Northern, Eastern and Western Devon
Clinical Commissioning Group

# Outline Business Case

| **Programme Name:** | Integrated Approach to Health & Wellbeing | | |
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## 1. Executive Summary

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

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

The programme will aim to engage with commissioning and delivery partners to establish a more collaborative, integrated and strategic approach to how the organisations commission and deliver services, with the aim of reducing costs, improving patient/service user experience and improving outcomes for residents in Plymouth. As part of this, the programme recognises the importance of investing in preventative and early intervention services in order to reduce demand on higher cost community and bed based services, particularly acute services, which have been under sustained pressure for much of the last 12 months. The programme will consist of the following three projects:

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

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

- *Wellness* - Universal or preventative services.
- *Community intervention* - Targeted services for those who may be at risk in the future, and services for people who need support in the community.
- *Complex and bed based care* - Services people with complex needs, who cannot be supported in the community.

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

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

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

## 2. Vision

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

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

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

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

## 3. Strategic Case

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

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

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

### 3.1 Case for Change

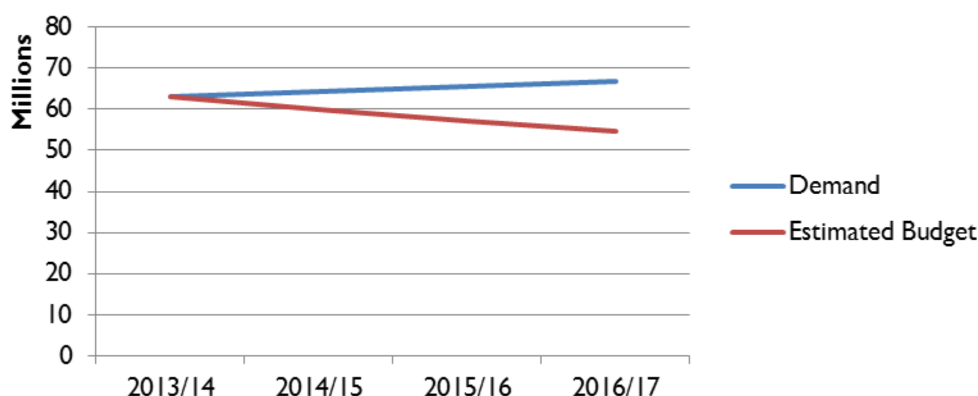
### 3.1.1 Local Strategic Drivers for Health & Social Care Integration

#### Local demographics and demand

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

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

The increase in population, and particularly the increase in older people, is likely to put significant strain on both health and social care services in years to come. The graph below illustrates the projected increase in demand for adult social care services (increase of 2% per annum) against the projected budget reduction for these services over the next four years:




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

Winter 2012/13 saw significant pressure on Derriford Hospital, main acute hospital in the region, with the hospital frequently being placed on black alert due to surges in demand. Unless significant action is taken to relieve pressure on admissions and increase the flow of discharges where possible, this pressure is likely to be present again this winter and in future years.

## Financial imperative

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

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

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

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

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

## Health & Wellbeing Strategy

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

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

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

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

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

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

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

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

## The Plymouth Children & Young People's Plan

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

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

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

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

10. Tackling risk taking behaviours through locality delivered services

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

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

## Children in need of protection

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

## PCC Transformation Programme

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

PCC's adult social care service has gone through a major transformation but has not been fully integrated with health provision with services provided around the customer.

11. Joint Commissioning is in place for some services but not all and there are opportunities to identify ways to achieve this and deliver value for money and more effective decision making.
12. The cooperative commissioning centre of excellence has not been fully developed and there needs to be an agreed approach to integrated commissioning with health and other partners
13. Services for children and young people could be integrated with schools, health and other partners in a more cost effective way which would deliver services cooperatively.
14. Some social care services that Plymouth City Council delivers could be more cost effective if they were delivered in an alternative way.

## Transforming Community Services

NEW Devon CCG has initiated a programme, called Transforming Community Services, to remodel community health provision across each of its three localities. This programme aligns to the national Transforming Community Services programme, and the current programme plan involves the re-procurement of community services in Plymouth by April 2016. The CCG intends to issue an ITN to suppliers in March 2014, and this programme will therefore need to consider whether it is appropriate for TCS to procure an integrated suite of community health and social care services, and if so, how this process can be managed.

## National Strategic Drivers for Health & Social Care Integration

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

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

## Health & Social Care Act 2012

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

## The Care Bill

Published on the 10th May 2013 and based on the White Paper Caring for our Future, the Care Bill takes account of the Dilnot Commission Report into the funding of care and support and the Law Commission report to codify Community Care law into a single piece of legislation. The Care Bill addresses the fact that the current social care system is inadequate, unfair and unsustainable. The Care Bill is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. It also places a new duty on Local Authorities to promote integrated care, mirroring the duties in the Health and Social Care Act 2012. The Bill makes it clear that this refers to housing, health and social care delivery/commissioning and not just health and social care. It will have profound delivery and financial implications, not just for social care but for the whole Council, through the new duty to assess self-funders, requiring a commensurate increased social work resource, and the new financial thresholds for care requiring the Council to track the care payments of people self-funders and step-in with financial support at a much earlier point than is currently the case.

## The Integration Transformation Fund

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

## National Quality Board

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

### Public Health Outcomes Framework 2013-1016

The Public Health Outcomes Framework addresses two key outcomes:

15. Increased healthy life expectancy
16. Reduced differences in life expectancy and healthy life expectancy between communities.

It requires the NHS, social care and voluntary sector communities to all work together to make this happen. It describes a whole system approach, refocused around achieving positive health outcomes for the population and reducing inequalities in health, rather than focused on process targets. Much of the proposed new public health system that is described in the document depends on the provisions of the Care Bill, which has yet to be passed by Parliament.

