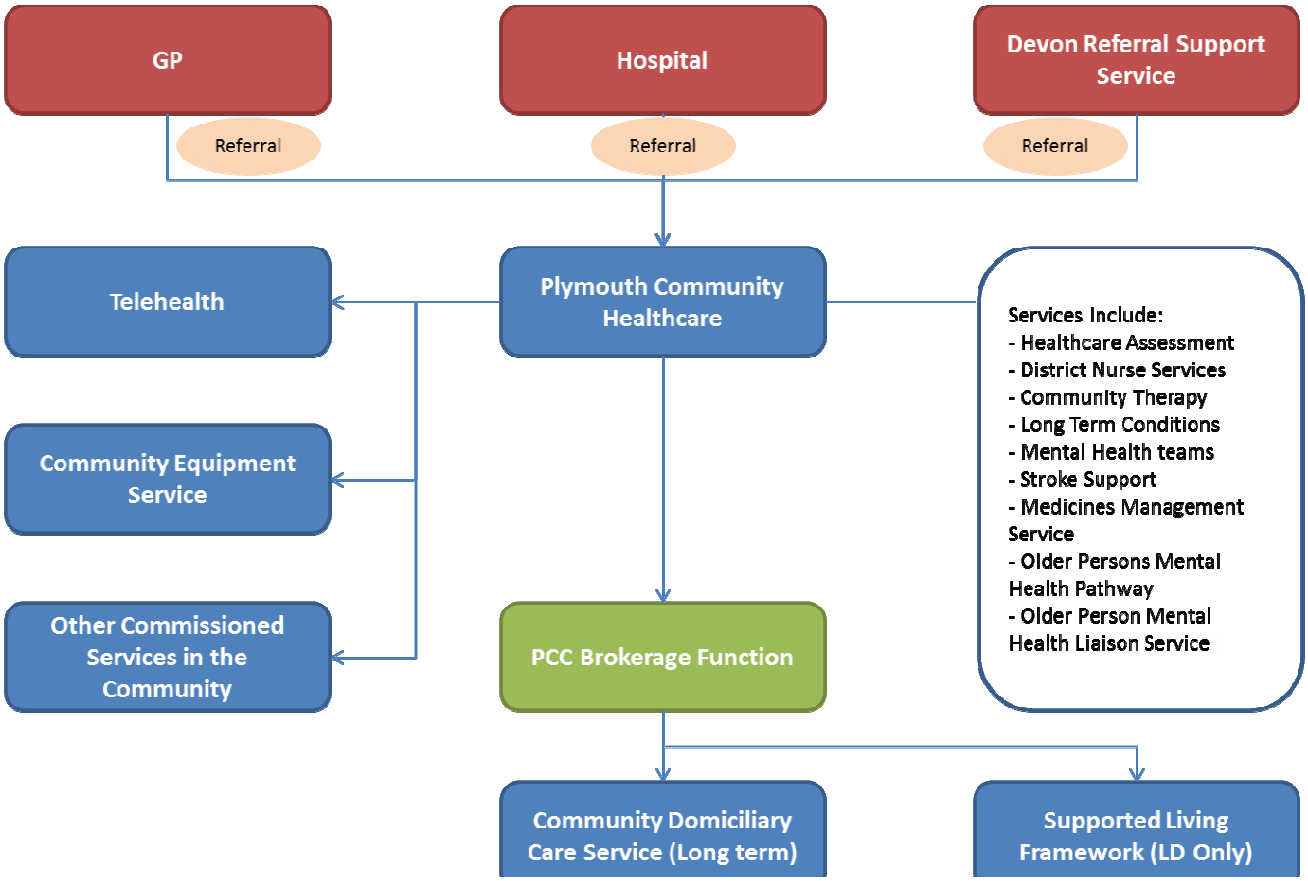
Long Term Support

The purpose of the existing provision is maintain people with on-going needs to live as independently as possible for as long as possible and to target support at those who may be at risk in the future of developing more complex needs. There is a variety of services within this area including day opportunities and most are currently commissioned through Plymouth City Council. However the system for adult social care and health are not interlinked. The below diagram below shows existing provision of long term support for people following an adult social care assessment.



This demonstrates that all of these services are delivered by the provider market and accessed via a direct payment or commissioned service.

The next diagram shows the services available for long term support following a Healthcare assessment. The majority of services for patients with a health need, are commissioned by CCG and provided by Plymouth Community Health Care Community Interest Company or brokered via the PCC function.



The opportunity for joining up the two systems is clear and responds to the feedback from service users about the need for a integrated health and social care system.

Personalisation gives people the freedom to decide how they wish their social care and health needs to be met. Currently, Adult Social Care allocates personal budgets following an assessment, and these can be deployed as a direct payment. Personalised health budgets are available to those people with long term conditions and those receiving Continuing Healthcare funded services e.g. personal care at home, physiotherapy, speech therapy, counselling. During 2014/15 the CCG has worked with people receiving these services to set up personal health budgets. The CCG currently has approaching 50 personal health budgets in place. Those people managing personal health budgets are reporting significant benefits enabling them to plan and manage their individual care requirements.

Other performance indicators that can be used to indicate how well long term support are described below.

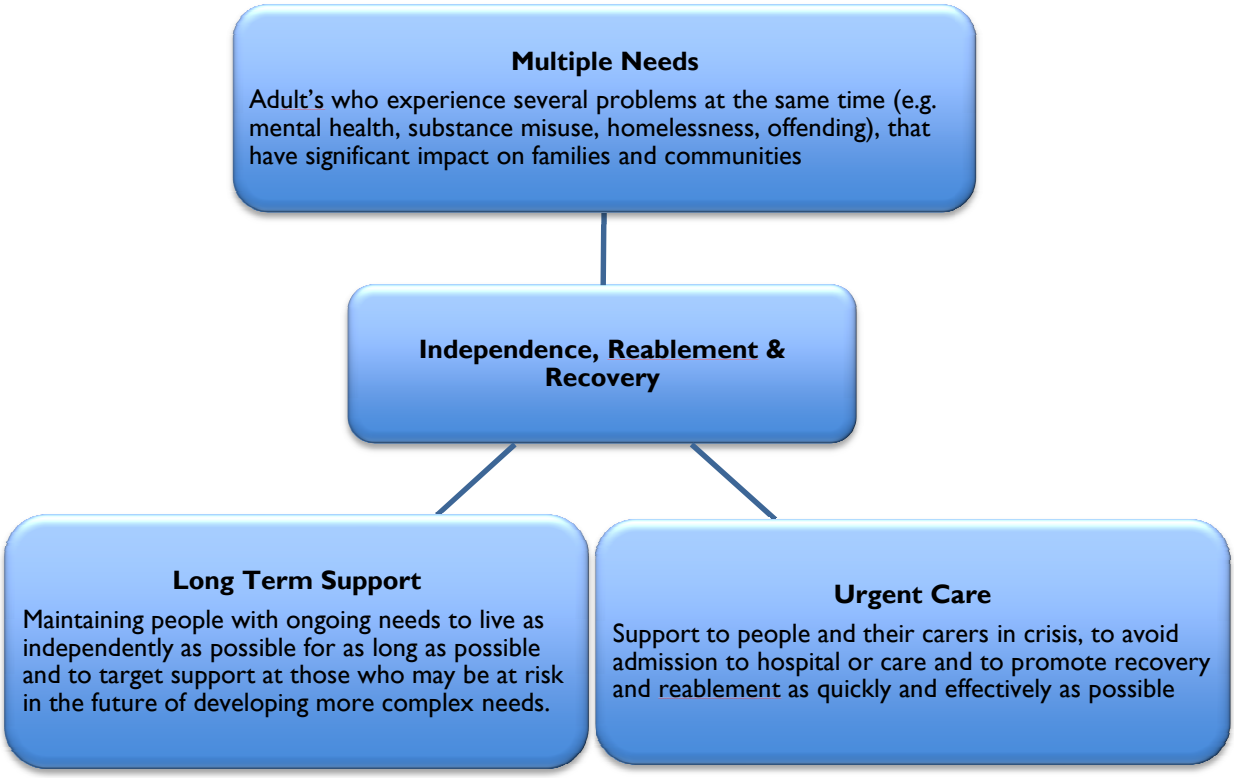
Performance Indicator	National	Local
ASCOF 1C Proportion of people using social care who receive self-directed support	62.1% (2013/14)	67.8% (2013/14)
Proportion of people using social care who receive self-directed support	19.1% (2013/14)	26.1% (2013/14)
Social care related quality of life	19.0	19.3
Satisfaction rates amongst social care clients	64.9%	67.8%

