

Transforming Community Services

Commissioner Case for Change – NHS Plymouth

September 2010

Executive Summary

This paper sets out the response from NHS Plymouth to the Revision of the NHS Operating Framework 2010/11, published 21st June 2010, in respect of the requirement for a separation of commissioning from provision by April 2011. NHS Plymouth is clear that if it is to achieve the ambitious challenges set out in its QIPP plan then this will require a 'transformation' of community services rather than simply a 'transfer' of the existing provider services. This in turn will create the appropriate vehicles through which to deliver the improvements described in QIPP plans for both the health of the local population and for the delivery of healthcare. The project therefore has two areas of focus:

- the Commissioning Intention for the service delivery model; and
- the preferred organisational form.

Plymouth is looking to create a care delivery system that has the following characteristics:

- I. The provision services close to home wherever clinically appropriate including within sub localities in Plymouth, differentiating services in accordance with the specific requirements of individual communities in order to both improve access and to address factors that can prevent future ill health.
- II. A bio-psycho-social approach that integrates provision across professions and partners that can best respond to the physical, mental and social needs of individuals in order to be most effective in improving outcomes.
- III. Close collaboration across primary, community and secondary healthcare alongside social care minimising duplication and hand-off's between teams / departments so as to improve the patient experience.
- IV. This increase in efficiency to be mirrored by an increase in productivity and a reduction in transactions between organisations.
- V. A workforce that is motivated to improve the well being of patients and public, that has a focus on quality and safety and has the skills needed to deliver integrated care.

Early discussions in Plymouth recognised the huge potential of integration across health and social care community services to deliver better outcomes for service users. Equally, the proposed model builds upon the elective work of Sentinel CIC and expands this model to cover the whole health system (and potentially the whole health and social care system) as a '**System Control**' function.

A strong understanding of patient flow is essential to ensure the constituent elements are maximised in terms of productivity. In some instances this will allow resources to be flexed to reflect demand. This improved understanding of flow, improved quality of referrals, and booking capability, will also enable

innovation. The system control element is fundamental to the effective running of the overall health system. As the market becomes more complicated, with a greater number of providers, the system control piece will be essential in ensuring a comprehensive choice offer is available for all patients. It is clear from the work of Sentinel CIC to date, that a stronger control of referral and management of patient flows improves our ability to “get it right first time” and gives us an opportunity to maximise productivity.

The aim is to establish **locality teams** working in an integrated multi-professional way, where a patient’s clinical condition would benefit from this, to support people with short or long term needs, so that people can maximise their independence. The new integrated approach will ensure improved communications between health and social care professionals by using joint assessment and care planning processes and a shared IT system. The intention is that community mental health and learning disability services would be provided by the locality teams in a fully integrated manner.

In addition, there will need to be **city wide resources**, for services where it would not be operationally effective to devolve down to localities.

A clear understanding has been developed about the co-dependency of determinants that affect successful outcomes for **children and young people** and a range of structures and strategies have been established to support the integrated delivery of services across partner agencies. The clear aspiration of both NHS Plymouth commissioner and its partners is that Transforming Community Services should continue to support the improvements that have already been made and increase the capability and capacity to address the ongoing needs. As a minimum, a new provider arrangement will need to enable delivery of an integrated care system. Given the current position of partner agencies, it is proposed that this can best be provided through the establishment of an employee owned organisation for services presently provided by NHS Plymouth provider. However it is the intention of these partner agencies to continue to explore further potential arrangements for an integrated provider organisation of a full range of children’s services under the umbrella of the children’s trust arrangements.

There are a number of services that either require greater scale to maximise productivity and ensure critical mass in driving best practice or have been highlighted as opportunities for further analysis and review. The Commissioner would embark on a process of market review across these services lines. This in turn could lead to a competitive procurement process. It is proposed to engage the provider market via the ‘invitation to participate in dialogue’ process (as set out in the ‘Procurement Guide for Commissioners of NHS-funded services) in some areas.

In consideration of organisational form, the commissioner looked at the various options in terms of vertical integration, horizontal integration and the establishment of an employee owned organisation, using the consideration of the parameters of:

- **Quality Improvement** – in terms of improving outcomes, improving quality, service integration and stakeholder engagement.
- **Increased Efficiency of Solution** – in terms of efficiency improvements and infrastructure utilisation.
- **Sustainability** – in terms of clinical and financial sustainability, the necessary skills and knowledge base critical mass and whole system fit.

NHS Plymouth supports the establishment of an employee owned organisation to provide a vehicle for transforming the community services in Plymouth working collaboratively with strategic partner organisations for primary care, secondary health care and social care in order to create an integrated care delivery system. In accordance with the original proposals developed in March 2010 and approved by SHA and DH, NHS Plymouth will consider the option for the creation of a social enterprise for adult services and another for children and families where this can be shown to meet the requirements of the commissioner for improvement and achieve sustainability.

A final decision will be made by NHS Plymouth Board through appraisal of the Integrated Business Plan(s) in October using the assurance tests published by DH in February 2010.

However the existing provider landscape in Plymouth and the South West peninsula is limited. Therefore further provider and market development is needed over the forthcoming period, particularly in community services, to run concurrently with the implementation of QIPP plans. In turn the configuration of the social enterprise that is established for April 2011 is not expected to remain the same beyond the initial contract period. Specifically it will be changed as a result of:

- Implementation of the QIPP programme and changes in both service delivery models and further changes in provider organisational arrangements that may be required to achieve revised pathways of care and increases in quality and efficiency. This may well involve organisational integration of services provided by existing provider organisations.
- A period of provider and market development, ideally involving cooperation between existing PCT's where appropriate.
- The development of the GP commissioning consortia and any changes to either commissioning intentions or footprint that occur as a result.

The above will provide opportunities for the new community provider as well as existing statutory providers and current community interest companies or VCS organisations. However new market entrants may also be encouraged where appropriate to develop services in accordance with "Plymouth's Healthy System" and revised service models derived through QIPP.

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1. Chapter One: The Strategic Case

1.1 Introduction and Purpose

This paper sets out the response from NHS Plymouth to the Revision of the NHS Operating Framework 2010/11, published 21st June 2010, in respect of the requirement for a separation of commissioning from provision by April 2011. NHS Plymouth is clear that if it is to achieve the ambitious challenges set out in its QIPP plan then this will require a 'Transformation' of community services rather than simply a 'Transfer' of the existing provider services. This in turn will create the appropriate vehicles through which to deliver the improvements described in QIPP plans for both the health of the local population and for the delivery of healthcare. The project therefore has two areas of focus:

- the Commissioning Intention for the service delivery model; and
- the preferred organisational form.

1.2 Clinical Case for Change

The health needs of the population of Plymouth are described in the findings from the Joint Strategic Needs Assessment and the recommendations arising are encapsulated in the Healthy Plymouth Strategy. From these documents, and in consultation with our partners, NHS Plymouth has identified a number of key challenges that must be faced if the vision for health, social care and well-being for the people of Plymouth is to be realised.

A full analysis of the health needs of the population of Plymouth, as defined by the Joint Strategic Needs Assessment, is available in the Healthy Plymouth Strategy; however the figure below provides a brief overview of the needs of the city's population.

Figure 1 - Overview of Plymouth's population

| | |
|--|---|
| <ul style="list-style-type: none"> • Though life expectancy is similar to national rates, there is a 13 year difference in life expectancy between the 'best' and 'worst' neighbourhood • A higher percentage of Plymouth's population describes themselves as suffering from a long-term illness, or as permanently sick and unable to work than the national average, especially men under 65 • Although emergency hospital admissions are reducing overall, more people than expected are admitted to hospital as an emergency from the deprived | <ul style="list-style-type: none"> • Alcohol misuse is on the rise and is causing increased health problems • Teenage pregnancy rates are decreasing but remain above national rates and the gap between deprivation groups is widening • There are important links between risky sexual behaviour, drugs and alcohol • 20.1% of the working age population in Plymouth is workless – there is a five-fold variation across the neighbourhoods • There is a growing trend in |
|--|---|

| | |
|--|--|
| <p>neighbourhoods</p> <ul style="list-style-type: none"> • There is likely to be large number of people (up to 16% of adults) suffering from a common mental health problem, especially in deprived areas • Smoking rates remain high in women and in those living in deprived areas and rates amongst pregnant women are a particular cause of concern • Obesity rates continue to rise and are a significant challenge • Breast feeding rates are particularly low in Plymouth • Physical activity rates are low compared to the south west region and country, and addressing this requires a partnership approach | <p>incapacity benefit claims which currently make up 11.6% of the working age population. This costs the public purse over £75 million a year</p> <ul style="list-style-type: none"> • There appear to be specific barriers for people with a learning disability who wish to access employment • There are high levels of non-decent housing in both the public and private sectors • More information on local health priorities and initiatives is in the Annual Report of the Director of Public Health and in the Joint Strategic Needs Assessment |
|--|--|

The inequalities present in Plymouth and the impact of economic, environmental and social determinants on the health of Plymouth's population is critical to our understanding if further improvements in outcomes are to be realised. This is equally the case for understanding patterns of access to planned and unscheduled health and social care and the need for further change in order for services to become both more effective and efficient in future.

The QIPP Plan (Quality, Innovation, Productivity & Prevention) of July 2010 sets out the initial plan for the Plymouth health and social care community to deliver services and financial sustainability for 2011/12 to 2013/14. This plan builds upon the strategic direction of the local community and is dependent upon a successful Transforming Community Services process. As such the focus of the work is on making better use of the available funding and healthcare resources by:

- Increasing personalised care and personalisation, and reducing preventable illness;
- Improving the way in which we organise and deliver healthcare services; and
- An increased focus on those patients with greater health needs, and a reduced spend on those treatments of proven lower effectiveness and value for money.

We are committed to transforming the present health care delivery system into an integrated, easy to access, personalised care model, with a focus on prevention and involved and committed clinical leadership. NHS Plymouth has NHS leadership responsibility as well as a real determination to address the root causes of ill health and to measurably improve the life chances for people living in the city's more deprived communities.

NHS Plymouth's vision for the delivery of health and social care services is encapsulated in the 'story of services for Joe', a person typical of many people living in the community with multiple needs, whose life is affected by many factors and who is therefore in receipt of a variety of services from each agency. The aim is that 'Joe' is able to gain easy access to advice and help which will offer him the maximum opportunity for self determination, choice and control. Joe will have the simplest processes for assessment and decision making, enabling the swiftest delivery of whatever help is required to meet Joe's individual needs, with no needless delay, having the least risk of errors and the highest quality outcomes.

The vision is to deliver an effective, whole system approach to the care and support of people and will embed key principles into service delivery. It will:

- be free from discrimination;
- eradicate needless delay;
- deliver evidence-based, high quality clinical care providing cost effective outcomes for individuals and the tax payer;
- be proactive in supporting self determination and independence – for example through the use of individual budgets, direct payments, self care, and self directed support, and
- work in partnership with the Third Sector to facilitate access to community based services to support individual's well-being - reducing dependence on statutory services

Our plans and priorities have taken into account national, regional and local objectives and reflect clinically selected outcomes and measures. The latest joint strategic needs assessment, incorporated into our Healthy Plymouth Local Strategic Partnership plan, has also been influential in shaping our system-wide approach. This formed the basis of the Strategic Framework for Improving Health in Plymouth, and has been the starting point and reference point for the Transforming Community Services agenda.

1.3 High Level Description of the Preferred Options

Given the description of need above Plymouth is looking to create a care delivery system that has the following characteristics:

- I. The provision of services close to home wherever clinically appropriate including within sub localities in Plymouth, differentiating services in accordance with the specific requirements of individual communities in order to both improve access and to address factors that can prevent future ill health.
- II. A bio-psycho-social approach that integrates provision across professions and partners that can best respond to the physical, mental and social needs of individuals in order to be most effective in improving outcomes.