### Adult Social Care Outcomes Framework

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

### NHS Outcomes Framework 2014/15

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

17. Preventing people from dying prematurely
18. Enhancing quality of life for those with long term conditions
19. Helping people to recover following episodes of ill health or injury
20. Ensuring people have a positive experience of care
21. Treating and caring for people in a safe environment and protecting them from avoidable harm

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

### NHS Call to Action

NHS England has recently published "The NHS belongs to the people: a call to action", which sets out the challenge facing the NHS, and states that the NHS needs to change in order to meet these demands and make the most of new medicines and technology. The paper focuses on the changing dynamics of supply of, and demand for, NHS services, and there is a particular emphasis on the increase in the proportion of the population with long term conditions. The paper makes the point that it is important to manage patients with long term conditions differently, by supporting them to provide their own care. In this context, an integrated

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

### Closing the NHS Funding Gap

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

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

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

### Effective implementation of national education policy

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

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

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

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

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

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

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

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

29. Ensuring that schools below the floor standard receive support

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

## The Academies Act 2010

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

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

## The Children and Families Bill 2013

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

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

## Working Together to Safeguard Children (2013)

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

### Welfare Reform Act 2012

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

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

### Transfer of Public Health to Local Authority control

From April 2013, Public Health functions have moved to be under the control of local authorities. In the context of this programme, this provides a significant opportunity to improve public health indicators in Plymouth, by leveraging on the existing capability within Public Health, and the local knowledge and transformational capability that exists within PCC.

### Integration of Health and Social Care – A Strategic Response

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

## 3.2 Aim

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

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

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

5. Focus on developing an integrated provider function stretching across health and social care providing the right care at the right time in the right place.

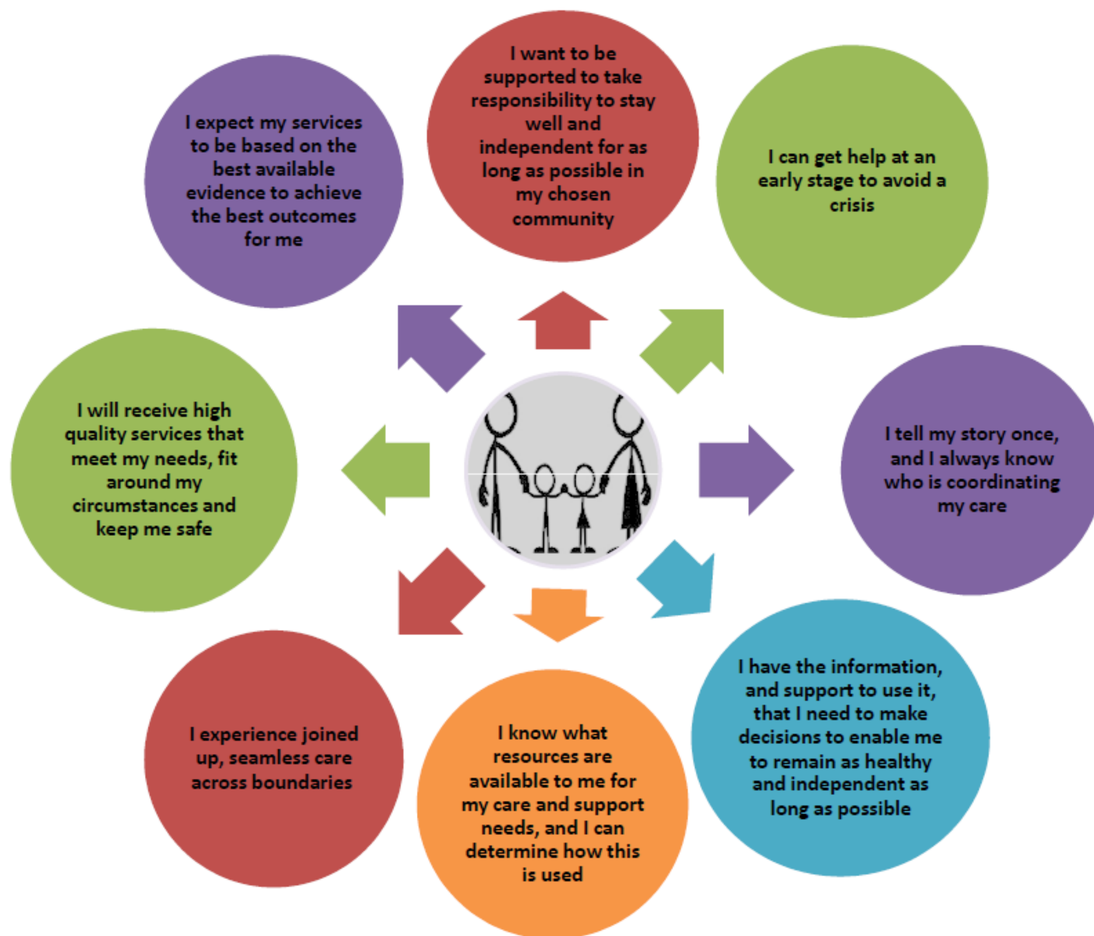
6. An emphasis on those who would benefit most from person-centred care such as intensive users of services and those who cross organisational boundaries

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

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

### 3.3 Outcomes

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




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

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

There are three overall outcomes of the programme:

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

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

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

### 3.4 Scope

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

It is important to recognise that, although there may be some services which will not be redesigned and will continue to be delivered in the same or a similar way, it is likely that changes in other parts of the economy will have an impact on the demand and spend in these services areas. At present, these services have been included within the addressable spend analysis that is laid out below.

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

**Service spend is in scope if:**

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

**Service spend is out of scope if:**

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

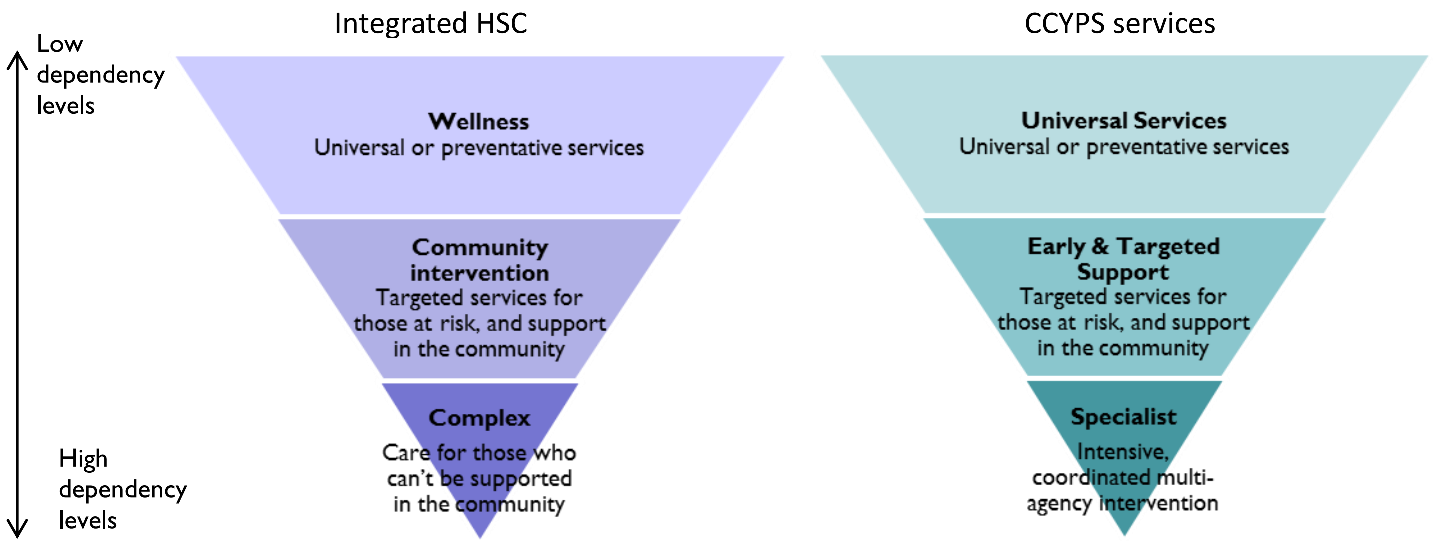
By assessing each service against these criteria, a baseline list of services that are in the scope of the programme has been devised. The detailed list of these services across PCC and NEW Devon CCG can be seen in the embedded spreadsheet in Appendix H. Note that this list is subject to agreement by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