5.4 Community asset mapping

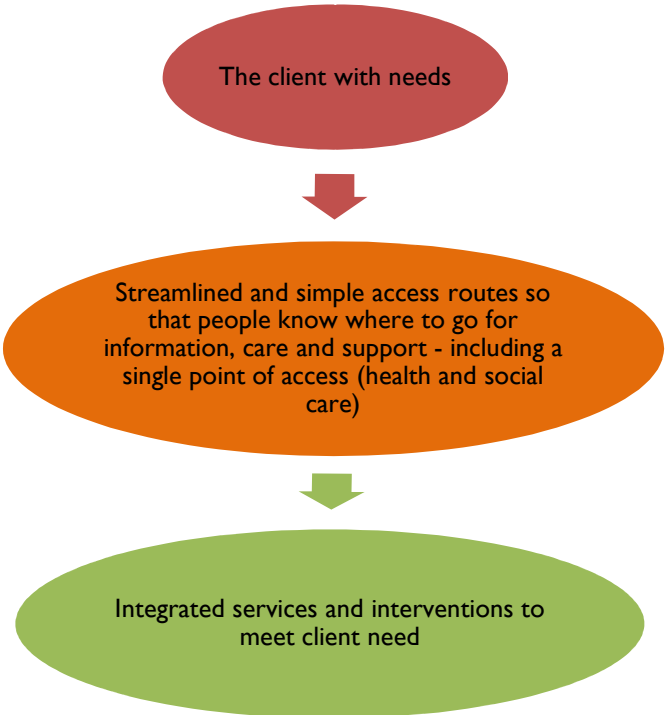
Asset mapping will be utilised to determine existing informal provision, assets and resources that people have access to in the community. A co-production approach will improve the understanding of local needs and assets and will be part of the wider needs assessment work carried out across the four strategies. The asset maps would then support the formally procured services as part of the long-term commissioning strategies (Adapted from Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014).

6.0 THE FUTURE 'COMMUNITY BASED CARE' SYSTEM MODEL

This section will pull together a summary of the above information around need and current provision, and describe what the future 'Community Based Care' System will look like in the future.



The needs assessment, strategic context and analysis of the current provision require a future system that responds to individual need through a streamlined and integrated provision. Whether a person needs support for multiple needs, around urgent care, or long term care what this means for clients is clear, simple, joined up solutions:



Multiple Needs

Commissioners responsible for existing different service elements will work together to commission a joined up 'whole system' to support people multiple needs. This will ensure services are integrated around the needs of the person, improve individual outcomes whilst also ensuring best use of resources.

Urgent Care

Commissioners are required to develop an integrated and seamless system that focuses on reducing acute episodes of care, responding quickly to a crisis, and focusing on timely discharge, recovery and reablement.

Key design principles include;

This work will be underpinned by the following design principles:

- choose to admit only those frail older people who have evidence of underlying life-threatening illness or need for surgery – they should be admitted, as an emergency, to an acute bed;
- provide early access to an old age acute care specialist, ideally within the first 24 hours, to set up the right management plan;
- discharge to assess as soon as the acute episode is complete, in order to plan post-acute care in the person's own home;
- provide comprehensive assessment and reablement during post-acute care to determine and reduce long term care needs.

Long Term Support

The Long Term Support system will target resources at those who need on-going support in the community, or at those who are identified at risk of needing support with the aim of:

- Promoting Independence and reducing dependency
- Maximising peoples potential to live full and rewarding lives
- Promoting self-care

- Promotion of choice and control

Increasingly this will mean a more personalised market tailored to individual needs

Long terms support should be focussed on those who would most benefit from NEW Devon CCG and PCC are currently working towards an integrated delivery approach for Health and Social Care for a single point of contact for people. For the effective use of resources and delivery of services, requires the alignment of health and social care. The Better Care Fund and the integration of health and social care will help provide a vehicle to enable this to happen.

6.1 Available Resources

The current approximate commissioning budget against each service element is described in the table below.

System element	Approximate current budget
Multiple needs	£7,091,797
Urgent care	£79,889,251
Long term support	£32,761,589
Total	£119,742,637

6.2 System Performance – Current and Future

The following outcome performance indicators have been identified as key to measuring how this strategy contributes to improvements across the whole health, wellbeing and social care system in Plymouth. These will form part of a comprehensive performance dashboard that will be used to monitor an overview of the system.

Indicator	National	Plymouth	Impact on system – why is this a measure?	Trajectory
PHOF 2.18 Alcohol related admission to hospital	637	708	Improving these indicators demonstrate impact on the	
PHOF 7.15 Successful completion of drug treatment	7.8	7.2		
Local BCF - Delayed transfers of care (days delayed) from hospital per 100,000 population (aged 18+)	887.9 (Q2 13/14)	1514.7 (Q3 14/15)	Improving these indicate a strong community based system that supports people at home for longer reducing the impact on services in the 'complex' strategy	843.3 (Q4 15/16)
ASCOF 2A Permanent admissions to residential and nursing care homes (aged 65+)	650.6	649.7		604.2 (15/16)
ASCOF 3A Percentage of adults using services who are satisfied with the care and support they receive	64.8% (2013/14)	67.8% (2013/14)		70.0 (2015/16)
ASCOF 2B Proportion of older people still at home 91 days after discharge	82.5% (2013/14)	80.8 (2013/14)		89.9 (2015/16)

7.0 COMMISSIONING PLAN 2015/16 – COMMUNITY BASED CARE

This section describes the key commissioning activity that needs to take place to develop the 'Future Systems' described above:

