Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Plymouth City Council**
Clinical Commissioning Groups	**Northern Eastern, Western Devon CCG**
Boundary Differences	**No significant boundary issues**
Date agreed at Health and Well-Being Board:	**[27th March 2014]**
Date submitted:	**[4th April 2014]**
Minimum required value of ITF pooled budget: 2014/15	**£5,660,000**
2015/16	**£19,610,000**
Total agreed value of pooled budget: 2014/15	**£5,660,000**
2015/16	**£19,610,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Northern, Eastern, Western Devon CCG (NEW Devon CCG)
By	Rebecca Harriott
Position	Chief Executive
Date	[27th March 2014]

Signed on behalf of the Council	Plymouth City Council (PCC)
By	Carole Burgoyne
Position	Strategic Director for People
Date	[27th March 2014]

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

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By Chair of Health and Wellbeing Board	Cllr S McDonald
Date	[27th March 2014]

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

We recognise the importance of engaging with our local providers and collaborating to develop integrated plans. We already work with acute and community providers to deliver integrated care, and in the past year have engaged with our key health providers across a number of events to share plans for further integration. Much of this interaction has taken place under the banner of the local ‘Transforming Community Services’ (TCS) initiative; both of the healthcare providers integral to this plan, Plymouth Community Healthcare Community Interest Company (PCHCIC) and Plymouth Hospitals NHS Trust (PHNT), have attended events relating to TCS in the past year. We consider this to represent a sound basis for the development of this plan given that the key TCS themes of joined-up care, putting individuals at the heart of the care plan, and reducing inequalities, are equally recognised in the Better Care Fund (BCF). In addition, the development of the wider NEW Devon CCG commissioning framework has included a recent provider event focused on a whole system approach. Specifically, a solution shop on integration and the BCF took place in December 2013 with Plymouth Health and Wellbeing Board, which has Chief Executive representation from both the acute and community based health care providers. The views gathered at these events, and through other interactions with providers, have had a direct impact on the development of this plan. They have also been used to develop our business case for an Integrated approach to Health and Wellbeing. Going forward we are developing a consultation and engagement plan around integration which will utilise existing forums around Residential and Nursing care, Domiciliary Care and Health Provider meetings. We have held meetings with both PCHCIC and PHNT on 7 March 2014 where the draft BCF plan was presented, and comments / contributions to the plan were requested from participants. This was further developed in a workshop attended by representatives from New Devon CCG, PCC, PHNT and PCHCIC on 20 March 2014 where plans for the achievement of national conditions and key schemes were discussed. In the Section covering *Implications for the acute sector*, we have discussed in more detail the potential implications of the plan on our core providers. However, given that Devon has been identified as a ‘challenged health economy’ we expect these plans to further develop over the course of the year.

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

Our plans are focused on delivering an integrated service to those who need it. At the heart of our work on community services there has been substantial patient,

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service user and public engagement including a specific focus on issues of relevance to integrated working. Engagement has included: • Health summits which have already taken place in many communities to gauge the initial views of local people- these summits so far have reached more than 1,500 people. • Voluntary sector events/other discussions. • Council events/attendance at meetings. • Local Healthwatch led survey of carers and housebound people. • Set up of community groups/reference groups for testing direction. Health scrutiny committees and Healthwatch have also been actively involved in the stakeholder events for Transforming Community Services (these events are already discussed in the provider section of this document). In addition, for people who can face barriers to engagement, HealthWatch events were arranged in January 2014 to discuss out of hospital services. Meetings with Plymouth Healthwatch specifically about the BCF have now taken place and there is a commitment to contribute to the development and monitoring of the Integration agenda going forward. There has also been elected member engagement as the BCF was considered by Caring Plymouth (Overview and Scrutiny Panel) on the 30th January 2014.

e) Related documentation

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

Document or information title	Synopsis and links
Integrated approach to health and wellbeing- outline business case	Programme covers integrated commissioning, co-operative children and young people's services, and integrated community health and social care provision. The overall aim is to establish a more collaborative, integrated and strategic approach to how organisations commission and deliver services, with the aim of reducing costs, improving patient/service user experience and improving outcomes for the residents of Plymouth. The business case considers a number of options regarding the vehicle to deliver an operating model of integrated care, and plans to develop these options. The outline business case and supporting documents are available on request to: Craig Williams, Programme Manager, Integrated Health and Wellbeing Programme, Plymouth City Council, Civic Centre, Plymouth, or craig.williams@plymouth.gov.uk.
Joint Strategic Needs Assessment (JSNA)	The JSNA looks at the current and future healthcare needs of the local population to inform and guide the planning and commissioning of health, wellbeing and social care services. **http://www.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/plymouthhealthandwellbeingjsna.htm**