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

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

The diagram below shows how PCC and CCG services may be conceptualised as part of an integrated economy. The top of the triangle represents patients or service users with lower levels of need and therefore lower levels of dependency on Council and CCG services. The bottom of the triangle represents service users with higher levels of needs and higher levels of dependency. Services are mapped to this

framework to provide a common baseline of services in scope:

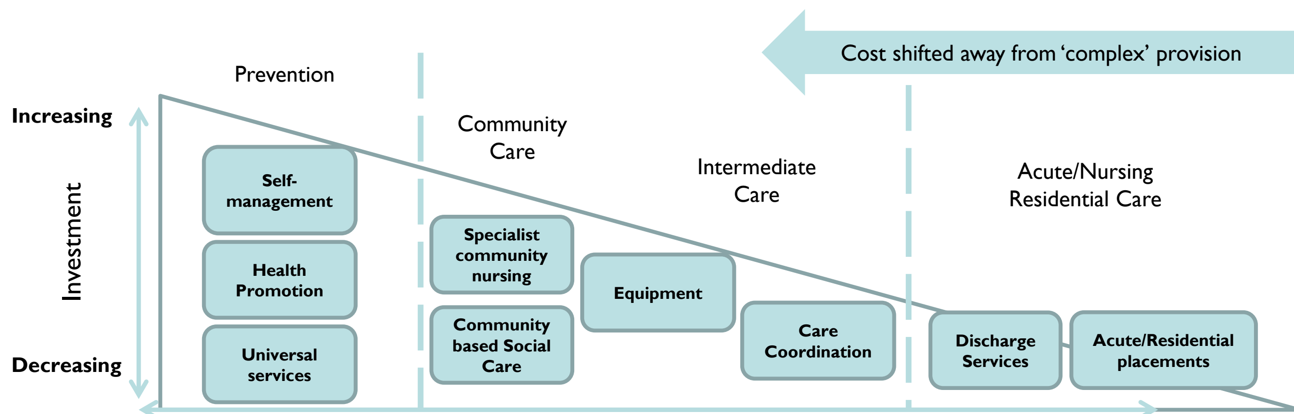



The two triangles are provided in order to reflect the different language which is recognised by partners across the scope of services, with commissioners and providers of services in the scope of CCYP services understanding the terms "Universal, Targeted and Specialist" services, in line with the current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

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

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

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




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

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

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

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

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

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

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

### 3.5 Out of scope

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

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

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

### 3.6 Assumptions

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

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

## 4. Options Appraisal

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

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

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

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

Table of Options for Integrating Health and Social Care

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

## 4.2 Conclusions

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

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

### Integrated commissioning

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

| | Description | Benefits | Risks |
|---|---|---|---|
| 1 | Commissioners come together with shared line management but commissioning budgets remain separate | • Budget reduction through reduced management function<br>• Ability to retain control of own organisation spend<br>• Commissioners can be aligned to particular services/groups of services to manage total spend<br>• Potential for 'cross-fertilisation' through commissioners sharing skills and expertise across service areas<br>• Support joint commissioning, maintains expertise and ensures relationship management across partners<br>• Can develop consistent approach | • No oversight of complete budget so unable to manage integrated spend strategically<br>• Potential risk of destabilisation as organisations can still act independently<br>• Providers have to deal with more than one organisation to discuss contracts<br>• Commissioners can retain a 'silo' mentality<br>• Low ability to extend to include further organisations |
| 2 | Commissioners come together with shared line management and pooled commissioning budgets (for services in scope of integration) but employer remains the existing organisation | • Budget reduction through reduced management function<br>• Strategic and operational oversight of complete integrated budget so can plan effectively<br>• Minimise transactional costs of moving staff across organisations<br>• Minimise risk of challenge on grounds of TUPE<br>• Legal agreement binding pooled budget to promote stabilisation | • Retention of original employer may create artificial barriers, preventing holistic service delivery<br>• Can cause operational confusion through different T&Cs |

| 3 | Commissioners and pooled budgets transfer into one existing organisation (via TUPE), thereby changing employer for some staff | • Alignment of roles and grades across the function<br>• Budget reduction through reduced management function<br>• Strategic and operational oversight of complete integrated budget so can plan effectively<br>• Single organisation is responsible for all commissioning – simpler for providers<br>• Greater opportunities for career specialisation and progression for staff<br>• Could be divested into a separate entity at a later date | • Will require robust shared governance<br>• Receiving 'host' organisation assumes superior position in decision-making<br>• Loss of influence by transferring organisation<br>• Potential for destabilisation if trust breaks down between the two organisations<br>• Potential negative impact on staff T&Cs<br>• Risk of challenge over redundancies if TUPE follows a restructure<br>• Transactional time and cost of transferring staff |
|---|---|---|---|
| 4 | Commissioners and pooled budgets come together to create a new commissioning entity | • Potential to sell services to other organisations/broaden remit of commissioning function<br>• Potential to broaden membership to other organisations<br>• Perception of independence makes partners equal<br>• Strategic and operational oversight of complete integrated budget so can plan effectively<br>• Single organisation is responsible for all commissioning – simpler for providers<br>• Greater opportunities for career progression for staff | • Cost of creating a new entity<br>• Cost of overheads of operating a new entity<br>• Potential increased procurement costs<br>• Lack of accountability for the commissioning entity<br>• Potential challenge under terms of 'state aid'<br>• Perception of 'outsourcing' the commissioning function is politically unsavoury |

