PLYMOUTH CITY COUNCIL

Subject:	Integrated Community Health and Social Care Delivery
Committee:	Cabinet
Date:	15 July 2014
Cabinet Member:	Councillor Tuffin
CMT Member:	Carole Burgoyne (Strategic Director for People)
Authors:	Dave Simpkins (Assistant Director of Adult Social Care and Co-operative Commissioning, PCC) Nicola Jones (Head of Western Locality Programmes, NEW Devon CCG)
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Ref:	IHWB/SD
Key Decision:	Yes
Part:	I

Purpose of the report:

The purpose of this report is to seek Cabinet's approval of a Business Case that sets out how Plymouth City Council and Northern, Eastern and Western Devon CCG propose taking forward Integrated Community Health and Social Care Delivery, in line with the Health and Wellbeing Board's vision of achieving Integration by 2016.

Many users of health and social care services experience care that is fragmented, with services reflecting professional and institutional boundaries when it should be co-ordinated around their needs. This can result in duplication, inefficiency, gaps in care, feelings that 'no-one is in charge' and ultimately poor outcomes.

National policy and guidance sets a clear direction that the services of the future must be based on simple pathways of care and support, focusing on individual outcomes and quality of life indices.

With the customer requirements combined with key drivers such as the Better Care Fund, Care Closer to Home, NEW Devon CCG strategy and initiatives such as Admission Avoidance the emphasis in setting up the integrated function requires a significant focus on services based in the Community.

The current service configuration and existing working relationships provides an opportunity to transform the community system to support more people in their own homes and to prevent admissions to more acute forms of provision.

Based on the personalisation agenda in 2011 Adult Social Care transformed and reconfigured to enable individuals requiring support to have timely access to advice, information and customer centred assistance. By providing personal budgets, the department has offered greater choice and control to the citizens of Plymouth.

In September 2013, Adult Social Care worked in partnership with Plymouth Community Healthcare, Plymouth Hospitals Trust and the voluntary sector to develop an integrated service to facilitate timely discharges from hospital and prevent hospital admissions when appropriate.

These approaches to the delivery of support have received extremely positive feedback from members of the public, users of the services and referrers to the service. The offers use the same key principles placing the individual in the centre whilst wrapping support around them, ensuring they have choice in how their care and support is delivered.

It is anticipated that by identifying and developing further areas where an integrated approach to service delivery will be beneficial, citizens of Plymouth will have improved access to the right support, at the right time and by the right person. This will remove current duplication and support statutory services to meet the growing demand of complex health and social care need across the city.

What will this Project mean for Plymouth?

In 2014-15 we shall work towards achieving the following:

- An offer which places the person in the centre and arranges appropriate support when needed 24/7
- An emphasis on self-management and prevention including the use of assistive technology
- A reduction in bed based support and a shift to community assistance
- A single contact point for all incoming work
- An integrated IT system
- A shared set of documentation
- A reconfiguration and remodelling of community services to deliver wrap around care
- Significant engagement with Voluntary sector to develop improved pathways
- Development of an Integrated Delivery specification

What will local people see as a result?

- Widespread engagement in how services are designed
- More care delivered in the community
- Better access to condition management information
- Only needing to tell their story once
- Improved sharing of information to enable people to make their own choices
- Support from an well informed professional worker who can provide information or assistance at the time it is needed
- Opportunity to take a lead in the on-going shaping of services

The Brilliant Co-operative Council Corporate Plan 2013/14 - 2016/17:

The propositions made in this business case align to the Plymouth City Council Corporate Plan by working co-operatively to meet the objectives of creating a Caring and Pioneering Plymouth. It also aligns to the Health and Wellbeing Board's vision of achieving Integration by 2016, as decided in June 2013.

This project will support the Corporate Vision through:

- Being **pioneering** in developing and delivering quality, innovative brilliant services with our citizens and partners that make a real difference to the health and well- being of the residents of Plymouth through challenging economic times.
- **Growing** Plymouth through learning and community development creating opportunities for vulnerable people to develop, making us and them stronger and more confident as a result.
- Putting citizens at the heart of their communities and work with our partners to help us **care for Plymouth**. We will achieve this together by supporting communities, help them develop existing and new enterprises, redesign existing services which will in turn create new jobs, raise aspirations, improve health and educational outcomes and make the city a brilliant place to live, to work and create a future for all that reflects our guiding co-operative values.
- Raising aspirations, improving education, increasing economic growth and regeneration people will have increased **confidence in Plymouth**. With citizens, visitors and investors identifying us as a "vibrant, confident, pioneering, brilliant place to live and work" with an outstanding quality of life.

The Fairness Commission Recommendations:

This report will contribute to the response to the Fairness Commission recommendations scheduled for August 2014.

The Council 50 Pledges that the Delivery Project will address:

Caring Plymouth

44. Continue our pioneering work to make Plymouth a dementia friendly city.
45. Continue to work closely with the NHS to provide a seamless service for older people's care including smoother discharge from hospitals.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

Transformation resources will be required for the duration of the project. These should be internal where possible and so will rely on staff being temporarily released from other areas of the organisation.

Requirement for Corporate Support (Legal, HR, Finance, etc.) will need to be managed due to the current high volume of requests for their support.

Project costs should be fairly shared between CCG and PCC.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

The report strengthens our approach to both Child Poverty and Community Safety by focusing on early intervention and prevention and giving every child the best start to life. In line with our Co-operative commissioning principles the approach adopted aims to build both community and individual capacity. Children living in families affected by poverty will feel the benefit of improved family health and wellbeing which directly and indirectly affects economic stability and resilience.