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
Multiple Needs	Commission a joined up 'whole system' to support people multiple needs	Reduced homelessness Recovery from substance misuse Reduced offending	**PCC**	April 2016
Urgent Care	Establish and develop an effective multiagency Urgent Care Control Centre	Deliver a minimum of 3.5% reduction in non-elective admissions to acute Trusts. Ensure the achievement of the 95% A&E 4 hour performance target. Ensure the achievement of SWASFT performance targets.	**CCG**	2016
	Develop the Urgent Care Model through a strategic review of urgent and unplanned care services	A clear map of the current network of urgent and unplanned care services	**CCG**	2016
	Implement two Progress Enablers: 1) Completion of data analysis on impact to length of stay / identify alternative diagnostic offerings and pathways 2) Successful sharing of patient data and information	Release pressure on the urgent care system	**CCG**	2016

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
	Further analysis of emergency admissions, repeat emergency admissions and potentially avoidable admissions	Concepts tested with reference groups for agreement	**CCG**	2016
Urgent Care Long Term Support	Jointly commission an integrated health and social care service that delivers all statutory functions and maximises opportunities for integration across all disciplines	Improved service user experience of health and care Improved health and social care outcomes Care Act 2014 compliance Improved ASC Performance	**PCC/CCG**	2016
	Complete Phase 1 Community Domiciliary Care procurement	To have block contracts arrangements in place with 8 providers Seamless transfer of approx. 225 clients from all spot contracts to a block contract provider Provider to implement the following key principles for care staff: - Paid at least the living wage - Paid for travel time - Offer guaranteed hour contracts	**PCC**	April 2015
	Undertake a needs data analysis to inform the procurement and complete Phase 2 of Community Domiciliary Care including market Development	To secure further block contract arrangements for domiciliary care market Provider to implement the	**PCC**	April 2016

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
		following key principles for care staff: - Paid at least the living wage - Paid for travel time Offer guaranteed hour contracts		
Long Term Support	Explore the opportunities to create "Community Health and Wellbeing Hubs" alongside other organisations	Streamlining information and support, based in local communities and making better use of resources and facilities	**CCG**	**2016**
	The next phase of implementation of personal health budgets will be aimed at those people with multiple long term conditions, frail elderly and mental health service users.	Improved health outcomes	**CCG**	**2016**
	Reconfigure supported living services taking a whole system approach. To include commissioning services jointly with the CCG, increasing the focus on reablement to improve outcomes and independence.	Remodelled in-house reablement service with increased focus on developing people's independent living skill so enabling a reduced reliance on care services Establish supported living services across client groups for people with eligible health and social care needs	**PCC**	March 2016
	Develop and procure further Extra Care Housing Schemes	Provision of additional extra care housing units as an alternative to residential care	**PCC**	By 2019

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
	Review the impact of other provision on the rate of admission to care homes including Extra Care Housing, Domiciliary Care, Telecare and Reablement	Reduced admission to Care Homes		March 2015
	Re-procurement of the wheelchair service	New service established which has an increased service user focus driving service improvements; delivering an improved offer alongside efficiencies through more effective practice.	**CCG**	November 2015
	Reprocurement of the Community Equipment Service	New service established which has an increased service user focus driving service improvements; delivering an improved offer alongside efficiencies through more effective practice.	**PCC**	April 2015
	Revise the Section 117 After Care agreement between PCC and CCG in line with the 2015 mental health Act Code of Practice and the Care Act 2014	Establishment of clear working parameters in line with best practice regarding the provision of 117 aftercare services	**PCC**	April 2015
	Refresh the day opportunities framework by opening up for new providers and revised offers	Increase the choice of daytime activities through the day opportunities framework	**PCC**	November 2015

APPENDIX ONE

Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/The SCIE aims to improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy

National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. There are also the following NICE Standards and Indicators areas:

1. *NICE Quality Standards* are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health or care and are derived from the latest evidence and best practice. The NICE Quality Standards are divided into 3 categories:
    a. *Quality standards for health* focus on the treatment and prevention of different diseases and conditions. Topics are referred to NICE by NHS England. They are reflected in the new Clinical Commissioning Group Outcome Indicator Set (CCGOIS) and will inform payment mechanisms and incentive schemes such as the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) Payment Framework.
    b. *Quality standards for social care* focus on the services and interventions to support the social care needs of service users. Topics include supporting people to live well with dementia, looked-after children and young people, autism and the mental wellbeing of older people in care homes. Topics are referred by the Department of Health and Department for Education.
    c. Quality standards for public health will support Public Health England, local authorities and the wider public health community. Topics include reducing tobacco use in the community, preventing harmful alcohol use, and strategies to prevent obesity in adults and children. Topics are referred by the Department of Health.
2. *Quality and Outcomes Framework (QOF)* is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. NICE's role focuses on the clinical and public health domains in the QOF, which include a number of areas such as coronary heart disease and hypertension.
3. *CCG OIS* is to support and enable Clinical Commissioning Groups (CCGs) and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of services commissioned by CCGs. It is also intended to provide clear, comparative information for patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes. All indicators are evidence based and draw on NICE quality standards, NICE guidance or NICE accredited guidance.

The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/

HSCIC is the national provider of information, data and IT systems for health and social care. The Health and Social Care Act 2012 sets out HSCIC responsibilities, which include:

- Collecting, analysing and presenting national health and social care data
- Setting up and managing national IT systems for transferring, collecting and analysing information.
- Publishing a Code of Practice to set out how the personal confidential information of patients should be handled and managed by health and care staff and organisations
- Building a library of 'indicators' that can be used to measure the quality of health and care services provided to the public
- Acting to reduce how much paperwork doctors, nurses and care workers have to complete by ensuring that only essential data is collected, and avoid collecting the same information twice
- Helping health and care organisations improve the quality of the data they collect and send to us by setting standards and guidelines to help them assess how well they are doing
- Creating a register of all the information that we collect and produce, and publishing that information in a range of different formats so that it will be useful to as many people as possible while safeguarding the personal confidential data of individuals.

NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/

NHS IQ is working to improve health outcomes for people by providing improvement and change expertise across the NHS in England. NHS IQ utilises good practice and builds improvement capacity and capability and to help develop knowledge and skills across the whole health and care system. They work to the five domains of the NHS Outcomes Framework:

1. Living longer lives
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/

Ofsted independently inspect and regulate services which care for children and young people, and those providing education and skills for learners of all ages. Ofsted will work with providers which are not yet good to promote their improvement, monitoring their progress and sharing with best practice.

Care Quality Commission (CQC) - http://www.cqc.org.uk/

CQC is the independent health and adult social care regulator. CQC monitor, inspect and regulate services to make sure they meet fundamental standards of whether the service is safe, effective, caring, responsive to people's needs and well-led. CQC will publish findings, including performance ratings to help people choose care. Regulated services include:

- Hospitals
- Dentists
- Care Homes
- Community Based Services

- GPs and Doctors
- Clinics
- Home Care Services
- Mental Health Services

Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/

HCPC are a regulator who keep a Register of health and care professionals who meet our standards for their training, professional skills, behaviour and health.

Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm

The HSE's work covers a varied range of activities; from shaping and reviewing regulations, producing research and statistics and enforcing the law.

There are also a wide range of regulators for health staff, such as the General Medical Council (GMC) for registered doctors in the UK, their good practice guidance will be considered wherever applicable.

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Department of Health

NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015

Public Consultation

February 2015

Published to gov.uk, in PDF format only.

www.gov.uk/dh

NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015

Public Consultation

Contents

Summary

- This consultation seeks views on the Government's proposal to amend the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, to bring NHS England's primary medical care functions within the permitted scope of partnership arrangements between local authorities and health bodies.

- Partnership arrangements and pooled budgets in particular can play an important role in underpinning a more joined-up approach to planning and commissioning across out-of-hospital care, and support efforts to deliver more integrated, person-centred care.

- Existing regulations already provide for pooled budgets across the key health functions of Clinical Commissioning Groups and the health-related functions of local authorities, including social care. They will underpin the operation of the Better Care Fund at local level in 2015/16.

- The proposed change will widen the potential scope of pooled budgets by making it possible for them to include funding for primary medical care, paving the way for greater integration across community health, social care and primary care.

- The proposed change provides greater flexibility and local powers around the use of pooled budget arrangements, and removes a potential legislative barrier to continued efforts to increase integration. It will not impose any *requirements* on areas or NHS England to make use of these additional flexibilities.

1. Background

1.1. Under Section 75 of the NHS Act 2006 (as amended), the Secretary of State can make provision for local authorities and National Health Service (NHS) bodies to enter into partnership arrangements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised. The specific provision for these arrangements is set out in the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. The regulations:

- Set out the NHS bodies and local authorities that may participate in partnership arrangements;
- Set out the functions of those bodies that may be the subject of partnership arrangements;
- Enable partners to enter into arrangements for or in connection with the establishment of a pooled fund;
- Enable partners to enter into arrangements for an NHS body to exercise the prescribed health-related functions of local authorities; and
- Enable partners to enter into arrangements for a local authority to exercise prescribed NHS functions.

1.2. As set out in *Integrated Care and Support: Our Shared Commitment*[1], the Government is fully committed to supporting more integrated, person-centred care, as the means to improve outcomes for individuals and make the best use of public resources. The powers and joint arrangements possible under Section 75 of the NHS Act 2006 are already used extensively by health bodies and local government to support and underpin more effective joint working, and to help drive integration across health and social care.

1.3. From 2015/16 this will include the implementation of the Better Care Fund, a £3.8bn pooled fund across Clinical Commissioning Groups and local authorities. The BCF is being implemented at local level through local pooled funding arrangements ('Section 75 agreements'), making use of the powers available through Section 75 of the NHS Act 2006.

Scope of Current Regulations

1.4. The existing NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 set out the local authority and health body functions which may be the subject of Section 75 partnership arrangements. For the purposes of pooled funds (such as the BCF), this determines the health body or local authority functions that expenditure from the pool may be used to fund (and therefore the types of funding that partners are likely to contribute to the pool).

1.5. At present, the prescribed functions cover the majority of Clinical Commissioning Groups' general functions to commission health services, for example urgent and emergency care, hospital care, rehabilitation, mental health services, and community health[2]. They also cover local authorities' key health-related functions, including public health and social care functions, and related services such as housing and services for the disabled.

[1] https://www.gov.uk/government/publications/integrated-care
[2] Certain CCG functions in relation to specialised services, such as radiotherapy and invasive treatments, are excluded.

1.6. However, the prescribed functions do not cover primary care services that are currently directly commissioned by NHS England, under their duties set out in Part 4, 5, 6 and 7 of the NHS Act 2006. This covers primary medical services (i.e. general practice), dental services, ophthalmic services and pharmaceutical services.

2. The Draft Regulations

The Proposed Amendment

2.1. The Government is clear that primary care, and general practice in particular, has an important role to play in delivering more integrated out-of-hospital care, and that more joined-up local commissioning models across primary care and wider community health and social care can offer significant benefits. Significant progress in this area is already being made, for example through the work on primary care co-commissioning being led by NHS England, and through innovative activity in local areas to put general practice at the forefront of delivering more person-centred care.

2.2. The Government wants to support further progress in this area, and provide local areas with as much flexibility as possible to develop future planning, partnership and commissioning arrangements that support the delivery of more integrated care. We are therefore proposing to amend existing regulations to bring NHS England's primary medical services functions (i.e. general practice) within the potential scope of Section 75 partnership arrangements.

2.3. This will create the flexibility to allow NHS England to participate in local Section 75 partnership arrangements, where this forms part of an agreed approach to working with local government and CCG partners to deliver more integrated care. Specifically, it would:

- Enable NHS England to choose to pool funding for general practice alongside the CCG and local authority funding for community and social care. Although most general practice expenditure is based on nationally consistent contractual arrangements, there is some flexibility to vary contractual arrangements to reflect local priorities. This change would enable NHS England, CCGs and local authorities to use those flexibilities in ways that supported a more co-ordinated approach to planning and commissioning community-based health and social care services; and

- Provide a more efficient and joined-up means for CCGs and local authorities to invest pooled budgets (such as the BCF) in additional services from general practice. The change would enable them to do this through asking NHS England to enter into a Section 75 agreement, and then using pooled funding to commission additional services through variations to core primary care contracts. This could be a more efficient and joined-up approach than the current typical use of standalone contracts with general practice providers held by the CCG or local authority.

2.4. The proposed amendment would provide additional flexibilities to NHS England and local areas around the use of pooled budgets – it does not impose any requirements for areas to make use of these flexibilities.

Other Primary Care Functions

2.5. The draft regulations address NHS England's primary medical services (general practice) functions, and do not add the NHS England's other primary care services (dental services, ophthalmic services and pharmaceutical services) to the list of prescribed NHS functions. Although each of these parts of primary care can play a role in supporting integrated care, the Government considers that the most significant benefits of formal partnership and pooled fund arrangements across health and local government bodies are likely to relate to general practice. However, as

part of this consultation the Government is keen to receive views from stakeholders on whether they think there would be significant benefits to allowing pooled fund arrangements across others aspects of primary care.

Outline of Draft Regulations

2.6. A draft of the *NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015* is included at **Annex A**. The draft regulations make an amendment to the existing regulations by adding to the list of prescribed NHS functions which may be the subject of prescribed partnership arrangements. Specifically, it adds NHS England's duty under section 83 of the NHS Act 2006 (as amended) to secure the provision of primary medical services. The addition of this NHS function to the list of prescribed functions will mean that, in addition to what is currently permitted:

- NHS England may enter into partnership arrangements in relation to the exercise of their primary medical services functions;
- A pooled fund established under Section 75 may be used to fund expenditure incurred in exercising NHS England's primary medical services function; and
- NHS England may enter into partnership arrangements for the exercise of their primary medical services functions by a local authority.