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

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

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

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

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

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

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

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

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

| | Description | Benefits | Risks |
|---|---|---|---|
| 1 | Council and Partners come together with shared line management but service delivery budgets remain separate. Examples of this already exist within the Children's and Young People's services, however, does not proffer the cost cutting benefits that are sought from this transformation programme. (e.g. PTSA) | • Budget reduction through reduced management function<br>• Ability to retain control of own organisation spend<br>• Ability to manage total spend<br>• Can develop consistent service delivery approach | • No oversight of complete budget so unable to manage integrated spend strategically<br>• Potential risk of destabilisation as organisations can still act independently<br>• Customers have to deal with more than one organisation to discuss contracts<br>• Potential of retaining the 'silo' mentality<br>• Low ability to extend to include further organisations |
| 2 | Council and Partners come together with shared line management and pooled Service Delivery budgets (for services in scope of integration) but employer remains the existing organisation. Examples of this already exist within the Children's and Young People's services, however, | • Budget reduction through reduced management function<br>• Strategic and operational oversight of complete integrated budget so can plan effectively<br>• Minimise transactional costs of moving staff across organisations<br>• Minimise risk of challenge on grounds of TUPE<br>• Legal agreement binding pooled budget to promote stabilisation | • Retention of original employer may create artificial barriers, preventing holistic service delivery<br>• Can cause operational confusion through different T&Cs |

|  |  |  |  |
|---|---|---|---|
|  | does not proffer the cost cutting benefits that are sought from this transformation programme. (e.g. Neighbourhood and Informal Learning) |  |  |
| **3** | Council and Partners budgets transfer into existing organisations (via TUPE), thereby changing employer for some staff | • Alignment of roles and grades across the function<br>• Budget reduction through reduced management function<br>• Strategic and operational oversight of complete integrated budget so can plan effectively<br>• Single organisation is responsible for all service delivery – simpler for providers<br>• Greater opportunities for career specialisation and progression for staff<br>• Could be divested into separate entities at a later date | • Will require robust shared governance<br>• Receiving 'host' organisation assumes superior position in decision-making<br>• Loss of influence by transferring organisation<br>• Potential for destabilisation if trust breaks down between the two organisations<br>• Potential negative impact on staff T&Cs<br>• Risk of challenge over redundancies if TUPE follows a restructure<br>• Transactional time and cost of transferring staff |
| **4** | Council and Partners come together to create a new service delivery entity in form of a Mutual or Cooperative Enterprise | • Potential to sell services to other organisations/broaden remit of service delivery function<br>• Potential to broaden membership to other organisations<br>• Perception of independence makes partners equal<br>• Strategic and operational oversight of complete integrated budget so can plan effectively<br>• Single organisation is responsible for all service delivery – simpler for stakeholders<br>• Greater opportunities for career progression for staff | • Cost of creating a new entity<br>• Cost of overheads of operating a new entity<br>• Potential increased procurement costs<br>• Potential challenge under terms of 'state aid' |
| **5** | Council and Partners come together to create new service delivery entities, which would be a 'Honey-Comb' of Cooperatives and operate through a Joint venture approach | • Potential to sell services to other organisations/broaden remit of service delivery function<br>• Potential to broaden membership to other organisations<br>• Strategic and operational oversight of complete integrated budget so can plan effectively | • Cost of creating new entities<br>• Cost of overheads of operating new entities<br>• Potential challenge under terms of 'state aid' |

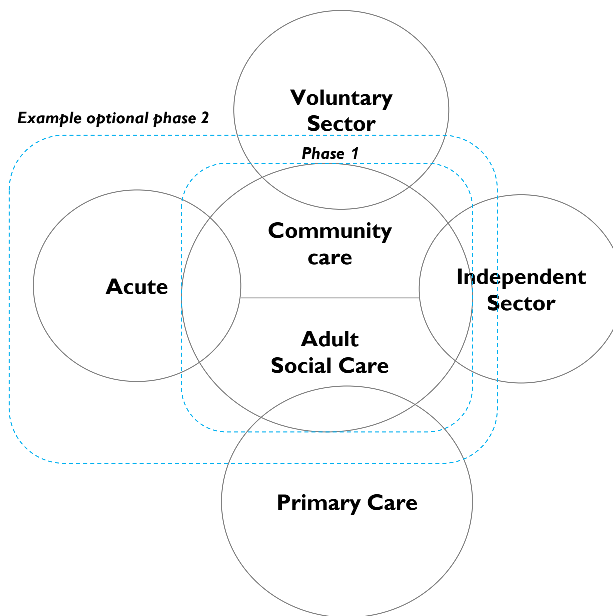
The options identified as the preferred options to explore further were 3 & 4 from the above table. This is because these options are best suited to deliver the outlined goals for the Co-operative Children's and Young People's services and also have the potential to broaden the scope and scale of the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

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

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

## Integrated provision

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




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

| | Description | Benefits | Risks |
|---|---|---|---|
| 1 | Providers come together (legal construct unspecified) into a single entity | • Fully integrated processes for finance, performance management and governance<br>• Full integration/ centralisation of back office and business functions (HR, IT, medical records and assessment)<br>• Legally binding arrangement, restricting opportunities for entry /exit<br>• Integrated budget avoids cost shunting<br>• Seamless organisation from patient perspective<br>• Staff within one organisation<br>• Opportunity to create single organisational culture, vision and strategy<br>• Commissioner will need to manage only one provider relationship and contract | • Costs associated with the transaction process and the management of organisations change and requires full support of merging organisations<br>• Increased risk on a single provider, posing a threat to local economy and required savings<br>• Divestment – may lose core areas of provision to integrating organisation<br>• Regulation (transitional) – meeting service standards during protracted period of integration. |
| 2 | Providers come together (legal construct unspecified) but not into a single entity | • Shared commitment to common vision and goals<br>• Separate statutory bodies – retain autonomy and identity<br>• Finance, performance and governance arrangements stabilised by e.g. S75, SLA<br>• Multiplicity – simplified partnership arrangements, with lower barriers to entry, mean opportunities for integration with a greater number/ range of partners<br>• No staff transfer – continuity of pensions and job specifications, and avoidance of TUPE liability<br>• Local partnerships strengthened, as possible precursor to more extensive integration | • Costs associated with the transaction process and the management of organisations change and requires full support of merging organisations<br>• Continuation of operational status quo – i.e. executive sponsorship but partner organisations view themselves as separate and distinct<br>• Planning of which organisational departments will integrate, and organisational management of integration process is both time consuming and has additional costs associated |
| 3 | Accountable lead provider model | • Centralised governance and management<br>• Single point of responsibility to improve care and deliver better outcomes and better health<br>• Incentives to invest in 'upstream' disease prevention and health promotion as well as diagnosis/treatment<br>• Promotes 'make or buy' decisions, hence creating opportunities to align clinicians across traditional boundaries and to encourage clinical collaboration<br>• Greater incentive and freedom to innovate<br>• Stronger accountability for patient-oriented outcomes<br>• Commissioning of individual services shifts from commissioner to lead provider hence giving the principal provider greater | • Require extensive reconfiguration of services, contracts and payment mechanisms , especially for the lead provider and therefore has its own cost and risk implications<br>• Increased financial risk on lead provider<br>• Risk of creating new silos centred on conditions and diseases in place of existing silos<br>• Staffing transition costs and implications where lead provider chooses to 'make' the service – potential TUPE |