Joint Health and Wellbeing strategy	Sets out the purpose and strategic approach of Plymouth's Health and Wellbeing Board, approach to health and wellbeing and guiding principles, approach to public engagement, use of evidence and data, and the initial priority areas that have been identified for action. **http://www.plymouth.gov.uk/mgInternet/documents/s51967/1%20Health%20and%20Wellbeing%20Strategy%20-%20V8.pdf**
NEW Devon CCG Commissioning Framework	This sets out the five year strategic direction for the CCG and specifically the plans that support delivery of the CCG vision for 2014/16. It is a modular document with new modules and information being added as work progresses. **http://www.newdevonccg.nhs.uk/who-we-are/what-is-clinical-commissioning/commissioning-framework/100925**

VISION AND SCHEMES

a) Vision for health and care services

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

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

The vision developed and aspired to by the Plymouth Health and Wellbeing Board is to create an integrated system of person centred care which fulfils the ambitions of National Voices, to achieve the following core outcome:

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

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

The Integration of Health and Social Care provides an opportunity to redesign the services offered to services users/patients. We shall be seeking to transform the functions of care:

- Single point of contact regarding information, advice and guidance on care.
- Community support and prevention – targeted services to help people stay in their own home and live healthy, independent lives.
- Assessment and coordination of services.
- Supply and range of services offered.

To be successful, integration must bring together the whole system and refocus the elements on the individual. The person requiring support must be at the heart of everything that is done on their behalf.

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

Strategic Aims and Principles

- Building on co-location of the western locality of NEW Devon CCG and PCC, and existing joint commissioning arrangements, the focus will be to establish a single commissioning function, the development of integrated commissioning strategies and pooling of budgets.
- Focus on developing an integrated provider network stretching across health and social care providing the right care at the right time in the right place.
- An emphasis on those who would benefit most from person-centred care such as intensive users of services and those who cross organisational boundaries.
- A focus on developing joined up population based, public health, preventative and early intervention strategies.
- An asset based approach to providing and integrated system of health and wellbeing, focusing on increasing the capacity and assets of people and place.

Core Workstreams

- **Integrated Commissioning**: a single, integrated and co-ordinated approach to commissioning across the social care and health system.
- **Integrated Health & Social Care Provision**: an alternative delivery model for health and social care services, and to facilitate the development of an integrated health and social care economy within Plymouth.

Key outcomes

Integrated commissioning

- Personalised care planning for individuals supported by primary care and social care frontline commissioning teams.
- A single team developing and implementing key commissioning strategies for health, care and other services.
- Cost savings achieved through better control, planning and utilisation of resources.
- An integrated budget for health and social Care.
- Team collaboration through sharing knowledge and skills on each strategy.
- A platform for further potential collaboration in future.

Integrated health and social care provision

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

For Individuals

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

b) Aims and objectives

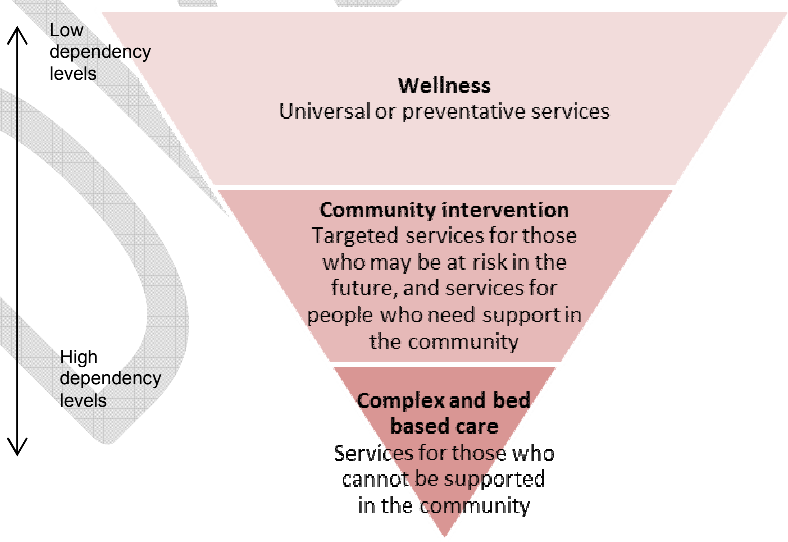
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