Managing Conflicts of Interest

2.7. If local areas and NHS England choose to make use of these additional flexibilities in future pooled funding arrangements, they should help to support the closer involvement of CCGs and local authorities in commissioning decisions in relation to general practice. While this could be an important part of creating a more joined-up approach to planning and commissioning across out-of-hospital care, the Government recognises the continued imperative of guarding against any potential conflicts of interest, given that the membership of CCGs is made up of GP practices.

2.8. The Government does not consider that the proposed amendment to the regulations will create new or increased risks around conflicts of interests, and believes that the current framework should continue to provide sufficient safeguards where these flexibilities are used. CCGs can and already do commission some additional services from general practice, and through the co-commissioning programme NHS England are already giving CCGs the opportunity to play a much greater role in decisions over 'mainstream' primary care commissioning (including, where appropriate, delegated commissioning arrangements).

2.9. In terms of existing safeguards:

- Section 14O of the NHS Act 2006 (as amended) sets out a range of statutory duties for CCGs around conflicts of interest, such as maintaining a register of interests, making arrangements for managing conflicts and potential conflicts of interest, and having regard to guidance on conflicts of interest published by NHS England;

- NHS England have recently published updated statutory guidance to CCGs on managing conflicts of interest. This includes strengthened requirements to reflect the additional role that CCGs will play under co-commissioning arrangements;

- The existing Section 75 pooled fund regulations include requirements for partners entering into pooled fund arrangements to have a formal written agreement in place, and for the 'host' partner to submit quarterly reports on income, expenditure and other information on the effectiveness of the fund to other partners – this will help ensure other partners have adequate oversight over spending decisions in relation to primary care; and

- The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 include a formal requirement that a CCG relevant body must not award a contract for the provision of health care services for the purposes of the NHS where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract.

Consultation requirements and the Better Care Fund

2.10. The draft regulations also make a minor amendment to the existing requirement for areas to consult before entering into pooled fund arrangements, to take account of arrangements around the Better Care Fund. Existing regulations specify that the local bodies intending to enter into Section 75 partnership arrangements must consult affected persons before doing so.

2.11. However, in the case of the Better Care Fund, under Section 223GA of the NHS Act 2006 (inserted through the Care Act 2014), CCGs and local authorities are effectively required to establish a Section 75 agreement for the purposes of the fund. The draft NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015 therefore amend the existing regulations to disapply the requirement to consult, where the bodies are already required to enter into partnership arrangements in connection with Section 223GA of the NHS Act 2006.

3. Consultation Questions

3.1. The Government would welcome views on the proposed amendment to the regulations. In particular:

(1) Do you agree that the proposed amendment will provide helpful additional flexibility, and support the Government's and local areas' continued efforts to drive more integrated and person-centred out-of-hospital care?

(2) Do you agree with the Government's proposal to limit the proposed amendment to primary medical services / general practice (rather than other aspects of primary care), on the basis that this is where the benefits of pooled fund arrangements are likely to be greatest?

(3) Do you agree that existing safeguards and guidance are sufficient to address any potential conflicts of interests where primary care funding forms parts of pooled funding arrangements?

(4) If not, what additional measures do you think are necessary?

(5) Do you have any other comments on the draft regulations?

(6) 'Do the proposals have any impact (adverse or positive) on people sharing protected characteristics, as defined in the Equality Act 2010?'

4. Responding to this Consultation

4.1. The deadline for this consultation is 8 March 2015. You may respond:

- In writing, to Jessica Sharp, Department of Health, Wellington House, 133-155 Waterloo Road, London SE1 8UG
- By email, to Jessica.sharp@dh.gsi.gov.uk
- By completing an online survey: http://consultations.dh.gov.uk/better-care/nhs-bodies-and-local-authorities-partnership-arran

4.2. As part of your response it would be helpful where relevant if you could confirm the name or type of organisation for which you are responding. A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Gov.UK website (www.gov.uk)

Comments on the consultation process itself

4.3. If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact

Consultations Coordinator
Department of Health
2e26, Quarry House
Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk
(Please do not send consultation responses to this address)

Confidentiality of information

4.4. We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

4.5. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

4.6. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

4.7. The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

ANNEX A – DRAFT REGULATIONS

STATUTORY INSTRUMENTS

2015 No.

NATIONAL HEALTH SERVICE, ENGLAND

LOCAL GOVERNMENT, ENGLAND

NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015

Made - - - -	***
Laid before Parliament	***
Coming into force - -	***

The Secretary of State, in exercise of the powers conferred by section 75(1), (2) and (3) and 272(7) of the National Health Service Act 2006(**3**), makes the following Regulations:

Citation and commencement

1. These Regulations may be cited as the NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2014 and come into force on [ ] 2015.

Amendment of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000

2.—(1) The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000(**4**) are amended as follows.

(a) In regulation 4 (partnership arrangements between NHS bodies and local authorities), for paragraph (2A) substitute—

"(2A) Paragraph (2) does not apply where the partnership arrangements—

(a) have been consulted upon pursuant to section 77(1A)(b) of the 2006 Act(**5**) and regulation 4 of the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 (consultation arrangements)(**6**); or

---

([3]) 2006 c.41. By virtue of section 271(1) of the National Health Service Act 2006 the powers conferred by these sections are exercisable by the Secretary of State only in relation to England.

([4]) S.I. 2000/617; relevant amendments are S.I. 2003/629 and 2012/3094.

([5]) Section 77(1A)(b) of the National Health Service Act 2006 was inserted by section 200(2) of the Health and Social Care Act 2012 (c.7).

([6]) S.I. 2012/3094.

(b) are entered into pursuant to section 223GA(3) of the 2006 Act (expenditure on integration)(**7**).".

(b) In regulation 5 (functions of NHS bodies), paragraph (a), for "sections 3, 3A and 3B" substitute "sections 3, 3A, 3B and 83".

(c) In regulation 7 (pooled fund arrangements)—

(i) in paragraph (6), for "the Audit Commission" substitute "the appropriate person or body"; and

(ii) after paragraph (6), insert—

"(7) "the appropriate person or body" for the purposes of paragraph (6) means the person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014(**8**). ".

Signed by authority of the Secretary of State for Health

Name
Parliamentary Under Secretary of State
Department of Health

Date

EXPLANATORY NOTE

(This note is not part of the Order)

These Regulations amend the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 ("the 2000 Regulations"). The 2000 Regulations make provision for certain NHS bodies and local authorities to enter into partnership arrangements under section 75 of the National Health Service Act 2006 ("the NHS Act"). Those arrangements include the establishment of funds made up of contributions by one or more NHS bodies and one or more local authorities ("pooled funds").

Sections 223B and 223GA of the NHS Act, as amended by section 121 of the Care Act 2014, make provision for a fund for the integration of care and support with health services (known as the Better Care Fund). As part of the Better Care Fund arrangements, the National Health Service Commissioning Board must require NHS bodies (in this case clinical commissioning groups) to make payments into a pooled fund as part of arrangements made with local authorities under section 75 of the NHS Act.