| | |
|---|---|
| | autonomy and lower resource requirement for the commissioner to manage contracts<br>• Allows for sub-contracting with the third sector, therefore potential opportunity to attract new providers who can offer better quality of care at reduced prices |

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

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

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

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

# 5 Management Case

## 5.1 Programme approach

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

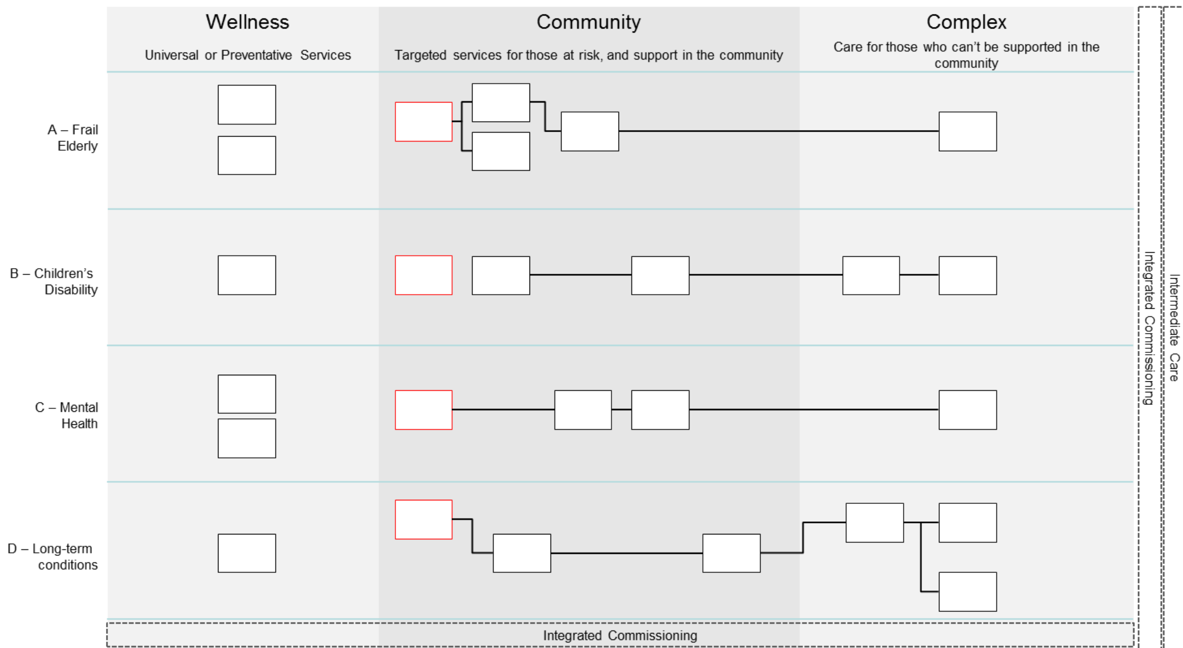
This approach will require a detailed analysis of specific areas of service provision in order to develop a series of 'mini-business cases' which will enable an informed strategic view to be taken by the Programme Board. In addition, this work will inform the detailed design of the future operating model,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

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

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

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

An illustrative example is shown below:



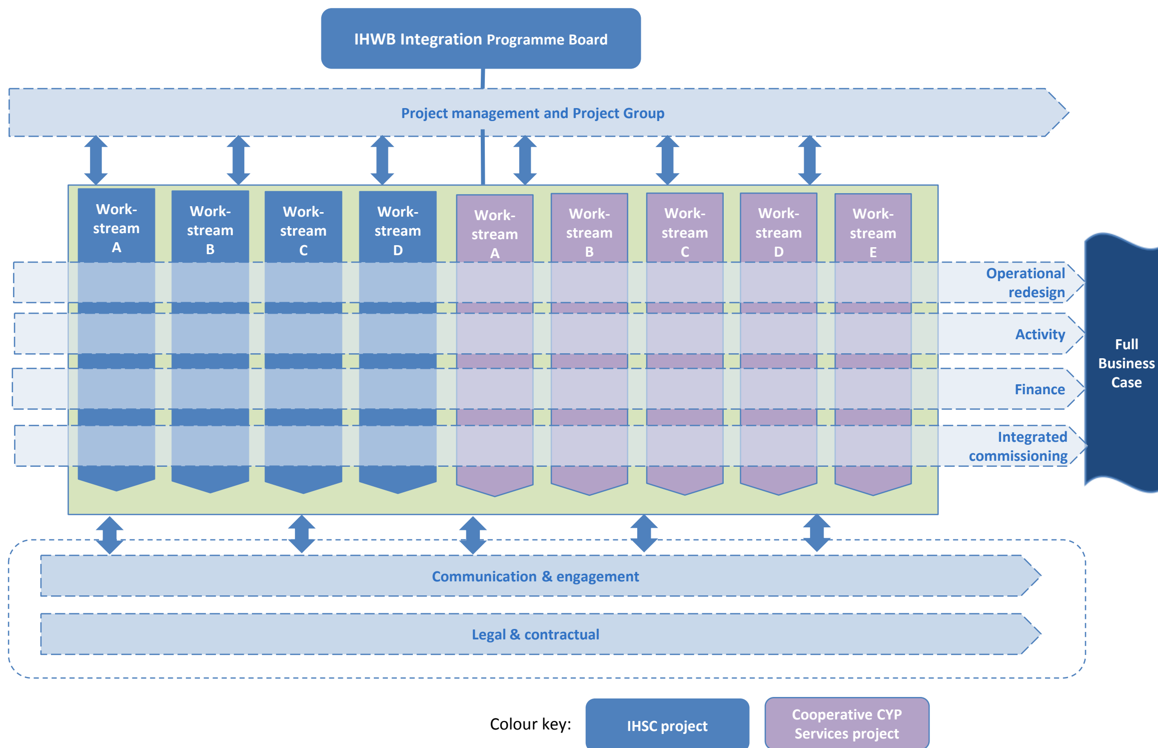

In the diagram above, red boxes represent the first point of contact for a service user or patient, while other boxes represent interactions that a service user or patient has with services.