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

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

Services underpinning provision

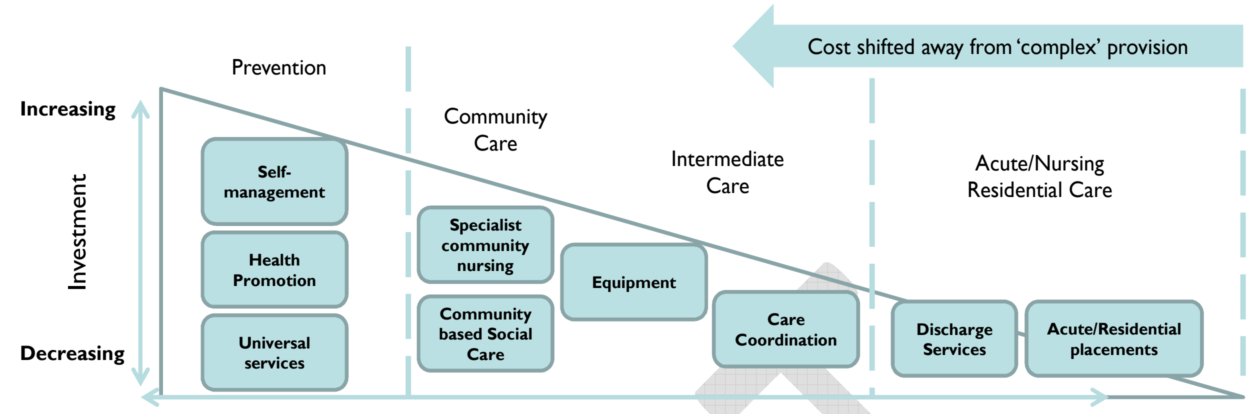
Services that will form part of the integrated provision programme have been grouped into three categories, which correspond to differing levels of need and complexity. The diagram below highlights the integrated system that we are seeking to achieve:



- *Wellbeing*: **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 care co-ordination, 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 and palliative care.

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



c) Description of planned changes

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

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

PCC and NEW Devon CCG (Western Locality) have developed and agreed an Outline Business Case planning to achieve integrated commissioning and provision by 2016. Detailed Business Cases for both Integrated Commissioning and Integrated Provision are in development.

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

Integrated Commissioning

- Development of new governance architecture.
- Development of commissioning strategies (Bed based/Community Support/Wellbeing).
- Integrated commissioning function.
- Development of personal health and care budgets.
- Section 75 for pooled (commissioning) budget.

Integrated Provision

- Section 75 for pooled budget.
- Process and pathway redesign activity.
- Integrated provider function established.

Specifically in relation to schemes covered by the BCF the following planned changes are scheduled:

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2014/15

- **Promoting independence (prevention and admission avoidance)**
    - Plymouth's eligibility criteria will be maintained at critical and substantial. In addition an enhanced universal offer focusing on information, advice and advocacy for all and a targeted early intervention and prevention offer based around floating support, befriending and handyperson person provision will be delivered.
    - Additional investment is to be provided to the Community Equipment Service over and above core funding levels. This will allow the service to meet increased levels of demand, facilitate hospital discharges and allow people to remain living in their own homes. The service will be re-commissioned during the year to provide an enhanced service the following year in line with the National Conditions.
    - The team will continue to ensure timely support to prevent hospital admissions and expedite discharges. The offer will manage up to 80 referrals across the system per week via a single access point; it will focus on continuing to reduce care home admissions building on the current improved performance of 3% conversion to long term care.

- **Minimising delayed transfers of care**
    - Investment will be provided to a third sector provider to support effective hospital discharges with the aim of reducing delayed discharges. The service will develop to offer a seven day service.
    - In order to support winter planning, provide timely support in a crisis and facilitate timely discharges 15 step up and step down beds will be commissioned. In addition Rapid Response Dom Care providing a two hour response will be available to expedite discharges seven days per week.

- **Reablement, rehabilitation and recovery**
    - Planned changes to the Reablement offer will see the service grow from delivering 1,500 hours per week to 2,000 hours per week.

- **Quality improvement**
    - The Quality Assurance Improvement Team will complete quality reviews of 50 Care homes, 15 Care Homes will pilot the Leadership Programme, 28 Care Homes will achieve the Dementia Quality Mark and quarterly Dignity in Care Forums will be held for Domiciliary and Care Home Providers.

2015/16

The following developments are planned for 2015/16:

- **Promoting independence (prevention and admission avoidance)**
    - An additional 40 units of extra care housing are planned as an alternative to residential and nursing Care.
    - Telecare and Telehealth will be part of the mainstream assessment process and offered where the need is identified.
    - In order to meet demand and keep people in their homes and communities. funding will be ring-fenced for DFGs.
    - Personal health budgets will be rolled out in order to promote choice and control.
    - We will continue to ensure Plymouth is a Dementia Friendly City and ensure a

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range of low level support services are in place.