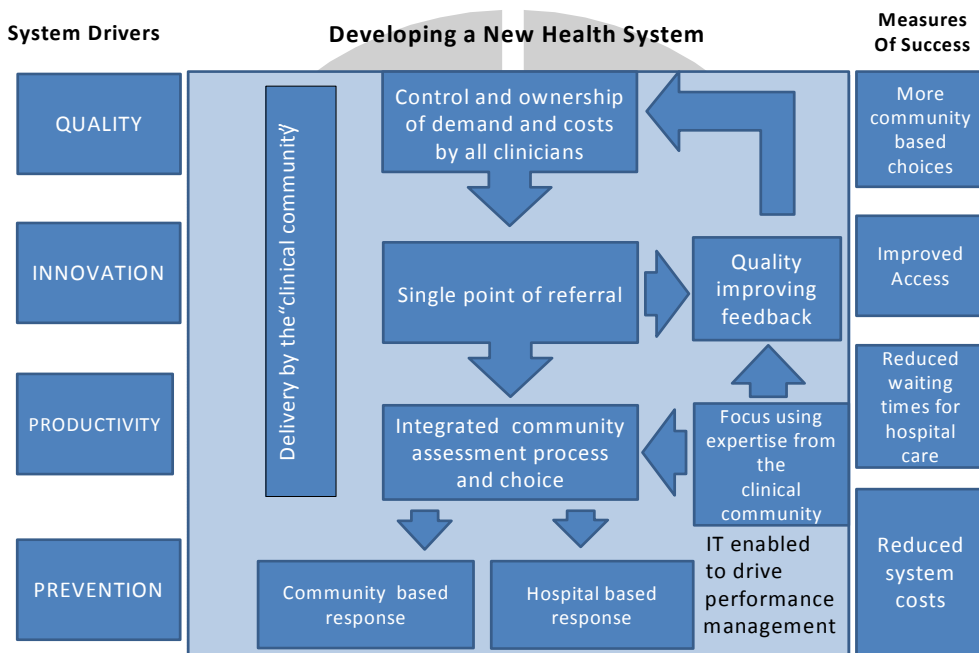
- III. Close collaboration across primary, community and secondary healthcare alongside social care minimising duplication and hand-off's between teams / departments so as to improve the patient experience.
- IV. This increase in efficiency to be mirrored by an increase in productivity and a reduction in transactions between organisations.
- V. A workforce that is motivated to improve the well being of patients and public, that has a focus on quality and safety and has the skills needed to deliver integrated care.

NHS Plymouth currently provides a broad spectrum of services in each of the main population groups reflected by the three directorates in the current provider arm, that range from specialist inpatient services to those with a community and public health focus. The vision and characteristics described in the sections above have underpinned consideration of the potential organisational options available. Plymouth's preferred option is one that can best promote an integrated delivery model, indeed displays the features of an integrated care organisation for its users and minimises the risk of fragmentation between each of the providers.

NHS Plymouth supports the establishment of an employee owned organisation to provide a vehicle for transforming the community services in Plymouth working collaboratively with strategic partner organisations for primary care, secondary health care and social care in order to create an integrated care delivery system. In accordance with the original proposals developed in March 2010 and approved by SHA and DH, NHS Plymouth will consider the option for the creation of a social enterprise for adult services and another for children and families where this can be shown to meet the requirements of the commissioner for improvement and achieve sustainability. This will allow the provider services to respond to the current engagement taking place with staff and partners and to develop options for the Integrated Business Plan. A final decision will be made by NHS Plymouth Board through appraisal of the Integrated Business Plan(s) in October using the assurance tests published by DH in February 2010.

Set out below is an illustration of the system in which future providers will operate to focus the flow of patient activity through a single point of referral and integrate the assessment and response.

Figure 2 – the Health Delivery System



The principle features of the future care delivery system:

- It will operate as a healthy system
- Patients will be supported in choice of place, time and treatment options
- It will be characterised by improved outcomes, productivity and allocation of resources.

The new health system will derive some productivity savings through the alterations in infrastructure, but significantly more savings as the service delivery vehicle for realising many of the QIPP schemes. NHS Plymouth has employed the learning from Sentinel CIC in their management of planned care in achieving the principle of 'right first time' and this underpins the service delivery model for the whole system.

1.4 Whole System Fit

Early discussions in Plymouth recognised the huge potential of integration across health and social care community services to deliver better outcomes for service users. These developments have been largely 'organic', deriving from the innovative ideas of front-line staff, the inspiration of examples elsewhere, especially Torbay, and the creation by system leaders of a supportive environment in which these developments can flourish. It is important to recognise the progress that has been made and to maintain a sense of continuity with this, but all parties recognise the need for increased pace and delivery within a clearer organisational framework.

In order to determine the way forward for Plymouth, the approach taken has been in line with the methodology adopted in 2009 and outlined in the Transforming Community Services Commissioning Framework – July 2009. This has involved:

- Service line analysis to determine the best option for each service, including an assessment of clinical and business risk, service quality and scope for improved efficiency.
- Overview for coherence – grouping together those services that are interdependent and best managed by a long term strategic partner as part of the fabric of local services and identifying those service lines that are ‘commodities’ and lend themselves to considerations of alternative models of provision; for example, certain functions may be best managed by a specialist trust or independent sector provider.

Using this approach it has been possible to distinguish between those services that can best be commissioned from a new local community provider to support the delivery of integrated care and those services where efficiencies may be realised by seeking alternative commissioning arrangements. However, given the geography of the peninsula and an assessment of the current provider market, it is recognised that there is a need for significant input to develop the maturity of the current supplier market community and a need to encourage market entry in to the Plymouth area. It is recognised that this will need to be done jointly with the local authority and with other commissioners across the peninsula and interim arrangements may therefore be required.

Sentinel CIC are the preferred GP commissioning consortium for the City of Plymouth (and subject to consultation and agreement with NHS Devon and NHS Cornwall & Isles of Scilly) to cover the catchment population for Plymouth Hospitals NHS Trust. Sentinel CIC are committed to the development and delivery of the bio-psycho-social approach as an essential component of the Healthy System model, and in their developing commissioning role will be a key partner in driving delivery, rather than in a direct integrated relationship with the social enterprise.

1.1 Stakeholder Engagement

Stakeholder engagement has been on ongoing process through a development path that has led to the Transforming Community Services proposals. This can be seen in the production of Plymouth’s JSNA and Healthy Plymouth Strategy, NHS Plymouth’s Strategic Framework, the Memorandum of Understanding with Plymouth City Council and establishment of Health and Social Care Integration Board supported by Joint Provider and Joint Commissioning committees. More recently the development of the QIPP plans has involved extensive collaboration between all partner agencies in the health and social care community.

Under the leadership of the Joint Provider management, staff directly involved in the provision of services have been working together to develop more integrated service delivery between primary, community and social care. Pilots have been created to enable learning from practice. As the proposed service delivery model has matured there has been a process of iteration with the health and social care commissioners via the Joint Commissioning Executive with significant input from the Joint Provider Executive, leading to the development of joint service models and in turn emerging specifications that can be used to contract for community services in future.

A key role in stakeholder engagement will be effective communication and involvement of the staff. There have already been a number of events involving staff across the statutory partners in discussing and designing the integrated team concept.

Sentinel have played a role in developing the service delivery model and in organisational form assessment – in their role as GP commissioners representing all GP practices across the city.

There has been input from other organisations – on 29th July a Joint Health and Social Care commissioner day invited Mental Health Providers to attend and discuss the emerging model. Representatives from NHS Plymouth mental health provider service and from Cornwall Foundation Trust attended. Following this event, a questionnaire has been sent to a number of providers requesting completion of the advantages and disadvantages of organisational form by directorate. This has helped with the option appraisal of preferred form – the final preferred option remaining the responsibility of NHS Plymouth.

Stakeholder mapping has taken place and a joint communication and engagement plan is being developed between the key statutory partners.

1.2 Current Service Delivery Arrangements

The local health community in Plymouth is dominated by a single acute provider and NHS Plymouth's own community provider services. On the one hand, this restricts competition and provides a challenge to the delivery of reform through market stimulation. However, it has allowed us to build up strong relationships with providers through alignment of strategic objectives and collaboration, which should also lead to improved quality of care.

The following are our main providers:

Plymouth Hospitals NHS Trust (PHNT)

NHS Plymouth's main hospital provider is Plymouth Hospitals NHS Trust, which is also a provider of tertiary services for the peninsula, and a leader in teaching and research.

Peninsula NHS Treatment Centre

This was amongst the first cohort of Independent Sector Treatment Centres,

commissioned to support the capacity required for elective orthopaedic services. Following a competitive tender process, the Treatment Centre has recently changed management to UK Specialist Hospitals – a sole Treatment Centre provider with units at Shepton Mallet in Somerset, Emersons Green in Bristol, Cirencester and Devizes.

Nuffield Hospital Plymouth

The Nuffield is Plymouth's private sector hospital and takes part in the Extended Choice Network – a national initiative giving access to NHS funded procedures in a range of elective specialties.

NHS Plymouth Provider arm

The NHS Plymouth Provider arm provides services in three directorates:

- Health Services for Children and Families
- Community and Rehabilitation
- Adult Mental Health and Learning Disabilities

Primary Care Medical Services

There are 42 GP practices and one GP-led health centre contracted to NHS Plymouth, providing primary medical services to registered and non-registered patients. Access is good and improving, with good uptake of 'extended opening' in practices, but further improved access remains a key priority.

Primary Care Dental Services

In the last three years NHS Plymouth has considerably increased NHS dental provision across the city. There remains a need to continue this expansion in service provision with a target of providing access for 65% of the population.

Community Pharmacy Services

50 community pharmacies provide patients with good access to pharmacy and medicines management services, both locally and nationally commissioned. NHS Plymouth is working to build on the strength of community pharmacy in line with the recommendations of the Pharmacy White Paper and 'World Class Commissioning – Improving Pharmaceutical Services' guidance.

General Optical Services

Across NHS Plymouth there is good access to Optometric practices in Plymouth with a choice of providers. Through the Local Eyecare Forum (a clinician to clinician group) NHS Plymouth has developed services through local opticians for areas such as diabetic retinopathy. The development of further local services for areas such as glaucoma and acute eye care conditions is being further developed.

Sentinel Clinical Assessment and Treatment Service (CATS)

NHS Plymouth commissions a Clinical Advice and Information Service and a Clinical Assessment and Treatment Service from Sentinel Healthcare South West. Sentinel is a Community Interest Company (CIC) which is owned and led by local GPs and practice managers. CATS manages the referral process within the health services in Plymouth. It aims to ensure that patients in

Plymouth receive the right care, at the right time and in the right place for every referral.

DevonDocs

Devon Doctors Limited is a Social Enterprise. Trading as Devon Doctors on Call they provide Out of Hours primary medical service for NHS Plymouth and recently won the tender to provide the GP Health Centre.

Third Sector providers

The 'Third Sector' is defined by Government as: 'Non-governmental organisations that are value driven and that principally reinvest their surpluses to further social, environmental or cultural objectives'. The Third Sector is composed of a wide variety of organisations, categorised most simply as: voluntary and community organisations (VCO's), social enterprises and cooperatives and mutuals. Closer working with the Third Sector is vital to NHS Plymouth and forms part of our commitment to improve health and well-being for the broader population and to tackle health inequalities. Plymouth has a large number of small VCS organisations (as oppose to consisting only of the large national organisations) who have established effective collaborative working arrangements over recent years. Consequently this sector is well placed and is actively involved in many aspects of service delivery. NHS Plymouth is signed up to the Plymouth Compact, which is a vital tool for improving relationships between organisations in the public sector and those in the Third Sector, providing a framework whereby this Sector has time and opportunity to respond to opportunities that emerge through our commissioning decisions for the future and/or continued delivery of services.

Private Sector Care Home providers

There are approximately 1,800 mainly frail elderly people in a range of residential or care homes in Plymouth funded through continuing health care and funded nursing care resources. Working closely with Adult Social care, an integrated review team and a Dignity in Care forum has been established whose purpose is to identify standards and improve these standards of care across the sector.