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

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

## 5.2 Programme structure

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




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

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

| **Delivery workstream: Operational redesign** | |
|---|---|
| **Purpose: To undertake a detailed analysis of the current pathways/service clusters and develop detailed specifications for the reconfiguration of services in the themed workstreams listed in the table above** | |
| **Key activities** | **Key outputs** |
| **Challenge, validate and update scope assumptions underpinning the OBC and identify gaps** | Updated, consistent and tested assumptions underpinning operational redesign and information gaps added to workstream plan |
| **<u>For IHSC project:</u>** **Working with Activity workstreams, analyse the existing pathway and design the 'to be'** | Completed 'to be' service specifications based on a modernised, optimised safe and sustainable integrated |

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

| **Delivery workstream: Activity** | |
|---|---|
| **Purpose: To develop detailed activity projections and resource requirements in order to inform the final redesign specifications.** | |
| **Key activities** | **Key outputs** |
| **Work with Operational design leads to agree parameters and assumptions to be used in Activity modelling** | Agreed parameters used to determine capacity requirements are clearly set out (e.g. occupancy rates, daycase rates etc) |
| **Develop or modify Activity modelling tools to deliver the required information within the agreed parameters** | Demand and capacity model to establish future service requirements |
| **Assess impact of national policy initiatives (demand management, shifts to primary care, choice, personalisation etc.)** | Activity projections linked to decisions about primary and community care services and how acute provision is being delivered |
| **Contribute to development of FBC document and appendices** | Relevant technical input where required |

| **Delivery workstream: Finance** | |
|---|---|
| **Purpose: To work with service areas to inform the service reconfiguration and develop the Financial business case** | |
| **Key activities** | **Key outputs** |
| **Detailed financial to define costs of new operating model** | FBC Financial Case including:<br>• Cost benefit analysis<br>• Transitional costs<br>• Long Term Financial Model (LTFM) |

| **Review , track and update the benefits throughout the project** | Updated benefits appraisal and visibility of transitional costs including consideration of double running costs and redundancy costs<br>Benefits realisation plan |
|---|---|
| **Identify resources required to deliver the implementation** | Workstream implementation plan including transitional costs and benefits |
| **Contribute to development of FBC document and appendices** | Relevant technical input to the following sections:<br>Financial Analysis<br>Cost benefit (VFM) analysis |

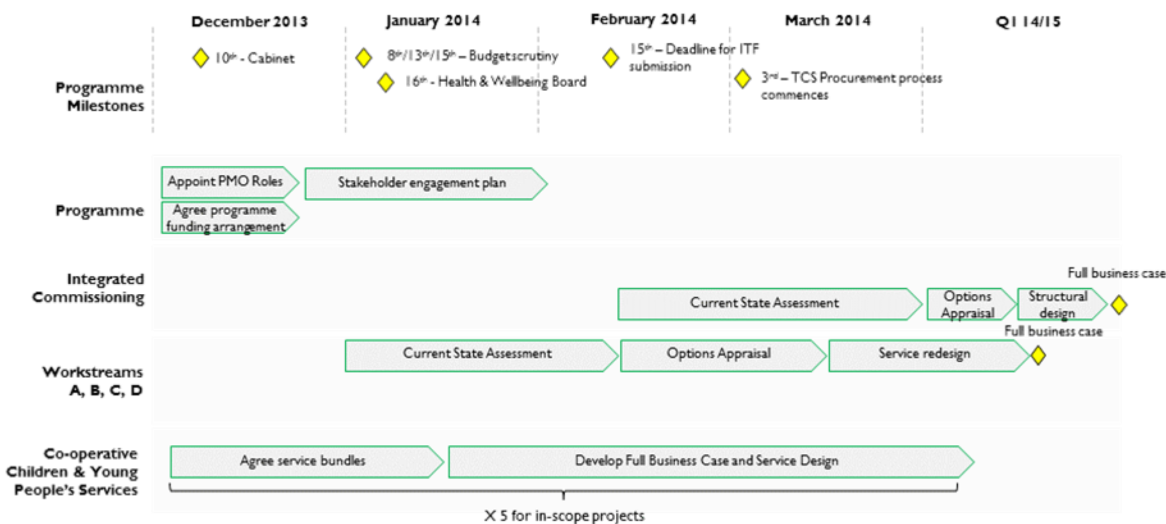
| **Enabling workstream: Legal and contractual** | |
|---|---|
| **Purpose: To deliver the activity required to provide the appropriate legal and technical support** | |
| **Key activities** | **Key outputs** |
| **Work with leads from each Workstream to identify legal and contractual issues** | Milestone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