- **Minimising delayed transfers of care**
    - Care coordination will ensure individuals discharge plans are established early on in their admission by linking with community hubs to improve timely transfers of care.
    - Increase the number of Pathway flats to provide timely discharge from hospital.
    - Step up, step down beds will continue to be commissioned with designated therapy support to ensure individuals have access to rehabilitation.

- **Reablement, rehabilitation and recovery**
    - The Community Equipment Service will be extended to offer a seven day service.
    - Specialist Dom Care will be commissioned for key areas including End of Life to ensure individuals have the right support.
    - Reablement will continue to grow to deliver over 2000 hours per week.
    - Therapy teams will be profiled to ensure timely support to individuals at home or in care settings.

- **Quality improvement**
    - There will be a focus on improving the workforce developing a person centred skilled workforce with a range of generic competencies.
    - Through the development of rotations we will ensure that we have a flexible workforce that can be deployed to areas of greatest demand.
    - The quality Improvement Team will be strengthened to cover Nursing Homes and Domiciliary Care Provision.

In addition, we will ensure the protection of social care through planned implementation of the Care Bill. Changes will include:

- **Personalisation**: Creating greater incentives for employment for disabled adults in residential care.
- **Carers**: Put carers on a par with users for assessment, and introduce a new duty to provide support for carers.
- **Information advice and support**: Link local authority information portals to a national portal, and provide advice and support to access and plan care.
- **Quality: **Provider quality profiles.
- **Safeguarding:** Implement statutory Safeguarding Adults Boards and establish a national minimum eligibility threshold.
- **Assessment and eligibility:** ensure continuity of care for people moving into area until reassessment, and clarify responsibility for assessment and provision of social care in prisons.
- **Veterans:** Disregard of armed forces GIPs from financial assessment.
- **Law reform:** Training social care staff in the new legal framework.

Alignment of other key plans

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

These principles fully align to our vision for the BCF, and the schemes and plans we are developing to achieve that vision.

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To further demonstrate this link we have detailed below NEW Devon CCGs 5-year strategic priorities, and the top six commissioning intentions, and how these link with the BCF plans outlined in this document.

NEW Devon CCG strategic priority	Link to Better Care Fund
Partnerships to deliver improved health outcomes	Integrated commissioning and integrated provision are core programme workstreams, with planned outcomes for both commissioning and provision described in this plan.
Personalisation and integration	We have described our current status and plans regarding joint assessment and assigning a lead professional for individuals at high risk at hospital admission. This is a national condition of the BCF and so is a key feature of our plan.
General Practice registered populations as the organising unit of care, provided at scale	Under the national condition for joint assessment and accountable lead professional we describe how this service is, and will continue to be, GP led.
A regulated system of elective care that delivers efficient and effective care for patients	Prevention and admission avoidance schemes are key features of the BCF plan. Our crisis support and joint discharge teams will be in place to ensure that care is delivered in the right setting.
A safe and efficient urgent care system	

NEW Devon CCG commissioning intention	Link to Better Care Fund
Right care: targeting resources to best effect	Emphasis on patient-centred care and provision of information, choice and control over care received.
Targeted follow ups: targeting resources to best effect	BCF should complement this intention through risk stratification of high risk admissions, and through provision of health and social care services outside of hospital where possible.
Elective orthopaedic care: focussing on conservative management and evidence based practice	Emphasis towards self-management, health promotion and primary prevention, and community diagnostic service.
Non-elective care: transforming our urgent care system with a real emphasis on services for frail older people	Moving from a bed-based model of reactive care to one that is closer to home and places prevention and well-being at its heart. This includes a need to diagnose those with dementia, which is proposed as the local metric for the BCF.
Individual patient placements: ensuring that individuals are cared for in the best setting to improve their outcomes and longer terms goals	A key aim of the BCF is right care, in the right place, at the right time. Our current work and plans for risk stratification and individual care plans will enable this.

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Diagnostics: standardising our approach to diagnosis and management planning	The key aim of this intention is to reduce variance. The BCF will contribute to this through integrated teams.

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

d) Implications for the acute sector

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

In 2014, the CCG in partnership with the Area Team for Devon, Cornwall and the Isles of Scilly published "*Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders".* This guidance has been adopted by the local Urgent Care Forum and integrated commissioning intentions and efforts will be focused on the following activities from 2014/15 onwards;

The concept of providing an integrated care pathway for frail elderly is based on a number of components across the whole system:

- Single point of access available to facilitate access to community services to manage crisis at home with specialist opinion and diagnostics.