Whilst all efforts are made for care for people locally, a number of such will require care further afield. NHS Plymouth funds and commissions beds with the intention to repatriate at the earliest, appropriate opportunity.

1.3 Strategic Benefits

There are five main strategic benefits sought from the change in organisational form which will be used as the key delivery vehicle for the transformation of community services.

- A contribution to delivery of the PCT's stated strategic ambitions;
- A contribution to defined priority outcomes;
- A contribution to achieving 'A Healthy System';
- A contribution to delivery of QIPP cash-releasing savings; and

- A contribution to the three critical areas set out in the national TCS guidance.

The degree to which a successful change in organisational form and the transformation of community services is expected to contribute each of the strategic benefits is summarised in the table below.

| Strategic Benefit Area | Benefit Contribution Sought | Anticipated Impact | | | | |
|--------------------------|--|--------------------|-------------------------|-------------------|--------------------------|----------------------------|
| | | 1 Negative impact | 3 No significant impact | 5 Some +ve impact | 7 Significant +ve impact | 9 V significant +ve impact |
| 1. Strategic Ambitions | 1.1 Reduce health inequalities | | | | | |
| | 1.2 Prevent ill-health | | | | | |
| | 1.3 Commission modern and innovative services | | | | | |
| | 1.4 Ensure value for money | | | | | |
| | 1.5 Improving quality* | | | | | |
| | 1.6 More control | | | | | |
| | 1.7 Wider choice* | | | | | |
| | 1.8 Easier access | | | | | |
| 2. Ten Priority Outcomes | 2.1 Reduce health inequalities for males and females | | | | | |
| | 2.2 Increase life expectancy for males and females | | | | | |
| | 2.3 Reduce the number of women smoking at the time of delivery | | | | | |
| | 2.4 Increase the number of infants breastfed | | | | | |
| | 2.5 Reduce hospital admissions for alcohol-related harm | | | | | |
| | 2.6 Reduce hospital admissions caused by unintended and deliberate injuries | | | | | |
| | 2.7 Improve coronary heart disease mortality rates | | | | | |
| | 2.8 Reduce teenage conception rates | | | | | |
| | 2.9 Reduce the number of acute delayed transfers per hospital bed* | | | | | |
| | 2.10 Improve the self-reported experience of patients* | | | | | |
| 3. A Healthy System | 3.1 Works with the PCT commissioned 'system integrator' (Sentinel CIC) to support delivery of a healthy system | | | | | |

| Strategic Benefit Area | Benefit Contribution Sought | Anticipated Impact | | | | |
|--------------------------|--|--------------------|-------------------------|-------------------|--------------------------|----------------------------|
| | | 1 Negative impact | 3 No significant impact | 5 Some +ve impact | 7 Significant +ve impact | 9 V significant +ve impact |
| | 3.2 Patients will be supported in choice of place, time and treatment options* | | | | | |
| | 3.3 It will be characterised by improved outcomes, productivity and allocation of resources* | | | | | |
| | 3.4 There will be a net reduction in cost and capacity | | | | | |
| 4. QIPP Areas | 4.1 Shifting settings of care and optimising urgent care | | | | | |
| | 4.2 Optimising elective care pathways | | | | | |
| | 4.3 Adopting best-practice care pathways for LTCs* | | | | | |
| | 4.4 Improving prescribing | | | | | |
| | 4.5 Improving primary and community care* | | | | | |
| | 4.6 Improving mental health* | | | | | |
| | 4.7 Improving learning disabilities* | | | | | |
| | 4.8 Improving non-clinical productivity | | | | | |
| 5. TCS Critical Benefits | 5.1 Improve quality* | | | | | |
| | 5.2 Increased efficiency of solution | | | | | |
| | 5.3 Sustainability of solution | | | | | |

The source and background to each of these five main benefit areas is described in the Strategic Framework for Improving Health in Plymouth 2010/11 – 2014/15.

In developing the medium term strategic plan to support the strategic framework, NHS Plymouth also identified the scale of the financial challenge for the local health economy with a most likely scenario of £20m gap per year for a forthcoming five year period. This sum is at the bottom end of the value being used by the PCT and NHS South West for QIPP planning – that is £63 to £93m over the three year period, and the latter is now judged to be a more likely prudent estimate of the requirement for cash releasing efficiency gains given the context of likely broader public sector budget reductions and the current financial position of the main acute hospital provider (Plymouth Hospitals).

From May to July this year the PCT worked with local partners in health and social care to develop plans to ensure service and financial sustainability using the work done by NHS South West as the start point i.e. QIPP. A summary of the efficiencies being planned for by QIPP area for NHS Plymouth is shown in the table below.

Estimated implications for spend by NHS Plymouth

| | Provider | 2010/11 Baseline | "Do Nothing" Growth | QIPP Impact | Net Effect |
|---|--|---------------------|------------------------|-------------|------------|
| | | £ms | £ms | £ms | |
| 1 | Plymouth Hospitals NHS Trust | 146.0 | 21.5 | 33.0 | 134.5 |
| 2 | NHS Plymouth Provider (incl MH, LD, Childrens) | 75.0 | 11.0 | 13.0 | 73.0 |
| 3 | Primary Care (incl GP, Dental, Pharmacy, Optom) | 54.0 | 7.9 | 3.0 | 58.9 |
| 4 | Non NHS (incl IS, ISTC, CHC, IPP) | 47.0 | 6.9 | 5.0 | 48.9 |
| 5 | Primary Care Prescribing | 40.0 | 5.9 | 2.7 | 43.2 |
| 6 | Specialised Services | 25.0 | 3.7 | 4.8 | 23.9 |
| 7 | Other | 63.0 | 9.3 | 4.7 | 67.6 |
| | TOTAL | 450.0 | 66.2 | 66.2 | 450.0 |

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In relation to QIPP, the clear expectation of the transformation of community services, supported by a new organisational form and operating as both a service provider and partner is that there will be a very significant positive impact on:

- Value for money and productivity, releasing cash for reinvestment in the host organisation or elsewhere in line with the benefits realisation plan for QIPP and the PCT's commissioning intentions
- The delivery of streamlined and personalised care for patients with long term conditions, mental health, learning disabilities and those requiring general rehabilitation services
- Innovation in the design and delivery of services, sourcing and adopting these as part of day-to-day good practice; the continued development of clinical collaborative working between primary, community and secondary care clinicians will support both dialogue and innovation

The new organisational provider is expected to play an active role in the continued development and refinement of QIPP initiatives and the overall QIPP programme, to ensure that the maximum available benefits are achieved for the local health and social care system.

1.7.1 Three Critical Areas for Benefit

The national TCS guidance summarises how a statutory separation of provision from PCTs, and a change to a new organisational host and form is expected to make a contribution to three critical benefit areas. Whilst there is overlap with local expected benefits, the PCT believes that it is important to clearly identify these as anticipated benefits and incorporate them into the overall benefits realisation plan.

| Critical Benefit Area | Test |
|----------------------------------|--|
| Improve quality | <ul style="list-style-type: none"> • Improve outcomes • Improve quality • Improve service integration • Stakeholder engagement |
| Increased efficiency of solution | <ul style="list-style-type: none"> • Efficiency improvements • Infrastructure utilisation |
| Sustainability of solution | <ul style="list-style-type: none"> • Sustainability • Whole system fit |

1.7.2 Key Strategic Benefits to Patients

The key strategic areas where there is expected to be a significant or very significant additional benefits to patients are:

- Quality
- Choice
- Delayed transfers of care
- Self-reported experience
- Outcomes

These will be in long term conditions, mental health, learning disabilities and general community services.

1.8 Strategic risks

NHS Plymouth recognises the need for an Assurance Framework that captures all of the risks and delivers a comprehensive assurance framework during this period of transformational change. It is recognised that there is a need to cover:

- Commissioning capacity & capability;
- Provider workforce, capacity and capability;
- Market development & provider sustainability;
- Stakeholder relations;
- Clinical capacity and capability.
- Cost control and risk sharing.

Given that the QIPP agenda was developed jointly across the Health and Social Care community, it is recognised that the Assurance Framework will

also need to be developed and assured through the commissioning partnership of the PCT, Plymouth Hospitals NHS Trust, Sentinel CIC as the emerging GP consortium and the Local Authority. The governance architecture developed to support this partnership in the delivery of QIPP, and specifically the Executive Programme Board, provides a forum for monitoring and responding to the emergence of any risks to collaboration or delivery of QIPP plans.

Appendix 6.5 sets out the Commissioning Assurance Framework 2010/11.

2. Chapter Two: The Economic Case

2.1 Critical Success Factors – what will constitute success?

This initiative is about ‘transforming’ community services, not solely ‘transferring’ community services. As such, the approach is captured within our QIPP agenda. Productivity savings are at the heart of the agenda.

In addition, the following principles are at the heart of our approach:

- Integration - It has been clear for some time that there is a need to incorporate our community services work with social services delivery. However, the TCS work highlights the increasing need for this to be a tri partied approach including Primary care services to offer a complete care approach.
- Single points of contact - We need to provide a more holistic approach to the patients and, where possible, provide a single point of contact.
- Coordination – the need to improve coordination between services, and reduce fragmentation and the duplication of activities that this causes.

2.2 Options appraisal

2.2.1 Options Appraisal for Service Delivery Model

Various options have been suggested for the organisational form the provider arm should take. In order to come to a conclusion about the best solution to deliver against, NHS Plymouth has undertaken the following analysis.

Stage 1

Initial analysis of the Organisational forms to establish those of more detailed consideration. In addition, a segmentation of the provider services by directorate as an appreciation that there may be more than one outcome by care group.

Stage 2

PEST analysis (**P**olitical, **E**conomic, **S**ocial, and **T**echnological analysis) to establish the conditions applying to the decision.

Stage 3

More detailed SWOT analysis (**S**trengths, **W**eaknesses, **O**pportunities, **T**hreats) of the options against the PCT’s needs and issues identified in the PEST analysis.

Stage 4

Analysis of service lines to establish which areas are core and non core. Service lines are examined against paired parameters to gain an understanding of the areas that are key to retain in a linked core provider.

Also areas that would deliver greater opportunities for efficiency and effectiveness gains in different organisational entities are identified.

Stage 5

Consider the associations and interdependencies of the service lines to ensure appropriate groupings of core and non core areas are coherent and synergies are maintained / developed. The groupings are then considered for scale to clarify whether there is scope for locality team provision or whether the service scale requires a broader city scope or broader geographic capability, to maximise long term efficiency and effectiveness.

In line with the White Paper – Equity and Excellence; Liberating the NHS, issued in July 2010 in which it states that local health improvement will transfer to local authorities, who will employ the Director of Public Health, it is assumed that the Public Health function of NHS Plymouth will be part of Plymouth City Council – this would include the Health Promotion service, Stop Smoking service and Screening roles. Further clarity will be set out in the programme for public health in a White Paper later this year, when this decision may be reviewed.

2.2.2 Options Appraisal for Organisational Form

The approach undertaken was engagement with potential providers for their assessment of the preferred organisational form, and discussions with commissioning colleagues in Adult Social Services, Childrens Services, and Sentinel CIC as our preferred GP Consortium solution. However it was clearly communicated to all stakeholders that the final decision would rest with NHS Plymouth commissioners.