These Regulations amend the 2000 Regulations to include the function of arranging primary medical services under section 83 of the NHS Act (a function of the National Health Service Commissioning Board) as a function in respect of which partnership arrangements can be entered into.

These Regulations also amend the 2000 Regulations so that, in the case of partnership arrangements entered into as part of the Better Care Fund, there is no longer a requirement on clinical commissioning groups and local authorities to consult persons who appear to be affected by such arrangements.

The Regulations also amend regulation 7 of the 2000 Regulations to reflect the fact that the Audit Commission is abolished by section 1 of the Local Audit and Accountability Act 2014.

An impact assessment has not been produced for this instrument as no significant cost impact in the private or voluntary sector is foreseen.

([7]) Section 223GA was inserted by section 121 of the Care Act 2014 (c.23).

([8]) 2014 c.2.

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CARE ACT 2014

Kate Jones
Project Manager

Graham Wilkin
Interim Senior Manager

Caring Plymouth – 5th March 2015

The Legislation

- The Care Act is an historic and significant piece of legislation that modernises the framework of care and support law, bringing in:
  - New duties for local authorities
  - New rights for service users and carers
- The Act places more emphasis than ever before on prevention – shifting from a system which manages crises to one which focuses on people's strengths and capabilities and supports them to live independently for as long as possible
- It aims to make care and support clearer and fairer and to put people's wellbeing at the centre of decisions, and embed and extend personalisation
- Local authorities have new responsibilities towards all local people, including self funders
- There are significant changes to the way that people will access the care and support system
- The Care Act 2014 introduces a range of duties for local authorities, as well as implementing the funding reforms laid out in the Dilnot report

Underpinning Principles (Section 1)

- Care Act places a Duty to promote the Well-being of individuals (Adults and Carers)

- The Duty applies to Local authorities and their staff / members when exercising ‘any function under part 1 of the Act The(i.e. Sections 1-80)

- When discharging an obligation under the Act the LA must have regard to:

  - the individuals views, wishes, feelings and beliefs
  - the need to prevent / delay the development of need for Care and Support
  - the need to make decisions that are not based on stereotyping individuals;
  - the importance of individuals participating as fully as possible in relevant decisions
  - the importance of balancing between the individual’s wellbeing and that of friend or relatives involved as Carers
  - the need to protect people from abuse and neglect
  - the need to ensure that restrictions on individual rights / freedoms be kept to the minimum necessary

Prevention (Section 2)

Local Authorities will under a general Duty to provide a range of preventative services that they ‘consider’ will:

(a) Contribute towards preventing or delaying the development of by adults in its area of needs for care and support

(b) Contribute towards preventing or delaying the development by Carers in it’s area of needs for support

(c) Reduce the need for Care and Support of adults in it’s area

(d) Reduce the need for Care and Support in its area

Integration with the NHS (Section 3)

Section 3 places a duty on local authorities to promote Integration with the health provision where it would:

(a) Promote the well-being of adults with needs & Carers in it's area; or

(b) Contribute to the prevention of the development of needs in adults/ carers;

or

(c) Improve the quality of care for adults / Carers, provided

A component of this duty includes the establishment of the Better Care Fund, to facilitate hospital discharge, prevent unnecessary admissions and promote Integrated packages of care.

Information (Section 4)

Local Authorities have an enhanced duty to provide adults in need / Carers with information about care and support arrangements, including;

- how care systems operate
- Care and support choices they have
- how to access support and
- how to raise safeguarding concerns

The duty includes how to access independent financial advice.

Duty to promote high quality providers (Section 5)

The provision Includes:

(a) ‘Market oversight’ arrangements that will involve the Care Quality Commission - amongst others (Sub sec 53-57 Care Act 2014)

(b) Temporary Intervention if a provider fails (sub sec 48-52)

(c) Duty to promote an effective and efficient local market ‘with a view to ensuring’ a variety of providers and high quality services to choose from

Cooperation (Sections 6-8)

- Section 6 -provides a general duty to cooperate.
- Section 7 enables Social Services to request assistance and this must be provided - unless it would be 'incompatible with its duties, or have an adverse effect on the exercise of its functions. (in such a case the body must provide reasons)
- Section 8 - contains an illustrative list of what may be provided to an adult in need of a Care - namely:

  (a) accommodation in a Care home or premises of some other type

  (b) Care and support at home or in the community

  (c) Counselling, advocacy and other types of Social Work

  (d) Goods and facilities

  (e) information and advice

Assessment of adults in need (Section 9)

- The duty within the Care Act 2014 to assess adults in need is closely aligned to the existing duty (sec 47 NHS and Community Care Act)

- The duty is triggered by the appearance of need.

- The assessment must have specific regard to the wellbeing criteria (ie s1(2) and must involve the adult and carer.

Carers Assessments (Section 10)

The new Duty is triggered by the appearance of need and is no longer dependent on upon the Carer providing or intending to provide regular or substantial care or on the Carer making a request.

The act also contains specific provision for Carers of disabled Children in transition and young Carers in transition into adulthood.

The assessments must ascertain:

- whether the Carer is able / willing to provide and continue to provide the care
- the impact on the Carers wellbeing
- the outcome the Carer wishes in the day to day life
- whether the Carer works or wish to work and or participate in education, training or recreation.

Eligibility Criteria (Section 13)

Where an assessment identifies that an individual has needs for care / support than the local authority must decide if these needs meet the eligibility criteria.

- Eligibility (for adults and Carers)now placed on a statutory footing

(1) The person is unable to carry out basic activity;

(2) The consequence is a significant risk to that persons wellbeing.

(The threshold is closer to the current Moderate than substantial banding)

The criteria for Carers measure (broadly) if the Carer is unable to undertake certain key tasks / roles, including employment, recreation, education and or, their health is at significant risk.

(The criteria is considered to be more generous than those previously in place)

Cap and Costs (Sections 15-16)

- The cap on Care costs has been set at 72k (Dilnot recommended 35k)

- 12k of care home fees will be deemed for ‘daily living costs’ (accommodation, food etc)

- 2016 change to the capital limits from 23,750k to 118,000k if a persons home is included in the calculation 27k if not

This means that someone with savings of 117,000k who seeks LA assistance will have to contribute 20,000k per annum from the capital at the same time lose their DLA / Attendance allowance care component.

Duty / Power to provide care and Support for adults / Carers (Sections 18-20)

- Where an Individual's needs(Adult / Carer) meet the eligibility criteria then there will be a duty to ensure their care and support needs are addressed.
- They must be an ordinary resident in the LA area.
- If their assets are above the financial limit, that they ask the LA to meet their needs.

The Governments impact assessment identified:

- 180,000-230,000 new care users
- Reviews to increase by between 440,000-530,000 in 2016-17 - increasing local authority costs by over £2bn per annum.

NHS Interface (Section 22)

The current boundary between Local authorities and the NHS (NHS continuing care boundary (defined by the *Couglan judgement) r*emain unchanged.