- A comprehensive geriatric assessment initiated rapidly, within four hours of referral, 8am to 8pm, seven days a week.

- Ambulatory emergency pathways with access to multi-disciplinary teams should be available with a response time of less than four hours for older people who do not require admission but need on-going treatment.

- Mental health services should contribute with specialist mental health assessments if appropriate.

- An interface or community geriatrician service is available to provide expert clinical opinion, clinical support and supervision to community teams and domiciliary care when needed to housebound patients.

- Rapid access ambulatory clinics available in acute and community hospital settings for the provision of rapid access to specialist advice from the multi-disciplinary team.

- A personalised care plan including emergency contingency plan, advanced care plan and the facility to allow a natural death order (if clinically appropriate) is in place and can be accessed by the patient and all services involved in their care and support.

- There are shared care protocols with ambulance organisations that can enable older people to remain at home.

- Good acute hospital care is available when (and only when) needed. The core components of this include:
  - Expert decision makers are available at the front door of the acute hospital from 8am to 8pm, seven days a week.
  - Specialist assessment should be available within 12 hours of admission, seven days a week.

- An identified Frailty Unit/Service should be available with staff trained how to look after frail focusing on rapid assessment, treatment and rapid discharge.

- The presence of one or more frailty syndromes should trigger a comprehensive geriatric assessment.

- Sufficient specialty and community hospital beds to look after all frail older patients with complex needs and enough relevantly trained staff to deliver high-quality care and assessment for them.

- Hospitals should have operational plans to reduce the number of ward moves, especially out of hours with accompanying plans to mitigate their adverse effects on continuity of care, reduction in harm and improved patient experience for frail older people.

With the implementation of these elements underway, the impact on NHS providers is expected to be as follows:

Plymouth Hospitals NHS Trust (acute trust)
Demand pressures have been increasing on the acute sector driven by an increase in emergency admissions and rising length of stay. Demand is closely related to demographic pressures (mainly the ageing population), which is increasing both admissions as well as length of stay. This is also linked to the deterioration in performance for the metrics around avoidable emergency admissions and delayed transfers of care (days delayed). Performance against both metrics is also worse than the national average.

However, our ambition is to enable more people to be safe and well in their own homes, and as such we will reduce delays with the ambition of being better than the national average by March 2015. Plymouth has a higher rate of avoidable emergency admissions compared to the national average, but this is not necessarily surprising as we are an urban centre with relatively high levels of deprivation. Our ambition is to ensure that there is no further growth in avoidable emergency admissions.

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It has been calculated that demographic demand pressure in relation to emergency admissions for PHNT (age stratified) has been increasing by about 1.3% per year. The actual growth in emergency admissions across PHNT has been increasing by around 2.6% per year over the period 2008/09 to 2013/14. Thus growth in admissions has been at a higher rate than could be predicted simply from population changes. Therefore our ambition to stop any future growth in emergency admissions will be equivalent to an annual improvement of 2.6% per year.

There are around 350 emergency beds occupied in PHNT at any given time occupied by Plymouth patients. Improving the level of delayed transfers of care to the national average and preventing all growth in emergency admissions will save an estimated 12 beds across PHNT (full year effect) with a potential efficiency saving of £1.66m.

NEW Devon CCG is working closely with PHNT to ensure the above changes are fully embedded in our future plans/ contracts. The performance will be monitored on a monthly basis through the Urgent Care Partnership board to ensure delivery of the improvements. The CCG is working to ensure there is sufficient investment/ capacity in those community services that can enable these changes to occur.

Plymouth Community Healthcare CIC (community services provider)

This 2014/15 CQUIN for PCH is aimed at integrating care for the frail elderly and delivering the underpinning of the Urgent Care Partnership's principles:

- choose to admit only those frail older people who have evidence of underlying life-threatening illness or need for surgery – they should be admitted, as an emergency, to an acute bed;
- provide early access to an old age acute care specialist, ideally within the first 24 hours, to set up the right management plan;
- discharge to assess as soon as the acute episode is complete, in order to plan post-acute care in the person's own home; and
- provide comprehensive assessment and re-ablement during post-acute care to determine and reduce long term care needs.

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

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

The CCG has identified the potential for c. £3m savings from acute providers during 2014/15, based on the better management and support of frail older people. We are still working through the absolute detail in terms of volume and value impact on individual providers for the 2014/15 year in detail and for the 2015/16 year.

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Devon has been identified as a 'challenged health economy' which means that a system-wide review will be undertaken in the forthcoming months. As a result, we expect plans to further develop through the course of the year as this work is undertaken in collaboration with our providers.