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

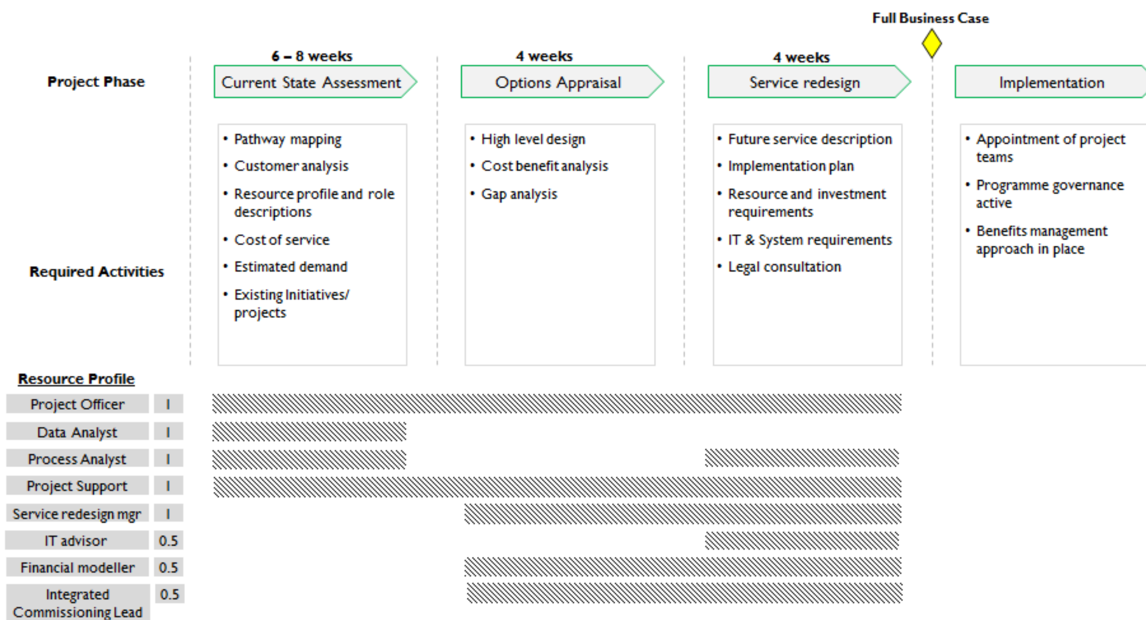
| | |
|---|---|
| **Manage stakeholders and develop appropriate communication and engagement toolkit** | Communication and engagement toolkit |
| **Liaise with PCC Transformation Portfolio Communications and Engagement Team** | Coordinated communication and engagement activity |
| **Working with HR where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

## 5.3 Programme Plan

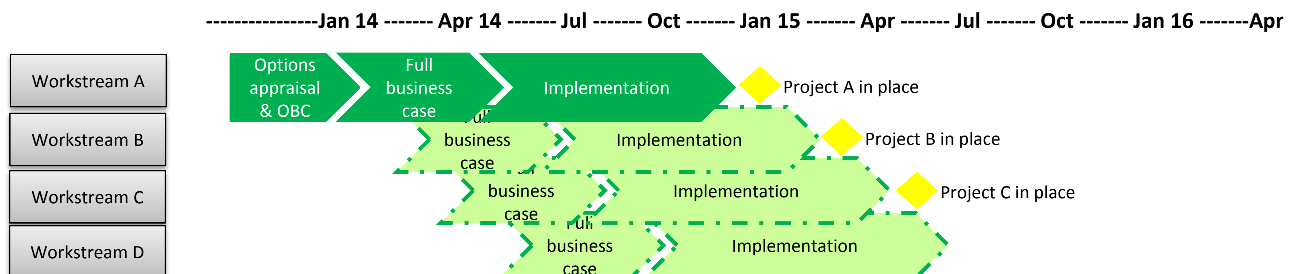
The programme plan shown below is a high level indication of the different projects within the programme.




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



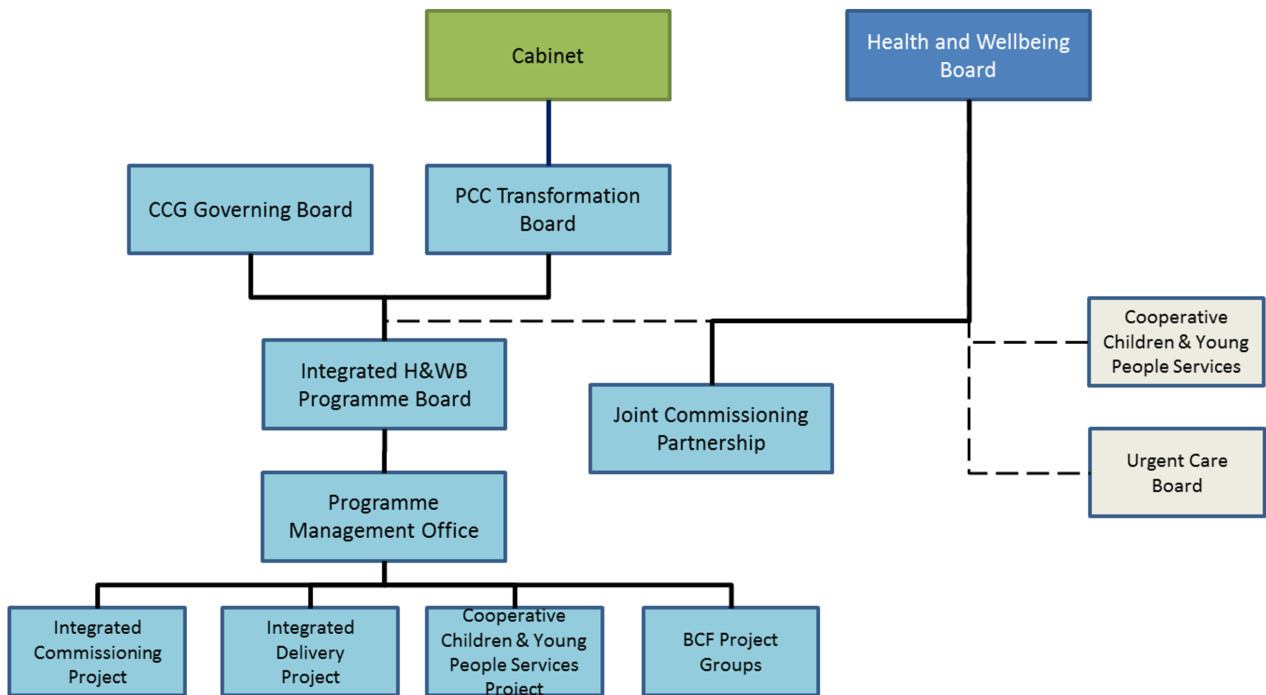

The resource profile set out above is what will be required **per pathway or service cluster**. This means that it is the minimum resource required to deliver one mini-business case at a time. If work is to be completed more quickly, with a number of pathways or clusters being assessed in parallel, the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




Refer to Appendix E for a detailed project plan.

## 5.4 Programme Organisation

The programme has the following governance structure:




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

Health & Wellbeing Board
Responsible for sign-off of the BCF plans. The Board will provide "systems leadership". The board will ensure alignment between the BCF plan and the IHWB programme and other initiatives

Cabinet
Responsible for overseeing the plans and performance of the BCF. The Cabinet has the responsibility for ensuring the BCF aligns with PCC strategies

New Devon CCG Board
Responsible for ensuring compliance with overall CCG requirements. Board will monitor the delivery and achievements of targets and benefits of the BCF plan.