Through the analysis that has been undertaken, there are key areas of consideration:

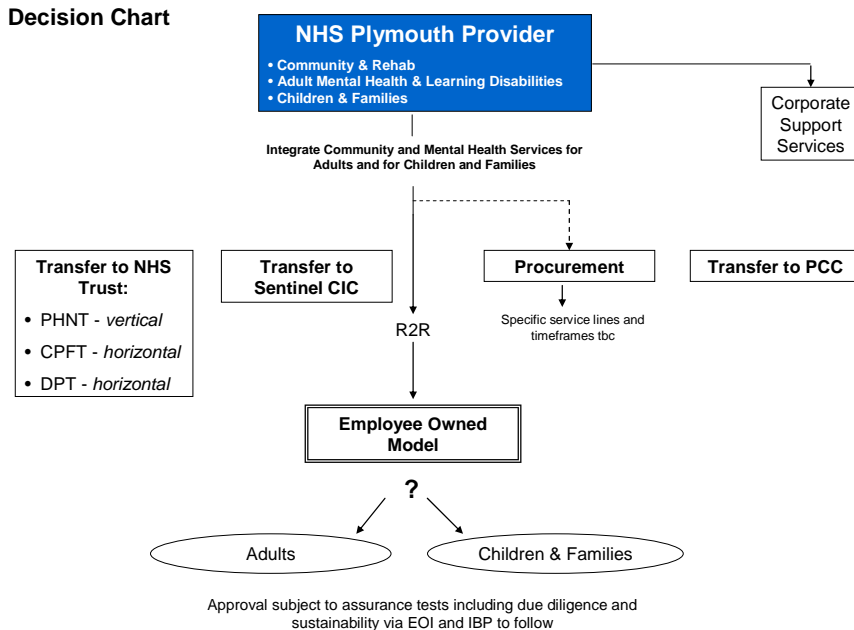
- **Quality Improvement** – in terms of improving outcomes, improving quality, service integration and stakeholder engagement.
- **Increased Efficiency of Solution** – in terms of efficiency improvements and infrastructure utilisation.
- **Sustainability** – in terms of clinical and financial sustainability, the necessary skills and knowledge base critical mass and whole system fit.

| | Adult Community & Rehabilitation | MH & LD | Children & Families |
|---------------------------------------|---|---|---|
| Vertical Integration with PHNT | Discounted due to: 1. Risk of monopoly supply. 2. Current financial challenges facing PHNT with the | Discounted due to: 1. Current financial challenges facing PHNT with the additional management of community | Discounted due to: 1. Current financial challenges facing PHNT with the additional management of community |

| | | | |
|---|---|---|---|
| | <p>additional management of community services potentially a distraction from resolving financial issues and limiting capacity to achieve transformation.</p> | <p>services potentially a distraction from resolving financial issues and limiting capacity to achieve transformation.</p> <p>2. Not appropriate for provision of MH and LD services.</p> <p>3. Separation of community from mental health services resulting in potential organisational barrier to delivery integrated service model.</p> | <p>services potentially a distraction from resolving financial issues and limiting capacity to achieve transformation.</p> <p>2. Not appropriate for provision of MH and LD services for children & young people.</p> <p>3. Separation of community from mental health services resulting in potential organisational barrier to delivery integrated service model.</p> |
| <p>Vertical Integration with existing NHS Mental Health Provider</p> | <p>N/ A</p> | <p>Discounted due to:</p> <p>1. Limited provider options to achieve VFM and requirement for market development preferably via sw peninsula commissioner approach.</p> <p>2. Separation of community from mental health services resulting in potential organisational barrier to delivery integrated service model.</p> | <p>Discounted due to:</p> <p>1. N/A for community services leading to separation of community from mental health services resulting in potential organisational barrier to delivery integrated service model.</p> |
| <p>Integration with another community-based provider</p> | <p>No existing NHS provider. Transfer to existing Community Interest Company discounted due to inconsistent with procurement and competition guidance.</p> | <p>No existing NHS provider. Transfer to existing Community Interest Company discounted due to inconsistent with procurement and competition guidance.</p> | <p>No existing NHS provider. Transfer to existing Community Interest Company discounted due to inconsistent with procurement and competition guidance.</p> |

| | | | |
|---|---|---|---|
| Integration with Local Authority | Discounted due to a move towards a commissioning only approach misalignment of staff T&Cs and potential problems in governance provision. | Discounted due to a move towards a commissioning only approach misalignment of staff T&Cs and potential problems in governance provision. | Discounted due to a move towards a commissioning only approach misalignment of staff T&Cs and potential problems in governance provision. |
| Social Enterprise / Employee Owned Model | Preferred Option | Preferred Option | Preferred Option |

Figure 3 Decision Chart for Organisational Form



The preferred option is to support the establishment of an employee owned organisation to provide a vehicle for transforming the community services in Plymouth, under the Right to Request scheme. NHS Plymouth will consider the option for the creation of a social enterprise for adult services and another for children and families, where this can be shown to meet the requirements of the commissioner for improvement and achieve sustainability, through the assessment process of IBPs.

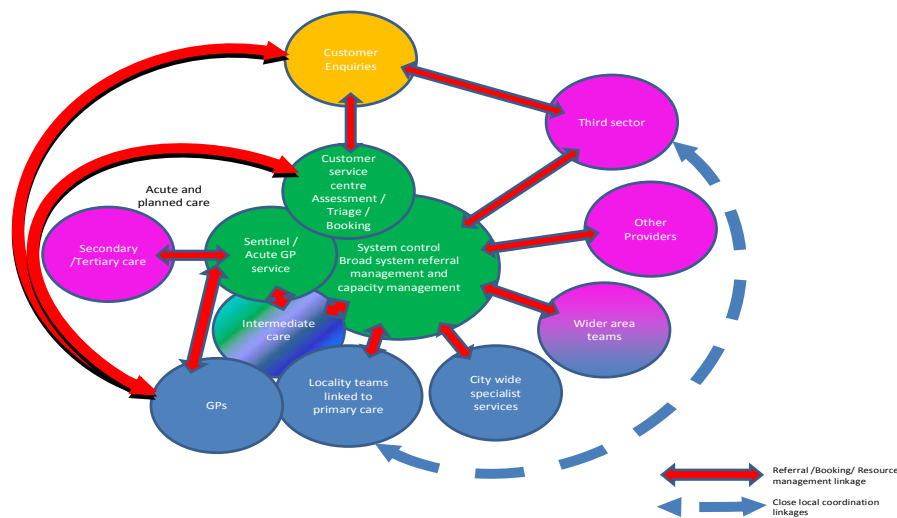
The social enterprise model(s) will have clearly stipulated Key Performance Indicators (KPI) which must be met. These would include a staged reduction in overall contract value, in line with the QIPP productivity requirements set out in the financial case for change section. Other performance indicators would assure the commissioners of improved quality outcomes. The Commissioners will also clearly communicate the service lines that will be subject to competitive tender and the timeframes for this. In the event of a single social enterprise, the commissioner will require 'open book

transparency' as an assurance that each of the three directorates is financially sustainable and to allow for further opportunities for service integration.

2.3 Description of preferred options for Service Delivery Model

- The focus of the system control element of this model should be to maximise the efficiency and effectiveness of the system through driving productivity by managing patient flow and providing the relevant information for system redesign. This is a fundamentally different focus from delivery functions where we wish the prime drive to be delivering a quality service.
- There is an opportunity to utilise the change to bring together the primary care clinicians with the community provider services this will potentially drive service improvement.
- Key focus of the commissioning team will be on the system control as this is likely to be the fulcrum in delivering QIPP.

Figure 4: Overview of the System Model



2.3.1 Single Point of Access and System Control

It is clear from the work of Sentinel CIC to date, that a stronger control of referral and management of patient flows improves our ability to “get it right first time” and gives us an opportunity to maximise productivity. The proposed model builds upon the elective work of Sentinel CIC and expands this model to cover the whole health system (and potentially the whole health and social care system) as a ‘**System Control**’ function.

A strong understanding of patient flow is essential to ensure the constituent elements are maximised in terms of productivity. In some instances this will allow resources to be flexed to reflect demand. This improved understanding of flow, improved quality of referrals, and booking capability, will also enable innovation. The system control element is fundamental to the effective running of the overall health system. As the market becomes more complicated, with a greater number of providers, the system control piece will be essential in ensuring a comprehensive choice offer is available for all patients.

The potentially increased complexity of the model may require greater navigation. It is therefore important to:

- Provide clarity for the public for access to health and social care non emergency activity;
- Provide customer contact in the most cost effective manner. The private sector recognise that a contact centre that can triage contacts and escalate as required is the most effective way of handling this;
- Provide an effective single interface for the public;
- Provide instant responses to the public and healthcare professionals on service availability and booking;
- Examine the opportunity of links to other contact centre providers.

Due to the potential booking requirement and inbound / outbound capability, it would be logical to align this element with the system control capability.

This suggests that alignment of these areas is required in terms of organisation, technology, information, process and behaviours to focus on system resource maximisation if we are to deliver the best outcomes for patients.

In addition currently we replicate services for different patient cohorts - mental health, the elderly, those with learning disabilities, for example. This leads to duplication of capability and inefficiency. If we manage all care through this system, regardless of diagnosis or label, we can take any differences into account when allocating service provision. This will ensure any specialist requirements are accounted for. There are key service areas that drive the flow through the pathways and these should be collectively managed in systems control.

2.3.2 Adults Community and Rehabilitation

The aim is to establish locality teams working in an integrated multi-professional way, where a patient's clinical condition would benefit from this, to support people with short or long term needs, so that people can maximise their independence. The new integrated approach will ensure improved communications between health and social care professionals by using joint assessment and care planning processes and a shared IT system. These services include community nurses such as district nurses, health visitors, & tissue viability nurses; end of life care teams; long term conditions management such as falls team and day therapy; and care co-ordination such as onward care. The team would provide services to all of the population regardless of whether the individual lived in their own home, or in a Care

Home. The localities may have differential resource allocation, due to the strategic ambition of reducing health inequalities, to target services where the need is greatest. This service delivery model approach focuses on supporting and enabling people to maintain their optimum level of independence with the lowest appropriate level of support and care.

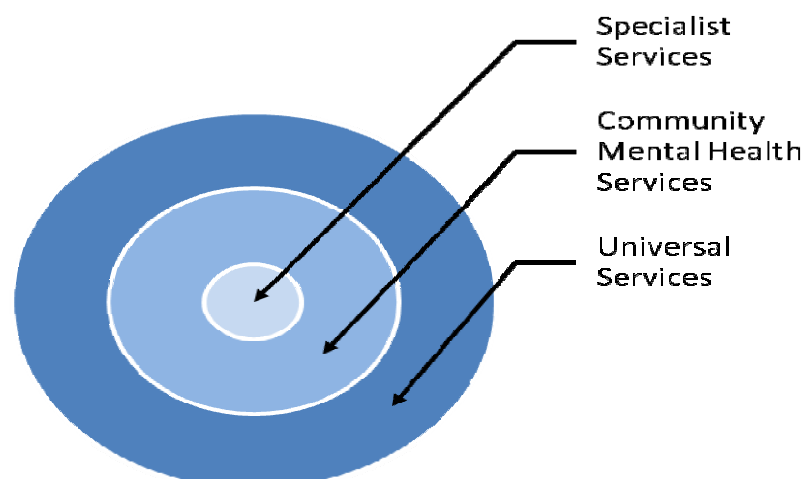
In addition, there will need to be city wide resources, for services where it would not be operationally effective to devolve down to localities – such as community cardiology services and Local Care Centre beds - which would be an available resource for locality teams to draw down support for individuals, as and when necessary. Referral within the locality team can be achieved in two ways – either through direct contact with another member of the team, or via the System Control function; either methodology will be overseen by the System Control function, who will be able to view individuals' available appointment slots and thereby monitor demand and capacity.

The function of intermediate care is defined locally as 'to meet the health and social care needs of individuals to prevent unnecessary admission, expedite hospital discharge and to avoid long term admission to care homes'. The aim of intermediate care is to use timely and focussed intensive support so that people can maximise their long term independence. This approach focuses on enabling people within their homes, so that they achieve optimum level of independence with the lowest appropriate level of ongoing support and care. Accordingly, on the basis of subsidiarity, it has been agreed appropriate for many of the intermediate care services to be provided from the locality teams or the city wide team. However, there is an element of intermediate care services that are more aligned to commissioning and system control, and these will be brought within the system control function.