Mental health parity

Our wider strategic plans for integration include the whole age spectrum and encompass people with mental and physical health conditions. We are currently out to consultation on a joint commissioning strategy for mental health services. This strategy is on behalf of PCC and NEW Devon CCG, but also Torbay Council, Devon County Council and South Devon and Torbay CCG. This BCF plan will enhance the services offered to patients with a mental health condition through integrated commissioning and integrated provision.

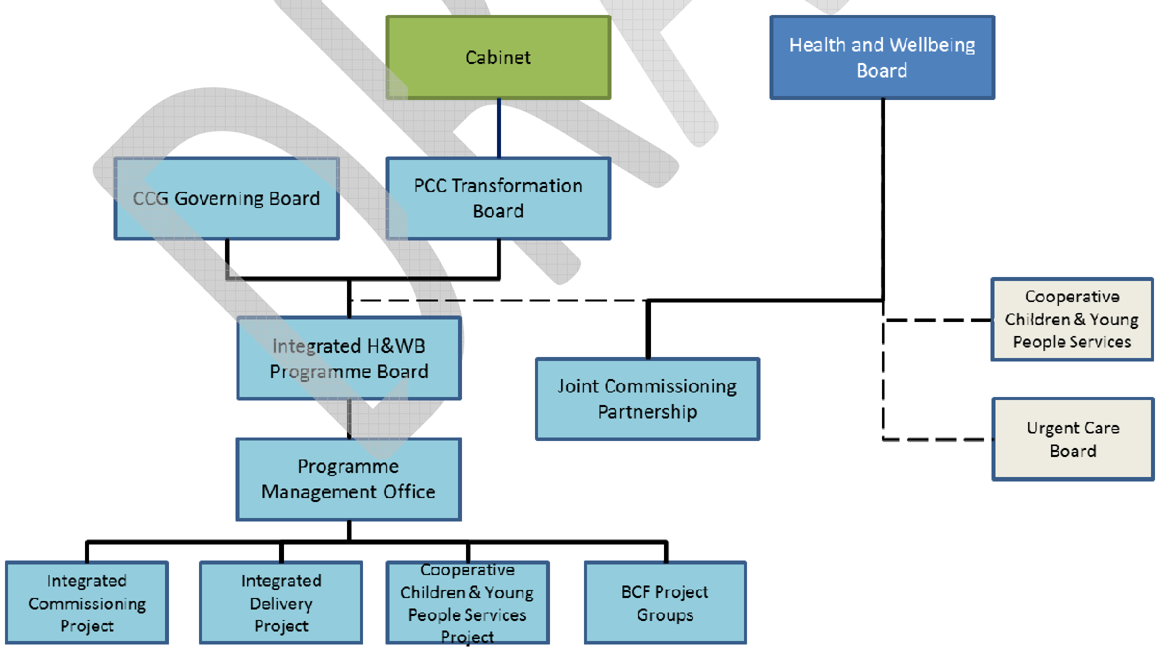
Specifically, we have been discussing plans with our mental health provider colleagues around Alzheimer support and the dementia pathway, and under the theme of prevention around prevention of escalation of mental health issues such as eating disorders.