Care and Support plans (Section 26)

The duty to prepare care and support plans for those who have been assessed as meeting eligibility is sustained within the Care Act. It does however include the following:

- Adults must have personal budgets
- Preparation of a support plan must involve; the adult, any Carer the adult has, and any person that appears to the authority to have an interest in the adults welfare.
- For Carers; preparation must include the Carer, the adult needing care, if the Carer asks and any other person whom the Carer asks.

Direct Payments (Sections 31-33)

The most significant change is that Direct Payments are now available to people in residential care placements. This change will come into force in April 2016.

Continuity of Care
(Sections 37-38)

- Where a Local Authority (1st local authority) is providing care and support for an adult and another LA (2nd authority) is notified that the adult will be moving into their area (and is satisfied that the intent is genuine) than it must, among other things, undertake an assessment of the adults needs, and those of any Carers they may have.

- If the assessments have not been completed by the time the adult actually moves, than the second LA must meet the needs identified by the first local authority, until the assessment is complete.

Safeguarding
(Sections 42-45)

The Act places on a statutory footing some of the Safeguarding obligations that were present in the guidance (principally the ‘ No Secrets Guidance)

Sec 42 places a duty to make enquires if adults with care and support needs:

- is experiencing, or is at risk of abuse or neglect; and
- is unable to protect him or herself against abuse or neglect.

There are statutory obligations to have a Safeguarding Board and to undertake investigations and to require individuals to provide information etc.

Independent Advocacy

(Section 67)

There is a duty on the LA under Sec 67 to arrange independent advocacy if the authority considers the individual would experience ‘substantial difficulty’ in participating in amongst other things their assessment and or the preparation of their care and support plan.

Statutory appeals process (Section72)

Guidance is currently being drawn up regarding the appeals process, however the new process is anticipated to include:

- Be flexible, local, proportionate system avoiding unnecessary bureaucracy
- Include element of independence from the Local Authority
- Seek to avoid duplication with existing arrangements for complaints and redress.

Human Rights Protection
(Section 73)

The Care Act extends the current Human rights Act 1998. Sec 73 provides that where care is arranged by a LA or paid for, directly or indirectly in whole or in part and that the care is provided by a registered care provider to an adult or a Carer either in their own home; than the provider is deemed to be a public authority for the purposes of the 1998 Act.

s117 Mental Health Act 1983 (Section 74)

After Care services are not defined by the 1983 Act. The care act inserts a new subSection (5) into the 1983 Act to limit services to those:

(a) Arising from or related to the Mental disorder and

(b) Reducing the risk of deterioration of the persons mental condition(i.e that they may require re-admission)

The Care Act confirms that ordinary residence is determined by where the person was based immediately prior to being detained and gives powers to the secretary of state power to resolve ordinary residence disputes. It also inserts a new s117 that provides for regulations to introduce a limited 'choice of accommodation' for persons subject to s117.

Implementation of the Act in Plymouth

- We have project plans in place for:
  - Assessments
  - Person Centred Care and Care Plans
  - Transitions
  - Ordinary Residence & Continuity of Care
  - Communications
  - Finance
  - Commissioning:
    - Wellbeing & Prevention
    - Information and Advice
  - Workforce Development
  - Informatics

Care and Support Needs New Policy

- This policy sets out the offer to Plymouth Citizens for Care and Support Needs.

- It includes:

1. Wellbeing and Prevention	9. Reviews
2. Information and Advice	10. Transitions
3. Assessment	11. Portable Accounts
4. Eligibility	12. Continuing Healthcare
5. Delegating Statutory Responsibilities	13. Safeguarding
6. Financial Assessment and Charges	14. Confidentiality
7. Support Planning and Personal Budgets	15. Policy Review
8. Carers and Personal Budgets	

Financially Assessing Carers

- Cabinet approval on 10th February not to financially assess Carers with eligible needs who might have a Personal Budget
- Rationale:
  - It could impact negatively on the Council should carers decide to withdraw from their caring role
  - We believe that the personal budgets carers might required for their unmet needs will be relatively low one off costs
  - Back office processes would be resource hungry for potentially little return in terms of income
  - This will be reviewed during 15/16 when we have a clearer understanding of the numbers of Carers receiving a Personal Budget

Deferred Payments
New Policy

This policy includes the following:

- PCC's Deferred Payments Policy Statements
  - Eligibility Criteria
  - Administration Fees and Interest Charges
  - Independent Financial Advice
  - Financial Arrangements
  - Types of Security
  - Deferred Payments Agreements
  - Termination of Deferred Payment Agreement
  - Review and Appeals Procedure

Deferred Payments
Independent Financial Advice

- Advice Plymouth (consortia delivers a universal advice and information service in Plymouth. The service holds a nationally recognised quality standard (Advice Quality Standard – AQS).
- PCC Co-operative Commission has mapped providers offering information and advice, and identified a number of organisations which will be supported to ensure their service offer is clear on the Plymouth Online Directory.
- Work is on-going nationally to identify how quality standards can implemented for information and advice providers which do not have the AQS.
- Advice Plymouth offers financial advice.
- Co-operative Commissioning has mapped providers of financial information and advice, and will be supporting those not already registered with SOLLA (Society of Later Life Advisors – accreditation programme recommended by ADASS as a standard). Providers will be supported to register on the Plymouth Online Directory.
- In addition to encouraging providers to become SOLLA accredited, Co-operative Commissioning is looking at extending the quality standards by discussing additional requirements.
- **NB.** The public will be signposted to POD but individual providers of information and advice will not be recommended.

Deferred Payments Administration Charges

- The provision of deferred payments must be cost neutral
- Under the Act we can apply administration charges
- We are applying an admin fee of £500 for setting up a deferred payments, These have been modelled on a cost neutral basis taking into account the time and tasks required to set up an agreement. We are not outliers across the region with these costs
- We are applying a fee of £100 a year to maintain the deferred payment activity each year, this cost is a guide and will change for each person where they actual charges are more or less than this. Again this fee has been modelled on a cost neutral basis

Deferred Payments Interest Charges

- Plymouth will set its interest rate in line with the gilt rate - This currently sits at 2.65%
- Setting it at this level ensures that the Councils not making a profit, but it does allow for some costs of ruining the scheme to be covered and the cost of borrowing money, if required to fund the scheme
- A person will be advised to seek independent financial advice

Length of time for a Deferred Payments

- A deferral of payment can last until death
- people will choose to use a deferred payment agreement as a bridging loan to give them time and flexibility to sell their home when they choose to do so
- This is entirely up to the individual to decide

Deferred Payments
Valuation of Property

- Initially we will use Zoopla as a means to value property.
- Once take up trends of deferred payments is known then we will review how we undertake our valuations
- We will periodically revalue a person's home to ensure that the property is not dropping into negative equity
- If a person can provide their own valuation if they wish
- At the point a person has deferred 70% of the value their circumstances will be reviewed
- The Care Act guidance sets out the equity limit of a person's property which will be the maximum anyone is allowed to defer.
- Where a property is joined owned the council will not enter into a deferred payment agreement unless all owners give their consent to a charge being placed on the property