2.3.3 Mental Health & Learning Disability Services

2.3.3.1 Mental Health Services

Based on national guidance and adapted from the work of the local Mental Health Atlas the following framework for services is proposed:



Chapter Two

The focus of the outer circle is on mental health promotion and building resilience. This builds upon a key theme in New Horizons that mental health is everyone's business. This develops the notion of a public mental health approach that is the prevention of mental ill health and the promotion of mental health. This outer circle covers a range of service areas including employment, housing, leisure, transport, money advice and benefits, and safer communities. Because of its breadth it requires agencies across the City working in a coordinated way. Whilst many of these service areas may be outside of the direct responsibility of any future provider of mental healthcare services, the provider will be expected to understand the co-dependency of these factors and the relationship between these services and the provision of healthcare. In turn the provider will be expected to contribute toward the development of related strategies, initiatives or service plans that assist the maintenance or recovery of good mental health at a city wide or local level.

The middle circle centres on community based mental health provision and on the principles of recovery and inclusion. The services within this area are wide ranging and include day service provision, accommodation based support, community mental health teams, employment and volunteering as well as IAPT and Assertive Outreach Services. These services will support users when they are moving from the inner circle on their journey to recovery and inclusion by supporting them to access and utilise mainstream universal services in the outer circle. The same group of services may also have a preventative role with a part of their remit to stop users from accessing acute services. It is proposed that these services are incorporated in to the locality team delivery model working alongside primary care (as described in the section on Adult Community and Rehabilitation above) whilst at the same time maintaining a specific mental health professional contribution and skill set. The mental health atlas produced by the public health development unit in Plymouth provides a basis for planning service provision and differentiating delivery where necessary to improve the take up of services. In addition Plymouth has indicated an intention to reduce admissions and length of stay in inpatient services both in and outside of Plymouth through its QIPP plans. Therefore the role and development of mental services in this area is critical to maintaining independence in community settings through early intervention and provision of specialist mental healthcare.

Finally the inner circle consists of acute, mostly inpatient provision. This is not a uniform provision and further work is required to segment this market by patient group and service line. It will continue to be essential to offer timely access to safe, high quality inpatient services for any patient that requires such a service. However, as indicated above, the commissioner will also seek outcomes that focus on supporting timely return to community living and the avoidance of readmission. NHS Plymouth currently commissions a range of services, such as PICU and specialist assessment or treatment placements outside of the NHS Plymouth provider. The commissioner will be seeking innovative solutions from any future provider that minimises the requirement for placements outside of Plymouth and, where these do occur, ensures a proactive shared care arrangement that reduces the length of stay.

Mental Health services could be commissioned from one mental health provider, working in an integrated manner for the locality provision, with either the same provider or a different provider focusing upon the more specialist acute service provision. The intention is to undertake a competitive process, ideally next financial year, for the more specialist service provision to ensure best value is achieved. It is recognised that a degree of market development is required prior to the competitive process, and that there may be opportunities for a peninsula commissioner approach.

2.3.3.2 Learning Disability Services

NHS Plymouth intends to commission learning disability services in three key areas, which will address the priority requirements for people with learning disabilities. The key areas for action are:

- **Challenging Behaviour Services** - It is vital that this service operates in tandem with existing mental health services, especially for out of hours services. The key tasks for the service are to assess individuals, plan in detail for their needs, prepare for potential crises and the team must be able to intervene at short notice with effective pre-planned interventions. It is proposed that this service is subject to market review.
- **Liaison in Specialist Health Services** - A key priority for modern learning disability services is to ensure that people with a learning disability access mainstream health services for all their health requirements. Priority areas include mental health, epilepsy services and dementia services but the principle applies to all health services. It is recognised that people with a learning disability will require extra support to access services and to ensure they achieve equal outcomes in comparison to people without a learning disability. It is therefore proposed that this service is provided within the integrated locality teams.
- **Liaison in Primary Care** - Since the publication of Valuing People Now (DH 2009) and Healthcare for All (DH 2008) there has been a significant emphasis on improving the health and well-being of people with learning disabilities. Within primary care there is already a Direct Enhanced Scheme to support GPs to undertake annual health checks but in order to maximise the benefit of this programme there will be a team of liaison nurses who can offer support.

2.3.4 Health Services for Children and Families

The recent external inspection of children's services in Plymouth by OFSTED and CQC has reported how agencies are now effectively working together to safeguard and improve the well being of children and young people in Plymouth under the leadership of the Children & Young People's Trust.

Notably Plymouth is judged to be outstanding in the way it listens to and engages children, young people and parents, creating positive opportunities for them to inform agencies about service provision. As a result of this information has already been gathered as part of the Children and Young People's Plan about the nature and characteristics of services that children, young people and families would like to see in the city.

Overall Plymouth has seen improved performance against the 5 outcomes for children and associated national performance indicators compared to previous years. There are many examples of good practice that have been recognised as leading to improvement in service provision as a result of increased cooperation between partner organisations, for example in Child & Adolescent mental health Services, services for children with disabilities and children in care.

The Children and Young People's Plan has provided a focus for the shared strategic development of joint priorities and alignment of resources across the individual partner organisations. Where appropriate this has been supported through shared resources, for example section 75 pooled fund for CAMHS as well as shared budgets for safeguarding and Youth Offending Services. Equally Plymouth has made significant progress in implementing the standards of the National Service Framework for Children, Young People and Maternity Services and thereby improving the quality of service provision.

Nevertheless there continue to be significant health needs in Plymouth and variation in health and access to patterns of healthcare associated with inequalities. Ongoing needs include:

- Promoting the health of parents and ensuring that young children receive a healthy start to life as measured for example in reduced rates of smoking in pregnancy, increased rates of breastfeeding and reduction in obesity.
- Reducing risk taking behaviour in young people as indicated by levels of alcohol and substance misuse, smoking and unprotected sex with consequent levels of STI's and under 18 conceptions.
- Increased care co-ordination for children with long term conditions, multiple and complex needs and children with disabilities as well as increased quality and choice in palliative care.
- Dental health is a persistent problem and is an area of significant inequality.
- A reduction in the high numbers of children and young people accessing unscheduled secondary care at hospital for both medical reasons and accidents including a reduction in the variation between different localities in the city.
- Promoting good mental health and reducing stigma.
- Improving the transition to adult services.

A detailed description of need is included in the needs analysis that has been developed by all partners in support of the latest iteration of the Children & Young People's Plan. This needs analysis also shows a significant increase in

the numbers of children who are subject to child protection plans whilst at the same time thresholds for social care child protection services have been assessed as being appropriate and safeguarding children training for staff has increased across all agencies. In looking to transform community services, not only will any new provider need to continue to meet the statutory requirements to safeguard and promote the welfare of children, but also to provide services at an early stage in conjunction with partners that are effective in reducing vulnerability and escalation of risk.

A clear understanding has been developed about the co-dependency of determinants that affect successful outcomes for children and young people and a range of structures and strategies have been established to support the integrated delivery of services across partner agencies. The clear aspiration of both NHS Plymouth commissioner and its partners is that Transforming Community Services should continue to support the improvements that have already been made and increase the capability and capacity to address the ongoing needs. In addition to the generic characteristics and features described in the sections above, it is expected that any future provider will ensure that:

- Children, young people and families continue to be involved in evaluating services and informing delivery in order that they remain child and family focussed.
- There is continued progress on developing a workforce with the necessary skills for meeting the specific needs of children, young people and families including safeguarding and promoting welfare.
- Services are delivered in an integrated way with professionals from partner agencies at both a locality team level as well as in city wide services, and a key requirement to involve primary care teams.
- Services are enhanced or targeted toward specific groups where there is increased vulnerability or reduced levels of access to healthcare. Providers to identify and address inequality within their service delivery and contribute towards a reduction in health inequality.
- There is access to services in dedicated facilities, provided by dedicated staff supported by a quality assurance process such as implementation of the You're Welcome standard or local variant.

As a minimum, a new provider arrangement will need to enable delivery of an integrated care system. Given the current position of partner agencies, it is proposed that this can best be provided through the establishment of an employee owned organisation for services presently provided by NHS Plymouth provider. However it is the intention of these partner agencies to explore further potential arrangements for integrated configuration of provider services in future under the umbrella of the children's trust arrangements. Improvements have been made in safety and quality through existing collaborative arrangements and these should continue to be supported through the proposed organisational arrangements. In order for these gains to be sustainable in future further progress needs to be achieved in efficiency in delivery along agreed pathways of care. This may best be realised through the development of a single integrated care organisation in future and

opportunities or options will be considered by partners during the contract period 2011 – 2014. Proposals via the Integrated Business Plan (IBP) for a new provider in 2011 will need to provide a basis for further integration of provider services in due course.

In addition there are a number of services where quality and value for money could best be realised by commissioning services over a larger population base. For example Plymouth has developed the provision of the inpatient adolescent mental health service for the South West peninsula with a purpose built unit scheduled to open at the end of 2010. Collegiate commissioning will continue to be required across commissioning organisations to secure relevant services, such as paediatric surgery, of an appropriate and safe standard whilst also facilitating access. The Children and Young People Needs Assessment is shown as Appendix 6.6 and a refresh can be found at: <http://www.plymouth.gov.uk/homepage/socialcareandhealth/childrensocialcare/pcypt/cypp.htm>

2.3.5 Services for Initial Market Review

There are a number of services that have been identified that either require greater scale to maximise productivity and ensure critical mass in driving best practice, or have been highlighted as opportunities for further analysis and review. The Commissioner would embark on a process of market review across these services lines and therefore retains the right to test the market in these areas, to ensure quality of service and value for money.

- Defined Mental Health & LD Provision
- Community Dental Services
- Wheelchairs and Disability Services
- Weight Management Services
- Medium and low secure services
- Parkinson Disease Services
- Primary Care GP Services (PCTMS)
- Stroke inpatient rehabilitation
- Neurological inpatient rehabilitation

A clear decision has been made however, to market test a range of mental health and learning disability provision. This constitutes a significant part of the QIPP agenda and this process will lead to a revision of the service model. It is proposed to engage the provider market via the 'invitation to participate in dialogue' process (as set out in the 'Procurement Guide for Commissioners of NHS-funded services) and the commissioner anticipates that this process will commence during 2011/12.

2.4 Value for money

Delivery of Value for Money is one of the key strategic objectives for the PCT and wider Health Economy. As such the provider will be expected to identify plans to deliver efficiencies in line with tariff and QIPP requirements.

2.5 Benefits realisation plan

The benefits realisation plan will be used to track the delivery of benefits for this programme. Continuing the development of joint or collegiate commissioning the benefits, including appropriate measures and milestones, will where relevant be specified in conjunction with key partners who share an interest in the service delivery area. All areas of potential impact will be monitored to ensure that where there is an expectation of significant or very significant benefits these are being achieved with the timescales expected, and where there is some or no significant expected impact that there are no intended consequences.

Progress against the key actions, milestones and expected outcomes and benefits will be reviewed monthly through a programme board. Failure to achieve agreed progress will be subject to performance management under contractual arrangements to be established with the new provider.

The framework for the benefits realisation plan is set out below.