e) Governance

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

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

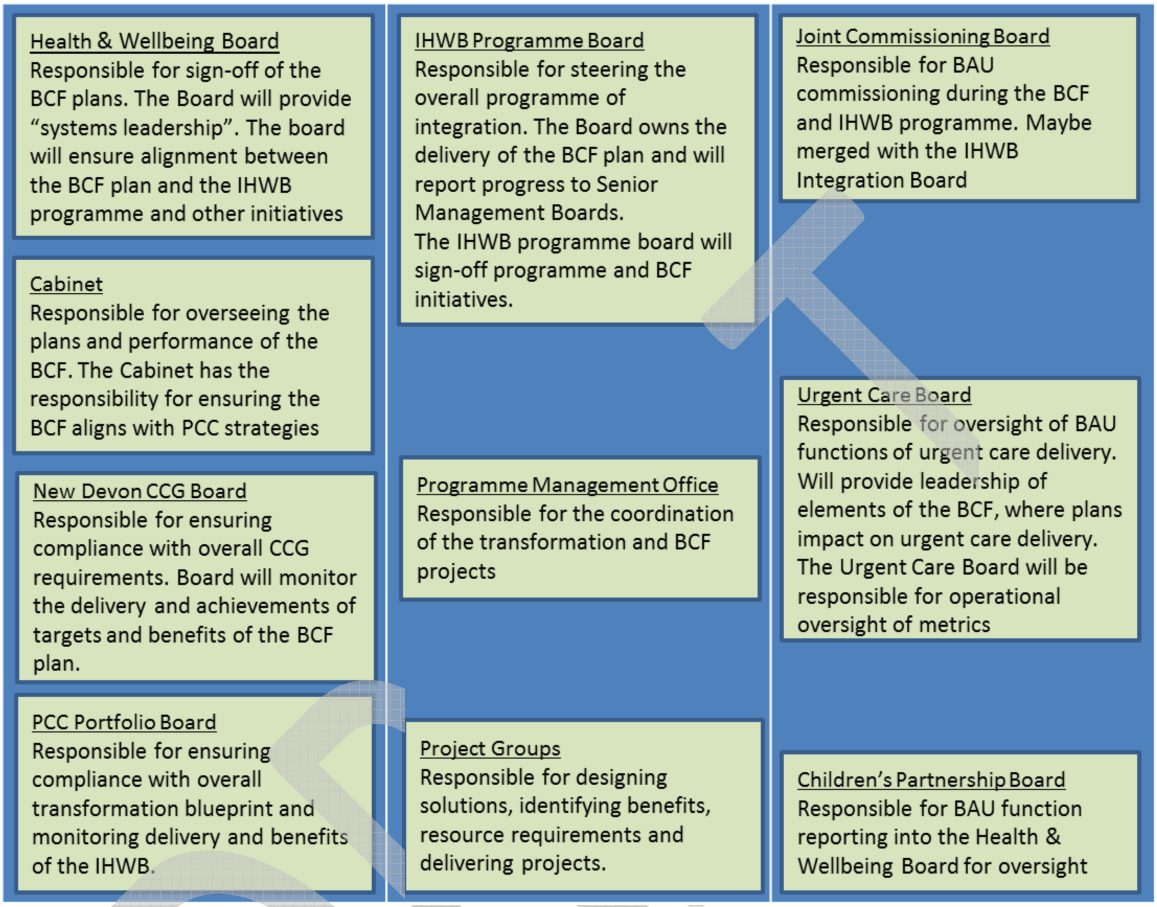
The governance structure is:



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

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

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



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

Membership:

- Managing Director and Chief Operating Officer – Western Locality, NEW Devon CCG (Joint-Chair and Senior Responsible Officer)
- Director of People, PCC (Joint-Chair and Senior Responsible Officer)
- Director of Public Health, PCC
- Chair of NEW Devon, CCG
- Managing Director – Partnerships, NEW Devon CCG
- Assistant Director – Joint Commissioning, PCC
- Assistant Director – Education, Learning and Families, PCC
- Area Team representatives, NHS England
- Programme Manager, IHWB Programme

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

- **Protecting Social Care**: a condition of the BCF transfer is that the PCC agrees with

NEW Devon CCG on how the funding is best used within social care and the outcomes expected from this investment. The agreement on how funding should be spent will be developed by the BCF project Group. This will be ratified by the IHWB Programme Board and signed off as part of the BCF Plan by the Health and Well Being Board.

- **Risk Sharing Agreement**: an agreed approach to risk sharing and mitigation will be developed by the BCF project group. The agreement will cover the impact on existing NHS and social care delivery and the steps that will be taken if activity volumes do not change as planned (e.g. if emergency admissions or nursing home admissions increase).

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

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

The Integration Board and the Urgent Care Board will be jointly responsible for monitoring of progress towards national conditions and outcome metrics. The Integration Board will have system leadership and accountability for achieving results and resolving issues and risks around plans. The Urgent Care Board will be responsible for day to day operational changes required to achieve targets.

2) NATIONAL CONDITIONS

a) Protecting social care services

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

Protecting social care services in Plymouth means ensuring that those in need continue to receive the care and support they require to remain healthy, well and independent for as long as possible. This entails maintaining current eligibility criteria for those assessed as needing statutory services but also promoting a comprehensive universal offer, for those who are not FACS eligible, based around information, advice and low level preventative services. We will adopt an evidence based approach for all service redesign changes. This will ensure all decisions to reduce or disinvest in social services will deliver better outcomes for services user/patients.