Care Act Part 2 Consultation

- This has now been issued
- Closing date is 28th March 2015
- We do not expect the final guidance and regulations until early summer
- By October 2015 we will be required to have our processes in place to assess any potential self-funders and for those with eligible needs set up their Care Account ready to start from 1st April 2016

CARING PLYMOUTH

Tracking Resolutions and Recommendations
2014 - 2015

Date, agenda item and Minute number	Resolution	Target date, Officer responsible and Progress	
7 August 2014 Minute 15 – Commissioning Strategy for Maternity Services 2014 – 19 (Draft)	Agreed that – 1. Caring Plymouth note the draft Commissioning Strategy for Maternity Services 2014-2019; 2. NEW Devon CCG consider the inclusion of information as out forward by the Caring Plymouth panel within the strategy; 3. a sub-regional scrutiny with Devon, Cornwall and Torbay is formed to assist in the development of the strategy.	Date	TBC
		Officer	Gwen Pearson
		Progress	PID to be produced and DSO to set up meeting with DSOs in Cornwall, Devon and Torbay to discuss further. Discussions taken place with Health Scrutiny Leads. Review of the strategy to take place at the end of January 2015.
11 September 2014 Minute 26 – Healthwatch	1. Healthwatch is invited to return to the Caring Plymouth panel in 12 months' time to share their next Healthwatch Plymouth Annual Report. 2. Healthwatch share their recommendations with the Caring Plymouth panel to seek alignment and add weight to the Healthwatch recommendations on a quarterly basis.	Date	June 2015
		Officer	Ross Jago/Amelia Boulter
		Progress	To schedule into the work programme on a quarterly basis for 2015/16.

Date, agenda item and Minute number	Resolution	Target date, Officer responsible and Progress	
11 September 2014 Minute 27 – Better Care Fund	Agreed that - 1. the Caring Plymouth panel note the update on the Better Care Fund submission. 2. the Caring Plymouth Chair writes a letter to the Department of Health of her concerns with the tight deadlines officers had to work to.	Date	March 2015
		Officer	Ross Jago
		Progress	A letter has been sent to the Department of Health highlighting the concerns raised at the meeting. Letter attached. Response to Councillor Aspinall's letter from Norman Lamb MP attached.
11 December 2014 Minute 34 – Thrive Plymouth (4-4-54)	The Panel noted the presentation and agreed to invite the Director of Public Health to a future meeting to provide an update on the progress made.	Date	2015
		Officer	Kelechi Nnoaham
		Progress	To add to the work programme for 2015-16.
11 December 2014 Minute 36 – Peninsula Treatment Centre	Agreed that the Panel to monitor the supply and demand following the closure of the Peninsula Treatment Centre; looking at capacity and ensuring Plymouth residents receive the best service.	Date	2015
		Officer	Karen Kay, NEW Devon CCG
		Progress	To add to the work programme for 2015-16.
11 December 2014 Minute 37 – Derriford Hospital Funding	It was felt by the Panel that the Health Sector was facing very challenging climate and for this Panel to look at in more detail the Health Deal for Plymouth. It was agreed that a review would be undertaken by Caring Plymouth looking at Plymouth's Health Economy.	Date	3 March 2015
		Officer	Ross Jago
		Progress	Co-operative Scrutiny Review taking place to look at Plymouth's Health Economy.

Recommendations sent to the Cooperative Scrutiny Board.

Date, agenda item and minute number	Caring Plymouth Recommendation	Corporate Scrutiny Board Response	Date responded

Recommendation/Resolution status

Grey = Completed item.

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

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Department of Health

From the Rt Hon Norman Lamb MP
Minister of State for Care and Support

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Your ref: CSI/14

Our ref: PO00000902063

Councillor Mary Aspinall
Chair, Caring Plymouth
c/o Ross Jago, Chief Executive's Department
Plymouth City Council
Ballard House
Plymouth PL1 3BJ

18 DEC 2014

Dear Councillor Aspinall,

Thank you for your letter of 18 November to Jeremy Hunt about the Better Care Fund (BCF).

I was sorry to read of Caring Plymouth's concerns about the BCF.

I would like to assure you that we agree that people living and working in an area are best placed to develop the best plans to join up local services.

The Department of Health is aware that some areas, such as Plymouth, already had local plans to integrate services. I am grateful to these councils for their ambitious approach.

However, the Department is also aware that there were areas that had no existing integration plans. We believe that every area, no matter how co-ordinated their care services already are, will benefit from learning from the experiences of others and the evidence of what works.

When local authorities submitted the first set of BCF plans, the Department judged that they required stronger evidence on how their aims would be achieved. That is why the new policy requirements were stricter.

I am grateful for the work of all councils in this area, and recognise that it has involved working to a challenging time scale.

I hope this reply is helpful.

pp C. McAuinchey

NORMAN LAMB

Approved by the Minister and
signed by his Private Secretary
to avoid delay

CARING PLYMOUTH

Work Programme 2014 - 2015

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
19.06.14	Cabinet Member for Public Health and Adult Social Care and Strategic Director for Place	The panel to be provided with an overview of the priorities for the next 12 months	Items for inclusion on the work programme	Carole Burgoyne
	Transformation	The panel to look at the Integrated Health and Wellbeing Transformation programme.		Craig Williams
	Work Programme	The panel to put forward items to be included on the work programme.		Candice Sainsbury
June/ July	Fairer Charging	To undertake a Scrutiny Review of Fairer Charging.	Key decision	David Simpkins
07.08.14	Carers Strategy			Katy Shorten
	Dementia Strategy			Katy Shorten
	NHS 111, Urgent Care and Out of Hours Doctor			Sharon Matson/ Nicola Jones
	Commissioning Strategy for Maternity Services			Gwen Pearson
11.09.14	Healthwatch	Presentation/overview of first 12 months		Karen Morse /Claire Anderson
	Better Care Fund and Transforming Community Services	Update		Craig Williams/ Craig McArdle/ Nicola Jones

Date of meeting	Agenda item	Purpose of the agenda item	Reason for consideration	Responsible Officer
11.12.14	Action plan addressing the revised approach to health inequalities across the city			Kelechi Nnoaham
	Peninsula Treatment Centre			Karan Kay
	Derriford Hospital Structural Funding			Joe Teape
~~29.01.15~~	~~Care Act~~	~~Impact on services~~		~~Dave Simpkins/ Craig McArdle~~
	~~Alcohol Strategy~~			~~Kelechi Nnoaham~~
	~~Urgent and Necessary Measures~~			~~Jerry Clough~~
05.03.15	Plymouth Plan			Caroline Marr/ Richard Grant
	Care Act			Dave Simpkins/ Kate Jones/Graham Wilkin
	Integrated Health and Wellbeing			Anna Coles/Craig McArdle
	Caring Achievements			Ross Jago

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.
Maternity Services	PID to be produced.
Plymouth's Health Economy	The review will consider – the financially challenged health economy across Devon and in particular its impact on the citizens of Plymouth; whether a commitment to system wide transformation and ownership of the problems/solutions is shown by all organisations within the local healthcare system.