Figure 5: Benefits Realisation Plan - Framework

| Strategic Benefit Area | Benefit Contribution Sought | Baseline Position (As at 31 March 2010) | Target Outcome (of community service activity) | Action Required (and by who) | Responsible for Action and Outcome | Key Milestones | Anticipated Impact | | | | |
|--------------------------|--|---|--|------------------------------|------------------------------------|----------------|--------------------|-------------------------|-------------------|--------------------------|----------------------------|
| | | | | | | | 1 Negative impact | 3 No significant impact | 5 Some +ve impact | 7 Significant +ve impact | 9 V significant +ve impact |
| 1. Strategic Ambitions | 1.1 Reduce health inequalities | | | | | | | | | | |
| | 1.2 Prevent ill-health | | | | | | | | | | |
| | 1.3 Commission modern and innovative services | | | | | | | | | | |
| | 1.4 Ensure value for money | | | | | | | | | | |
| | 1.5 Improving quality* | | | | | | | | | | |
| | 1.6 More control | | | | | | | | | | |
| | 1.7 Wider choice* | | | | | | | | | | |
| | 1.8 Easier access | | | | | | | | | | |
| 2. Ten Priority Outcomes | 2.1 Reduce health inequalities for males and females | | | | | | | | | | |
| | 2.2 Increase life expectancy for males and females | | | | | | | | | | |

| Strategic Benefit Area | Benefit Contribution Sought | Baseline Position (As at 31 March 2010) | Target Outcome (of community service activity) | Action Required (and by who) | Responsible for Action and Outcome | Key Milestones | Anticipated Impact | | | | |
|------------------------|---|---|--|------------------------------|------------------------------------|----------------|--------------------|-------------------------|-------------------|--------------------------|----------------------------|
| | | | | | | | 1 Negative impact | 3 No significant impact | 5 Some +ve impact | 7 Significant +ve impact | 9 V significant +ve impact |
| | 2.3 Reduce the number of women smoking at the time of delivery | | | | | | | | | | |
| | 2.4 Increase the number of infants breastfed | | | | | | | | | | |
| | 2.5 Reduce hospital admissions for alcohol-related harm | | | | | | | | | | |
| | 2.6 Reduce hospital admissions caused by unintended and deliberate injuries | | | | | | | | | | |
| | 2.7 Improve coronary heart disease mortality rates | | | | | | | | | | |
| | 2.8 Reduce teenage conception rates | | | | | | | | | | |
| | 2.9 Reduce the number of acute delayed transfers per hospital bed* | | | | | | | | | | |
| | 2.10 Improve the self-reported experience of patients* | | | | | | | | | | |

| Strategic Benefit Area | Benefit Contribution Sought | Baseline Position (As at 31 March 2010) | Target Outcome (of community service activity) | Action Required (and by who) | Responsible for Action and Outcome | Key Milestones | Anticipated Impact | | | | |
|------------------------|--|---|--|------------------------------|------------------------------------|----------------|--------------------|-------------------------|-------------------|--------------------------|----------------------------|
| | | | | | | | 1 Negative impact | 3 No significant impact | 5 Some +ve impact | 7 Significant +ve impact | 9 V significant +ve impact |
| 3. A Healthy System | 3.1 Works with the PCT commissioned 'system integrator' (Sentinel CIC) to support delivery of a healthy system | | | | | | | | | | |
| | 3.2 Patients will be supported in choice of place, time and treatment options* | | | | | | | | | | |
| | 3.3 It will be characterised by improved outcomes, productivity and allocation of resources* | | | | | | | | | | |
| | 3.4 There will be a net reduction in cost and capacity | | | | | | | | | | |
| 4. QIPP Areas | 4.1 Shifting settings of care and optimising urgent care | | | | | | | | | | |
| | 4.2 Optimising elective care pathways | | | | | | | | | | |
| | 4.3 Adopting best-practice care pathways for LTCs* | | | | | | | | | | |
| | 4.4 Improving prescribing | | | | | | | | | | |

| Strategic Benefit Area | Benefit Contribution Sought | Baseline Position (As at 31 March 2010) | Target Outcome (of community service activity) | Action Required (and by who) | Responsible for Action and Outcome | Key Milestones | Anticipated Impact | | | | |
|--------------------------|---|---|--|------------------------------|------------------------------------|----------------|--------------------|-------------------------|-------------------|--------------------------|----------------------------|
| | | | | | | | 1 Negative impact | 3 No significant impact | 5 Some +ve impact | 7 Significant +ve impact | 9 V significant +ve impact |
| | 4.5 Improving primary and community care* | | | | | | | | | | |
| | 4.6 Improving mental health* | | | | | | | | | | |
| | 4.7 Improving learning disabilities* | | | | | | | | | | |
| | 4.8 Improving non-clinical productivity | | | | | | | | | | |
| 5. TCS Critical Benefits | 5.1 Improve quality* | | | | | | | | | | |
| | 5.2 Increased efficiency of solution | | | | | | | | | | |
| | 5.3 Sustainability of solution | | | | | | | | | | |

* Main areas of expected benefit for patients

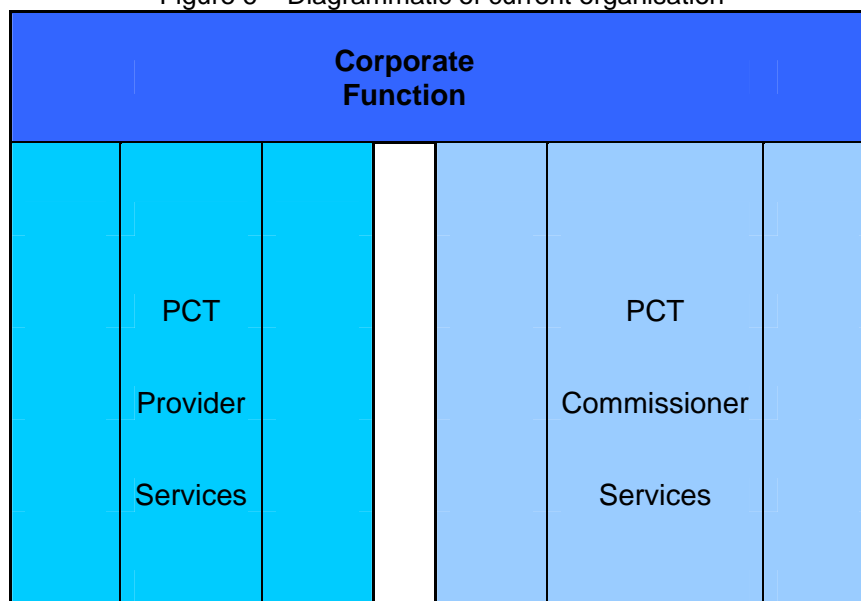
2.6 Impact on the PCT Commissioner Function

2.6.1 Corporate Function

NHS Plymouth understands its legal obligations as a statutory body and must act in accordance with the legislation enacted by Parliament. The PCT is the statutory body through which the National resource allocation is made and for which the Board is held to account. This will need to be retained in to the future, until such time as legislation changes.

The current organisational form of NHS Plymouth, as can be described as having three basic parts – these are set out in figure 6.

Figure 6 – Diagrammatic of current organisation



In workforce terms, there is over 2,000 whole time equivalent staff in the organisation and the current split between the three areas is as follows:

- Corporate Function 14%
- Provider Services 80%
- Commissioning Function 6%

Clearly, transferring the provider services to an alternative organisational form will have implications for the remaining organisation.

With the number of organisational elements across the city, there is the potential for duplication of support elements which could potentially increase the cost base. There are recognised and considerable benefits for support services to operate across a number of organisations. It is not intended for these services to form a separate organisation in their own right, but will need to be hosted in one organisation, using service level agreements.

There are a number of key steps:

- Identify which areas should remain with the commissioning function of the PCT, which should transfer with the provider services.
- How the support functions will be enabled to operate to continue to provide the essential inputs required to all parties.
- Develop an appropriate Service level Agreement and mechanism to ensure that all parties have appropriate levels of access to the support services.
- Assess how surplus asset is gained as a result of this transaction, and how this should be handled
- Consider any overhead implications and arms length costing model, to ensure provider meets fully the costs of any support.

There are a number of opportunities to work collaboratively across the wider peninsula. This is already happening to a degree in a number of areas including primary care, medicines management, public health and PHNT Acute commissioning. Discussions are ongoing on other opportunities to share resource and reduce duplication of effort.

2.6.2 GP Commissioning Consortia

The publication of the White Paper 'Liberating the NHS' sets out the vision for the future commissioning arrangements. In NHS Plymouth, the preferred lead clinical commissioning mechanism is with Sentinel Community Interest Company. The Board has held three developmental sessions with the Board of Sentinel and Sentinel have confirmed their willingness to take forward the development of a GP Commissioning Consortium for Plymouth. A joint programme of development is to be pursued over the coming months, which will focus on what will be involved in commissioning in the future and ensuring that NHS Plymouth plays its part in supporting the consortium to get off the ground and enable its authorisation by the NHS Commissioning Board in due course.

2.6.3 Estates and Infrastructure

With respect to the management of the estate, the intention is for the Commissioning body to retain ownership of all of the estate, and for the provider to operate as a tenant, under a lease agreement. This model is currently operating successfully for the Peninsula NHS Treatment Centre. Estates offer a huge opportunity for the PCT. Effective management of the estate requires expert management and an aggregation of asset bases across a broader geography to maximise the potential portfolio. This would allow investment in skilled labour to effectively manage the estate which has significant opportunities for value creation – more detail is covered in Chapter Four.

The decision to pursue this model of operation is made for a number of reasons, but largely as it is perceived that otherwise commissioning leverage would be weakened:

- A commissioner's ability to negotiate service improvements or reconfiguration is limited; and
- Concentration of key sites, assets and high cost equipment in the hands of a small number of providers could act as a barrier to new market entrants.

Facilities management will be aligned to the provider function in its operational management role of the estate.

2.6.4 Support Services

The principle of a collective support organisation that operates across a number of organisations is raised in section 2.6.1. Initial thoughts on the services that could potentially form part of this arrangement are:

- Human Resources – to cover the transactional element of HR.
- Finance & Information – the balance between management, financial accounting and information provision will vary dependent upon the organisation. However, the breadth of skills and productivity of these services would be enhanced by scale. The ownership of the financial accounts will need to remain an organisational accountability.

In addition, there are a number of currently purchased areas that could be functions of a centralised shared management capacity facility:

- Legal – currently employed on a bespoke basis. Potential for advantaged solutions either in contractual terms or through block employment.
- Energy – a significant and growing expenditure which can be significantly reduced through expert management.
- Travel – a reasonable spend that can be impacted by effective purchasing practice.

3. Chapter Three: The Commercial Case

3.1 Market management

We will apply our market development process in the areas we have scheduled for market testing.

The market review and development process is the way in which we formally review current market arrangements from the supplier base in delivering against the needs of the population in a defined area of requirement. This review process will consider a number of elements:

- The importance of the area, as described by public health information, patient and public feedback, political and economic factors;
- The disease and population characteristics;
- The ability to deliver person centred integrated care;
- The relationship type required to maximise the potential in this area;
- The alignment of the suppliers to the needs of the commissioners;
- The ability to deliver QIPP plans;
- The current market place and it's level of provision;
- Supplier performance;
- The ease of change; and
- The need for a strategic shift in provision.

From these characteristics, the priorities for change are established. NHS Plymouth will plan to drive the market to deliver improved outcomes identified through the work above - this may be through increased competition, but driving improvement through developmental approaches with providers is also an area where increased focus is being placed.

3.1.1 Driving Market Change

The breadth of available levers is indicated below:-

- a) Strategic review process – The use of this approach will ensure the correct focus on areas to drive maximum benefit.
- b) Engagement – With patients the public and clinicians. This will deliver a more detailed understanding of the patient need, and clinicians are far more involved in the development of the resulting services.
- c) Supplier development - Monitoring of provider outcome performance will be utilised to drive continuous improvement in supplier performance. Where appropriate, the PCT may instigate improvement programmes where a performance issue exists.
- d) Robust contracting processes – The contracting approaches are more robust as the PCT uses the standard documentation produced by the

Department of Health. Service specifications are focused on performance outcomes.

- e) Integration – Through integration with social services, new ways of working will be adopted that will drive synergies towards our joint vision for health and care provision.
- f) Collaboration – The potential of collaborating with other PCT areas.
- g) Choice – The choice agenda is broadening the supply base and this in itself offers greater opportunity for market development.
- h) Information – The increasing availability of robust information provides a stronger foundation for decision making in driving pathway and supplier development. This information requirement is one of the prime drives for the creation of a single point of access and system control element. It will also collect patient feedback to ensure services become more patient centred.
- i) Reverse marketing – We will look not only at current market places but at associated areas where we may attract new providers into the market to benefit from their innovation and expertise.
- j) Opportunity marketing - We will not only look for local solutions but attract the best suppliers of services to the area by indicating the opportunity available being aware of providers needs and ensuring as far as possible we are preferred customers within Value For Money constraints.

Contestability is therefore one of a set of options we will utilise to leverage the supply market in the areas we are considering for a market test and is not considered to be the only way to improve services.