PCC Portfolio Board
Responsible for ensuring compliance with overall transformation blueprint and monitoring delivery and benefits of the IHWB.

IHWB Programme Board
Responsible for steering the overall programme of integration. The Board owns the delivery of the BCF plan and will report progress to Senior Management Boards.
The IHWB programme board will sign-off programme and BCF initiatives.

Programme Management Office
Responsible for the coordination of the transformation and BCF projects

Project Groups
Responsible for designing solutions, identifying benefits, resource requirements and delivering projects.

Joint Commissioning Board
Responsible for BAU commissioning during the BCF and IHWB programme. Maybe merged with the IHWB Integration Board

Urgent Care Board
Responsible for oversight of BAU functions of urgent care delivery. Will provide leadership of elements of the BCF, where plans impact on urgent care delivery. The Urgent Care Board will be responsible for operational oversight of metrics

Children's Partnership Board
Responsible for BAU function reporting into the Health & Wellbeing Board for oversight

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

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

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

# 6 Financial Case

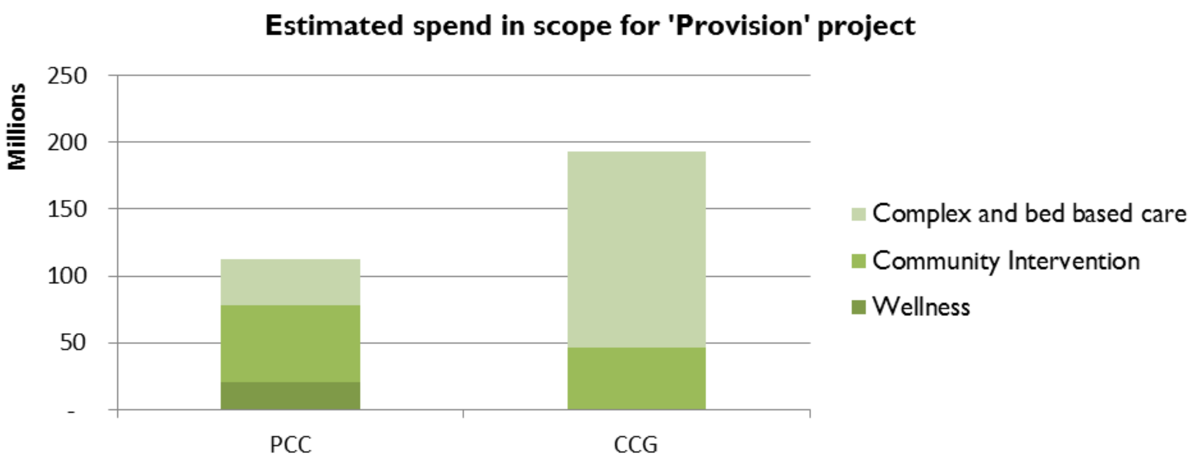
## 6.1 Addressable Spend

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

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

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

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




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

## 6.2 Approach to Benefits

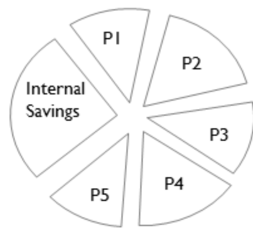
The benefits of the programme can be divided between financial benefits (see 5.3) and health & wellbeing outcomes.

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

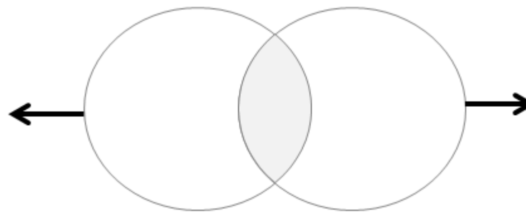
| Category | Performance measure | **3 year benefits target** |
|---|---|---|
| **Complex/ Community** | Delayed transfers of care | Return to national average |
| **Complex** | Delayed transfer of care due to adult social care | Return to average of comparator group |
| **Complex** | Emergency admissions: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

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

Measured through a series of projects which contribute to programme goals




Cashable benefits    Improved Health & Wellbeing



Measured through performance against targets for national indicators

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

### 6.3 Cost and Benefits Analysis

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

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

**Indicative Phasing of Average Financial Benefits**

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

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

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

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

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

In addition, further additional income may be achieved through

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

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

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

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

Refer to Appendix A for detailed cost benefit analysis.

**6.4 Expected Costs**

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

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

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

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

The cost of each workstream has been estimated below:

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

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

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

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

Refer to Appendix A for detailed cost-benefit analysis.

## 7 Risks and compliance

### 7.1 Risk Analysis

Refer to Appendix C for detailed risk log.

### 7.2 Interdependencies

Within PCC, there are key interdependencies with the Blueprint, version 2.0 of which is currently being developed, and the other programmes within the Transformation Portfolio. The Blueprint will drive the way in which the Council operates in the future, and as such it is vital that any options and recommendations made in the outline business case are compliant with this document. The other programmes within the PCC Transformation Portfolio will provide support around engaging with staff, developing new ways of working, and redesigning customer services.

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

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

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

### 7.3 Constraints

There is a constraint around delegated authority for approving decisions concerning integration within the CCG. Plymouth City is exclusively within the Western Locality of the CCG, but decisions around integrated commissioning and provision, and the alignment with the Transforming Community Services programme, will potentially affect other localities within the CCG, meaning that the Western Locality board may not be able to sign off on plans on its own, and approval from the CCG board may be required.

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

### 7.4 Stakeholders

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

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

## 8 Programme Organisation

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

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

### 8.1 Benefits Management

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

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

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

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

## 8.2 Guiding Principles and Methodologies

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

## 8.3 Quality Management

Quality Management Strategy and Plan – Portfolio Office

## 8.4 Portfolio level Benefits Management

Portfolio Level Benefits Management Strategy will be used

## 8.5 Risk Management Strategy

Corporate Risk Management Strategy

## 8.6 Methodologies

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

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

## 8.7 Equality Impact Assessment

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

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

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

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

## 8.9 Programme documents

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

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# 9 Appendices

## Appendix A – Capability Assessment

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

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

**Appendix B – Risk Log**

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

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

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

**APPENDIX A**

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

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

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

powerpoint

## BRIEFING GOVERNANCE ARRANGEMENTS - TRANSFORMATION

David Trussler

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

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

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

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

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

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

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

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

Their role in leading the Programme includes:

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

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

The Project Executive

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

The Transformation Portfolio Board is supported by the Portfolio Office.

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

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

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