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

Funding currently provided under the Social Care to Benefit Health grant has to date been used to enable PCC to sustain current eligibility criteria and to work with providers and CCG colleagues to further integration plans. This level of investment will need to be sustained, if not increased, to meet increasing demand and complexity of need, as well as meeting the requirement to deliver seven day working and meet the requirements of the Social Care Bill. In order to change the balance of care towards a more community based model that promotes independence, well-being and choice and that reduces reliance on residential and nursing care and prevents hospitals admissions and improves discharges, a strengthened social care offer based around the following priorities is required: • Maintenance of eligibility criteria at Substantial and Critical. • A focus on improving the quality of service provision. • An enhanced Community Equipment Service. • Hospital Discharge Services. • Increased Reablement Capacity. • Rapid Response Domiciliary Care. • Greater choice and control through Self Directed Support. • Promotion of assistive technology (Telecare and Telehealth) • An enhanced universal offer focusing on early intervention and prevention.

b) 7 day services to support discharge

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

Current position Our starting point for consideration of seven day services has been to evaluate the services we currently provide. Our Care Co-ordination team is available seven days per week to complete assessments and arrange plans for discharge from hospital. This team

is able to access a wide range of support services to facilitate discharges 7 days per week. It is currently available 8am – 6pm Monday – Friday and 8am – 4pm Saturdays and Sundays. Early analysis suggests that 5% of referrals to the team occur at the weekends. In the future we will ensure that wards are encouraged to facilitate discharges at the weekends by ensuring that the infrastructure within the hospital settings are appropriately geared up to interface with the Care Co-ordination offer. As part of our on-going evaluation we are working to identify whether additional access to additional support services will be required to achieve the normalisation of 7 day discharge arrangements.

This team also has wider responsibilities around admission avoidance by providing access to a range of support services to prevent unnecessary hospital admissions through the offers of Reablement, domiciliary care, and step down placements. The team is available Monday – Sunday 8am – 8pm. Initial analysis indicates that 7.5% of referrals to the team occur at the weekend. The interface with Primary Care cover arrangements requires further development to maximise the teams' potential. In addition an evaluation of the offers available to support individuals in crisis and whether access to the support can be extended to ambulance services will form part of our on-going development with providers. Out of hours arrangements are also in place for social care, who are able to assist with emergency situations and provide advice and information if required, usage of this service is minimal since the launch of CCT. There are Out of Hours arrangements for community nursing teams. It is our intention to scope whether additional services would benefit from offering extended response to address needs e.g. stroke services or community therapy. Further work is taking place to establish pathways between out of hours mental health provision and CCT to ensure services are aligned to afford individualised support.

Future plans and intentions

We are committed to providing seven-day health and social care services. Our urgent care commissioning intensions include the aim of providing a service which is available seven days a week, including bank holidays. We would also expect to extend operating hours so that referrals can be made between 7am to 10pm. This would be delivered by an integrated team comprised of a centralised hub of health and social care staff and resources. During 2014/15 providers and commissioners will be working together to increase the number of relevant services operating seven days a week and to provide access to support provision to facilitate 7 day discharges and prevent admissions 24 hours per day.

c) Data sharing

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

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

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

Plymouth City Council is committed to adopting the NHS number as its primary identifier for correspondence. PCC is PSN compliant and has recently gained N3/IGSOC connectivity and therefore is working towards the pre-requisites for PDS connectivity. Plans are being constructed now, with the first step application to become an End Point

Site, following which detailed plans will be constructed. Technical and business discussions will take place shortly to determine the impact on business processes to inform the planning exercise and hence determine timescales for full implementation. The target date to use the NHS Number as primary identifier, for new clients, is 1st April 2014.

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

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

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

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

d) Joint assessment and accountable lead professional

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

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

The team interfaces closely with Primary Care and the ambulance service to identify individuals who are at risk of hospital admission or inappropriate care settings, providing nursing, therapy and social care support to achieve individual outcomes. The team work off a unified IT system with access to mobile technology to facilitate better sharing of information across the health and social care system. Since the launch of the team, it has been able to respond to an average of 72 referrals per week and by re-profiling this urgent work, capacity has been released for existing case management teams such as Social Care and District Nursing to more proactively manage individuals at greatest risk of inpatient stays.

The team manages all hospital discharges for the acute and community providers in

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Plymouth, delivering timely access to integrated discharge plans. By delivering an integrated and joined up approach to both discharge and community crisis intervention the team is able to identify those individuals whose needs are most unpredictable and ensure the right support is targeted, as such data from this team will further build on the risk stratification of the Plymouth population.

The next steps in this area that we are now working on are:

- Use the team to form the platform to meet the "accountable GP" initiative by providing a single access point for individual care needs.
- Focus on Frailty and further develop pathways across acute and community pathways
- Develop the Emergency Care Practitioner function to support 24hr 7 day per week delivery model
- Explore case management function across community health and social care, identifying points for join up
- Further develop and implement usage of Risk Stratification tools.

3) RISKS

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

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

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

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