Going forward we are designing an open approach to our contact and system control hub in terms of referral, booking and data management this is to enable a more open market approach in the future.

The goal will be to:

“Drive our markets so that we are in an advantaged position to deliver future healthcare goals, we are treated as a preferred customer and we are served by a committed and productive supply base delivering value, quality outcomes and innovation.”

3.1.4. Safeguarding

Key aspects of provision involved in monitoring and ensuring safety will be disentangled from the core provision to ensure that review occurs impartially across all providers. These areas include aspects of infection control and

safeguarding adults and children.. These along with clinical governance overview will be retained in the commissioning enterprise.

3.1.5 Local Market Development

At this stage the existing provider landscape in Plymouth and the South West peninsula is limited. Therefore further provider and market development is needed over the forthcoming period particularly in community services. Consequently it is the view of NHS Plymouth that the configuration of the social enterprise that is established for April 2011 will not necessarily remain the same beyond the initial contract period. Specifically it will be changed as a result of:

- Implementation of the QIPP programme and changes in both service delivery models and further changes in provider organisational arrangements that may be required to achieve revised pathways of care and increases in quality and efficiency. This may well involve organisational integration of services provided by existing provider organisations.
- A period of provider and market development, ideally involving cooperation between existing PCT's where appropriate.
- The development of the GP commissioning consortia and any changes to either commissioning intentions or footprint that occur as a result.

The above will provide opportunities for the new community provider as well as existing statutory providers and current community interest companies or VCS organisations. However new market entrants may also be encouraged where appropriate to develop services in accordance with "Plymouth's Healthy System" and revised service models derived through QIPP.

The Social Enterprise will have clear key performance indicators (KPIs) in their contract. These will have been developed and agreed by clinicians through PEC, Sentinel CIC and with key partners through joint commissioning arrangements. The commissioner will retain the right to market test areas where non-adherence to these indicators occurs. See section 2.5 for further detail.

3.2 Payment mechanisms

There is currently a NHS standard contract in place for Mental Health and Learning Disabilities and a separate NHS community services contract for Adults and Older People and Children's and Families services.

The contracts were agreed on a three year basis, commencing April 2010 so would be available to be rolled forward if required. However, they may need to be novated in order to reflect any changes in the organisations legal entity.

It is possible that any new provider organisation may be formed on a social enterprise basis. The guidance around Social Enterprises requires any new organisations to be contracted with for 3 to 5 years without the provided services being re-tendered. However, there is no guarantee regarding income levels, or continuation of services which can be varied in line with the standard NHS contracts requirements.

There is currently a 'quasi' activity based contract in place for the provision of services by the PCT's provider function. This will need to be extended in order to drive through the required service changes and demonstration of improvement in patient outcomes. Examples being:

- Introduction of Payment by Results (PbR) for mental health services, including the reporting of outcomes
- Development of the CQUIN methodology to enhance quality
- Improved patient experience demonstrated through surveys and other stakeholder feedback.

Tariff will be applied as required nationally, and where tariff does not apply, the agreement of local prices reflective of cost of delivery will be required.

Penalties and fines will be applied per national standard contract.

The contractual mechanism should be reflective of risk and reward, and be variable in nature wherever possible in order to ensure appropriate incentives are embedded to drive and reward delivery.

3.3 Commercial Risk Management

There will inevitably be a bedding in period, during which the legacy corporate organisation and new provider would need to understand and appropriately mitigate risks to delivery.

It is expected that the provider will be a key partner in the delivery of the Plymouth Health Community Transformation programme, and as such will form part of the programme governance. This will require participation in the Executive Programme Board, and the rules of engagement in the delivery of risk management wherever possible.

No financial guarantees can be assumed at this stage.

4. Chapter Four: The Financial Case

4.1 Impact of the proposed transaction

The provider will be expected to produce an Integrated Business Plan, incorporating the financial forecasting of its key statements over the next five years. This will be expected to include the impact of all of the following, including QIPP and any internal efficiencies required.

Financial Due Diligence will explore the past performance of the organisation through detailed analysis of Income and Expenditure, Cashflow, Balance Sheet, and Efficiency Programme delivery.

4.1.1 Corporate and Support Functions

The transaction will require the separation of the range of corporate services being provided to the current organisational entity. This will include:

- Finance and Financial Services
- Workforce Development and Payroll
- Estates (Strategic and Operational) and Facilities
- IM&T (already provided by a 3rd party)
- Governance
- PCT Board and Corporate Office

In most cases a definitive transfer of the relevant service would be most cost effective, with an inter-organisational service agreement being created between the host organisation and the customer.

Over the forthcoming period of development, the PCT retains the opportunity to seek further efficiencies by delivering support services jointly with other partners. The outcome of which may mean a short term holding position whilst options are explored and delivered. The provider will deliver non-clinical productivity efficiencies in line with QIPP, delivering its appropriate share of the total programme of £10.8m.

4.1.2 Contractual Relationship with NHS Plymouth Commissioner

The development of the contractual relationship will need to be addressed in the Integrated Business Plan. This will need to set out the risks and mitigating actions to delivery of the Health Care system. The contract to date has remained only semi-activity based, and the development of the balance of service line contracting will need to be addressed. There are further risks to both clinical and financial sustainability that need to be addressed in Commissioner Case for Change and the Integrated Business Plan. The current year income and expenditure envelopes for the Provided services are set out in Table 1.

4.1.3 Income and Expenditure, Financial Balance

The Provider will plan to deliver at least financial balance between income and expenditure in each year. The Integrated Business Plan will evidence the

delivery of sustainable financial balance for the strategic period and on-going viability. The plan will include all source of income including from other NHS Commissioners, but also from Social Services and other sources. Significant convergence of income planning assumptions from commissioners and other sources of income will be required for the Integrated Business Plan. The management of upside and downside scenarios will be exemplified in the Integrated Business Plan, and will be assessed for strength in terms of planning assumptions and viability of response. The management of planned investments in capital assets, such as IM&T infrastructure will need to be managed through delivery of surpluses, cashflow management, and strength in the balance sheet.

4.1.4 Balance Sheet (Statement of Financial Position)

The Provider will exemplify the statement of financial position through the strategic past to include 2010/11. The Integrated Business Plan will exemplify plans for the sustainable strength of its balance sheet in the future. This will require disaggregation of the Balance Sheet across the legacy organisation.

4.1.5 Cashflow

The analysis of past cashflow, through extraction of actual balances and payments will be required to evidence past delivery of effective cash management. The Integrated Business Plan will identify best practice cash management processes, and plan to deliver sustainable cash balance in the future.

4.1.6 Assets and Estate

A significant element of the corporate organisation relates to the ownership and utilisation of the existing NHS estate. The Provider Integrated Business Plan will evidence delivery of the expectations laid out in the Commissioners Integrated Asset Management Strategy (CIAMS). This includes timescales for the strategic development and rationalisation of the estate, and will require planned and systematic withdrawal and /or maximisation of usage of the remaining estate. Strategic Asset Management responsibilities will remain with the NHS Commissioner, and are planned to be delivered through partnership or outsourcing arrangements. The provider will enter into fully repairing lease arrangements for each asset over the period of the contract (between 3 and 5 years) – although the exact requirement is subject to clarification at a national level to ensure a cost neutral position overall (i.e maintain status quo to the current status of the asset). The delivery of Operational Estates will be managed by the Provider. The impact of Capital Charges resultant from planned investment and maintenance in the properties will be reflected in variations to lease prices. Ownership of Information Technology assets, including all Personal Computers, Laptops, Printers, Patient Administration and other Clinical Systems, other software, and Infrastructure will be transferred to the Provider. On-going investment and development will be the responsibility of the Provider through financial security and planning.

4.1.7 Accountability

The Integrated Business Plan will be required to set out the financial governance and accountability framework, to include external and internal audit functions and responsibilities, together with the risk assurance framework.

4.1.8 LIFT and LIFTCO organisations

The legacy exclusivity agreement with Resound, the Primary Care Trust's LIFT partner will remain with the legacy NHS organisation, the commissioning PCT. The Provider will be required to sign up to the partnering agreement, and will be required to utilise LIFT as the preferred organisation for all significant estate development that it pursues outside of the leased estate arrangement from the commissioning PCT. The legacy leases for the currently operational estate and current developments (the Tier 4 Child and Adolescent Mental Health Services centre) will remain with the commissioning PCT. The agreed Lease Plus charge (including additional costs) will be the basis of the sub-lease to the provider, under the same arrangements as the LIFTCO leases, including Retail Price Indexed rental increases and decreases for the period of the lease.

4.1.9 .Other Services

Provided General Medical Services (PCTMS) and Dental Services (DAC) are currently provided by the PCT Provider function under separate Service Level Agreement from the core SLA. The new Provider will be expected to continue to provide these services under separate sections of an integrated Service Level Agreement, which will continue to maintain the equity of treatment with all independent contractor contracts. Uplifts are calculated in accordance with the Doctors and Dentists Remuneration Board (DDRB) agreements.

NHS Plymouth has the co-ordinating commissioner role for the Peninsula Dental School. This role will remain in place, ensuring equitable treatment and access across the peninsula commissioning PCT's. The individual running of buildings and services remains with the new provider, and is incorporated under a separate section of the Service Level Agreement. Income is dependent on Dental SIFT, HEFCE and other external sources of funding.

4.1.10 National Health Service Litigation Authority (NHSLA)

The Provider will be able to participate in the NHSLA scheme, and will examine the mechanics of the transaction through analysis of on-going liabilities (provisions and contingent liabilities), together with the on-going contributions to CNST. Disaggregation of commissioner elements as appropriate will be required.

4.1.11 Reference Costs

The current PCT Provider provides reference costs on an annual basis. The new provider will continue to provide reference costs in accordance with planned deadlines to ensure there is common understanding of the benchmarked efficiency of the PCT provider, which will inform local pricing structures where necessary. The new provider will set out plans to be at least 100 in benchmarking the costs of provision of its reference costed services.

Where prices are set by tariff the new Provider will be required to deliver within that price structure.

4.1.12 Management Costs

In line with the NHS White Paper, Equity and Excellence, Liberating the NHS, the reductions in management costs will be delivered by the Provider as planned. The provider will participate in the analysis and identification of on-going management cost targets across PCT commissioner and provider.

4.2 QIPP Contribution

The Provider will have a proven track record of delivery against its efficiency plans. The Integrated Business Plan will set out the last three years programmes including budgets and evidenced delivery, to include 2010/11 as planned. The new provider will set out its future efficiency plans within its Integrated Business Plan in order to respond to the commissioner's targets to deliver balance within the overall income envelope, including QIPP. Co-operation and participation in the Health Community Transformation Programme (to include QIPP) will be required, which will include sharing of all efficiency programmes ensuring synchronicity with other organisational and community goals and objectives. The planning assumptions to be used for the purposes of the Integrated Business Plan should be consistent with those set out in the Strategic Framework, Medium Term Financial Plan and QIPP submission and plans. Wherever possible, commissioner convergence will be expected to ensure the IBP delivers as planned. Commissioner convergence will be expected with all significant commissioners. Planning assumptions from the 2010/11 to 2013/14 Strategic Framework are included in Table 3.

Table 1 – NHS Plymouth Provider Services 2010/11 Budgets

| Expenditure Budgets - 2010/11 | Next Yr | Total | Pay | Non Pay | Income |
|--------------------------------|--------------|--------------|-------------|-------------|--------------|
| | £'m | £'m | £'m | £'m | £'m |
| Adult Mental Health Services | 26.9 | 28.6 | 26.5 | 3.4 | -1.3 |
| Adults and Older People | 26.6 | 31.4 | 24.6 | 10.8 | -4.0 |
| of which: | | | | | |
| PCTMS | | | | | |
| Dental Access Centre | | | | | |
| Dental School | | | | | |
| Childrens and Family Services | 7.7 | 8.2 | 10.7 | 1.1 | -3.6 |
| Medical Staffing | 0.1 | 0.3 | 0.3 | 0.0 | 0.0 |
| Total Service Provision | 61.4 | 68.6 | 62.1 | 15.4 | -8.9 |
| Corporate | 0.8 | 0.8 | 0.7 | 0.1 | - |
| Workforce Development | 1.7 | 1.8 | 1.5 | 0.4 | -0.1 |
| Finance | 3.6 | 3.7 | 2.0 | 1.7 | -0.0 |
| Facilities | 4.5 | 4.5 | 2.8 | 1.7 | -0.1 |
| Central Contracts | 2.3 | 1.9 | - | 1.9 | - |
| Capital Charges | 3.7 | 3.7 | - | 3.7 | - |
| Reserves | - | 0.1 | - | 0.1 | - |
| Total Support Services | 16.6 | 16.5 | 7.0 | 9.6 | -0.2 |
| Total Services | 77.9 | 85.0 | 69.1 | 25.0 | -9.0 |
| NHS Plymouth SLA | -69.0 | -76.7 | - | - | -76.7 |
| NHS Cornwall SLA | -8.9 | -8.3 | - | - | -8.3 |
| NHS Devon SLA | - | - | - | - | - |
| Total SLA Income | -78.0 | -85.0 | - | - | -85.0 |
| Financial Balance | -0.0 | 0.0 | 69.1 | 25.0 | -94.1 |

The process of due diligence will evidence the reconciliation of the Service Level Agreement, and inter Trust Agreement for the provision of support services with the Income and Expenditure budgets. It should also set out medium term plans for Service Line income and expenditure in the delivery of the QIPP Programme.

As a result the values in Table 1 may change.

Table 2 – NHS Plymouth Health Community QIPP Programme

| NHS Plymouth QIPP Plans – 2011/12 to 2013/14 | 2013/14 £'m |
|--|----------------|
| Shifting the Settings of Care | 16.5 |
| Optimising Elective Care Pathways | 17.2 |
| Best Practice Care Pathway for Long Term Conditions | 4.1 |
| Improving Medicines Management | 2.7 |
| Improving Primary and Community Care | 9.9 |
| Improving Mental Health | 6.0 |
| Improving Learning Disabilities | 5.1 |
| Non Clinical Productivity / Other | 4.7 |
| Total Services | 66.2 |

Table 3 – NHS Plymouth Strategic Framework Planning Assumptions

| Planning Assumptions - Base | 10/11 | 11/12 | 12/13 | 13/14 |
|----------------------------------|--------|--------|--------|--------|
| | % | % | % | % |
| SIF Local Contingency | 0.38% | 0.41% | 0.45% | 0.45% |
| SIF Voluntary | 0.36% | - | - | - |
| SIF Topslice | 0.38% | 0.41% | 0.45% | 0.45% |
| SIF Recurrent Headroom | 0.75% | 1.24% | 1.65% | 1.95% |
| SIF Surplus | 1.00% | 0.69% | 0.45% | 0.15% |
| CQUIN | 0.65% | - | - | - |
| Public Health | 0.10% | 0.10% | 0.10% | 0.10% |
| Improving Access | 0.30% | - | - | - |
| Quality Fund | 0.10% | - | - | - |
| NHS VFM Savings | 0.50% | - | - | - |
| Inflationary Assumptions | | | | |
| Tariff Inflation | 0.35% | 0.25% | 0.25% | 0.25% |
| Tariff CRES | -0.35% | -0.45% | -0.45% | -0.45% |
| Prescribing | 5.00% | 5.00% | 5.00% | 5.00% |
| Primary Care | - | - | - | - |
| Non NHS | 1.00% | 1.00% | 1.00% | 1.00% |
| Capacity Planning | | | | |
| Elective Growth | 2.00% | 2.00% | 2.00% | 2.00% |
| Non Elective Growth | 4.00% | 4.00% | 4.00% | 4.00% |
| Other NHS | 2.00% | 2.00% | 2.00% | 2.00% |
| A&E / OP / ESS | 1.00% | 1.00% | 1.00% | 1.00% |
| PCT Provider | 1.00% | 1.00% | 1.00% | 1.00% |
| Continuing Healthcare | 3.00% | 1.00% | 1.00% | 1.00% |
| Efficiencies Requirements | | | | |
| Minimum efficiencies over tariff | -4.87% | -0.57% | -0.43% | -0.31% |

| Planning Assumptions - Downside | 10/11 | 11/12 | 12/13 | 13/14 |
|----------------------------------|--------|--------|--------|--------|
| | % | % | % | % |
| Inflationary Assumptions | | | | |
| Tariff CRES | -0.35% | -0.40% | -0.40% | -0.40% |
| Efficiencies Requirements | | | | |
| Minimum efficiencies over tariff | -4.87% | -0.89% | -0.75% | -0.64% |

| Planning Assumptions - Upside | 10/11 | 11/12 | 12/13 | 13/14 |
|----------------------------------|--------|--------|--------|--------|
| | % | % | % | % |
| Base Case Scenario | | | | |
| Baseline Growth | 5.89% | 2.50% | 2.50% | 2.50% |
| Inflationary Assumptions | | | | |
| Tariff CRES | -0.35% | -0.35% | -0.35% | -0.35% |
| Efficiencies Requirements | | | | |
| Minimum efficiencies over tariff | -4.87% | 1.19% | 1.38% | 1.55% |

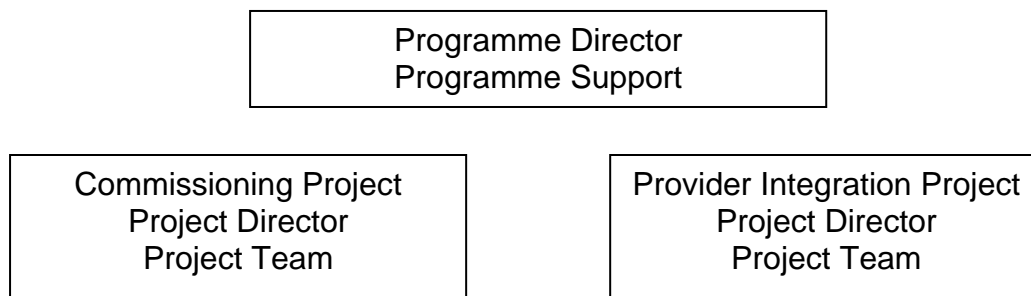
5. Chapter Five: The Management Case

5.1 Implementation capability

It is clear that the success of both the TCS Project and the QIPP programme are inextricably linked. The Executive Team meetings have taken on the role of Project Board for Transforming Community Services, with clearly nominated individuals. This needs to be driven by strong and focused leadership across the Health and Social Care Community and this is achieved via the Health and Social Care Integration Board.

A separate project team has been established for the Integration Project, reporting up through the Provider Executive Team to the Provider Board.

It is the intention to appoint a Programme Director, whose role will be to oversee both strands of work for NHS Plymouth, with dedicated project support.



The high level work programme was shared with the Strategic Health Authority for the end of July 2010. This workplan is being strengthened and consolidated as the emerging vision and direction is being finalised.

5.2 Project roles for the Primary Care Trust

This paper sets out the role for NHS Plymouth as 'Commissioner' in this process. However, it must be recognised that for the 'organisation' there are also key roles for the board in respect of the 'provision' role and for some individuals, it will be necessary to have dual roles in the overall process.

In terms of commissioning the project roles are as follows:

| Project Role | Appointed Individual | Areas of Responsibility |
|-----------------------|-------------------------------|---|
| Project Director | Paul O'Sullivan | Oversee the overall project from a commissioning perspective. |
| Project Manager | Fiona Phelps David Bearman | Support the Project Director in all aspects of the commissioning project. |
| Finance & Information | Ben Chilcott | Finance, Performance and Information workstream lead. |
| QIPP | Sharon Palser | Ensures integration with QIPP agenda, and also lead for Estates |
| Governance | Liz Cooney | |
| Communication | Corinne Shore | Develops Communications plan and lead for Stakeholder Engagement. |
| | | |

5.3 Business Continuity

NHS Plymouth and each of the Directorates within the Provider Organisation have existing Business Continuity Plans. It will be necessary to assure the Programme Director that the current Business Continuity Plans are fit for purpose, in light of the Transforming Community Services Programme.

The provider will need to demonstrate through the IBP that they have the necessary capacity and capability to achieve the transformational change or have made arrangements to secure that additional required capability.

It is the prime concern of all partners to ensure that on 1 April 2011 that a safe service for the public is available on transfer day.

5.4 Commissioner Strength

NHS Plymouth has a strong local vision and goals behind which major providers and stakeholders are aligned. WCC assessed the PCT as 'green' reflecting a vision which is firmly grounded in the PCT and national context, is underpinned by thorough analytical research into needs and priorities, is

ambitious and realistic and provides confidence that the PCT will deliver all of the local NSR vision, the national priorities and it's own top strategic priorities.¹

The assessment in April 2010 also recognised that the PCT has made significant progress in strengthening its commissioning arrangements. when the PCT was assessed as improved in eight of the eleven competencies and further progress has continued to be made.

The PCTs ability to learn from feedback and rapidly improve and the strength in the following areas are reflected in the quotes below from the WCC assessment report and provide assurance of strong governance and the organisation's ability to lead and manage the transformation of community services, to address local priorities and national policy:

Formulating the vision for health and healthcare in Plymouth:

"Following last year's feedback the PCT has focused on getting its processes right, and has made important progress in detailing what the characteristics of the future health and social care in Plymouth will look like. The panel were able to sense the values and purpose that underlies the PCT's work."

Clinical leadership

"The panel was impressed by the degree of empowerment of clinicians that the PCT has achieved – for example, through the work with Sentinel CIC as well as with acute, mental health and social care professionals – and can see that the PCT is putting together the building blocks of the delivery system in Plymouth. The panel observed a process to improve the health of relationships across the local health and social care system, which is supporting changes in culture and behaviour."

Strategy

"The PCT vision of nine priorities references the PCT and national context, and addresses specific locality needs addressing pockets of deprivation based on a strong underpinning analytical research."

Finance

The PCT has a strong track record in financial management which was recognised in the WCC assessment of 'green' reflecting the fact that "Historically the PCT's financial performance has been in line with SHA expectations. The PCT is forecasting a surplus in each of the next 5 years in line with SHA expectations."

Board

The PCT's strength in governance was reflected in an assessment of 'green' in two key areas:

Organisation – reflecting clear and well defined organisational structures, roles and responsibilities, clarity about capacity and capability gaps and plans in place to address them.²

¹ WCC assurance handbook year 2 p86 -criteria to be met to achieve a green assessment for vision and goals

Delegation – reflecting that in joint, collaborative and specialised commissioning arrangements there are clear and delineated roles, responsibilities and accountabilities, evidence of robust processes for decision making and clarity about how these arrangements will support delivery of the strategy³

Organisational Development (OD) plan

The PCT has an existing plan for organisational development which is framed around the McKinsey model of organisational health. This is in the process of being refreshed to reflect the significant progress made towards the local model of clinical commissioning, the feedback from the WCC assessment and also to reflect the outcome of the capacity and capability gap analysis currently underway with partners across the health and social care community to support the delivery of the QIPP programme.

An OD plan will be developed to ensure appropriate skills and capacity are in place along with robust governance and management arrangements to implement the model of care for Plymouth and ensure the strength and sustainability of the new organisational model.

Contracts with the new provider or providers will specify requirements in relation to the integrated delivery of care across the health and social care system. It is also intended to establish a mechanism to allow flexibility to continue to develop the initial model during the first twelve months to ensure that progress in the integration of health and social care in particular can be accommodated.

² WCC assurance handbook year 2 p92 -criteria to be met to achieve a green assessment for organisation.

³ WCC assurance handbook year 2 p94 -criteria to be met to achieve a green assessment for delegation

6. Chapter Six: Appendices

- 6.1 Option Appraisal of Organisational Form
- 6.2 QIPP Slide – Plymouth’s future care delivery system
- 6.3 Service line analysis – methodology
- 6.4 Service line analysis – outcome
- 6.5 Commissioning Assurance Framework
- 6.6 CYPP Needs Assessment