This report will contribute to the response to the Fairness Commission recommendations scheduled for August 2014.

The project will follow the Risk Management Strategy set out for Transformation Programmes and Projects by the Portfolio Office.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? Yes

When considering this proposal it is important to have due regard to the public sector equalities duties imposed upon the Council by section 149 Equalities Act 2010 to

- Eliminate unlawful discrimination, harassment and victimisation and
- Advance equality of opportunity between people who share a protected characteristic from those who do not and to
- Foster good relations between people who share protected characteristics and others

The relevant protected characteristics for this purpose are: (a) age; (b) disability; (c) gender reassignment; (d) pregnancy and maternity; (e) race; (f) religion or belief; (g) sex; (h) sexual orientation.

Compliance with the duties in this section may involve treating some persons more favourably than others.

A programme wide detailed equality impact assessment has been completed and will be updated throughout the process.

Recommendations and Reasons for recommended action:

Public Services are facing challenges from rising demand, increased complexity and financial pressures. To address these concerns and improve outcomes for service users and patients, Plymouth City Council and NEW Devon CCG propose to integrate health and social care services.

The recommendations drawn from the analysis are:

1. Plymouth City Council to work with NEW Devon CCG to develop a Section 75 agreement that pools relevant Adult Social Care and CCG budgets to facilitate the creation of a single community health and social care delivery model
2. Plymouth City Council to work with NEW Devon CCG to develop robust governance, contractual and financial systems that provide appropriate assurance to both organisations
3. Plymouth City Council works with NEW Devon CCG and Plymouth Community Healthcare (PCH) as the incumbent local community health provider, on developing and evaluating options for the integration of Community Health and Adult Social service delivery in the City by April 2015.
4. To consult with staff, unions and stakeholders in developing the new service model.
5. The final position to be presented to Cabinet and NEW Devon CCG Governing Body in November 2014 for decision.

Alternative options considered and rejected:

1. *'Do Nothing'*

This option has been considered however this has been rejected due to the significant and time-critical budget pressures facing Plymouth City Council and NEW Devon CCG meaning that this option is not feasible.

2. *Delivery workforce remains in existing structures. Pathways for people requiring support are reviewed and streamlined. Budgets are re-profiled to follow individuals.*

And;

Delivery workforce is re-configured to sit with shared line management arrangements linked to individual pathways. Staffing budgets are aligned accordingly.

Agreement was made during the options appraisal process that these two options would not generate the customer benefit or financial savings that we are aspiring to achieve, and so were discounted as options.

3. *Delivery services' staff come together under single management with some provision budgets joined to support specific pathways.*
This option raised concerns regarding achievable benefits, which would only be achieved through pooling budgets, as in the recommended option.

Partners are committed to improving services and outcomes for individuals and communities and recognise that to achieve this, a commitment to achieving the largest scale of integration possible is required.

Published work / information:

Corporate Plan 2013/2014 – 2016/2017, Report to City Council, 22nd July 2013.
http://www.plymouth.gov.uk/mgInternet/documents/s48110/Corporate%20Plan%20Full20Council%2022.07.13.pdf

The Brilliant Cooperative Council Three Year Plan, Report to City Council, 16th September 2013.
http://www.plymouth.gov.uk/mgInternet/documents/s48110/Corporate%20Plan%20Full%20Council%2
022.07.13.pdf

The Brilliant Cooperative Council Three Year Plan, Report to Cooperative Scrutiny Board, 16th October 2013.
http://www.plymouth.gov.uk/modgov?modgovlink=http%3A%2F%2Fwww.plymouth.gov.uk%2FmgInten
et%2FieListDocuments.aspx%3FCId%3D1071%26amp%3BMId%3D5544%26amp%3BVer%3D4

Transformation Programme, Report to Cabinet 25th March 2014, including the IHWB Outline Business Case.
http://www.plymouth.gov.uk/mgInternet/documents/s53610/transformation%20cabinet%20march%222014%20final%20MCv1%202.pdf

Health and Wellbeing Strategy, Published by Plymouth City Council, February 2014
http://www.plymouth.gov.uk/healthwellbeingstrategy.pdf

Co-operative Commissioning Framework, Published by Plymouth City Council
http://www.plymouth.gov.uk/cooperative_commissioning.pdf

NHS NEW Devon CCG Five-year Strategic Plan (draft), 4 April 2014

http://www.newdevonccg.nhs.uk/who-we-are/what-is-clinical-commissioning/commissioning-framework/100925

NHS NEW Devon CCG – Community services: a strategic framework (draft) - http://www.newdevonccg.nhs.uk/involve/community-services/101039

Your health, your future, your say – Western Locality's engagement report on Transforming Community Services
http://www.newdevonccg.nhs.uk/permanent-link/?rid=101537

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
Equality Impact Assessment	x								

Sign off:

Fin	mc14 15.20	Leg	It20 617/ 2/03 /07/ 14	Mon Off	DV S/2 07 08	HR	HR-CS2 5.6. 14.	Assets	Dt1 415. 02	IT	Dt 14 15. 02	Strat Proc	Dt1 415. 02
Originating SMT Member: Dave Simpkins (Assistant Director of Adult Social Care and Co-operative Commissioning)													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

Integrated Health and Wellbeing

Business Case

Project Name:	**Integrated Community Health and Social Care Delivery**		
Date:	18-06-2014	**Version:**	2.0
Author:	Paul Walshe, Anna Coles, Dave Simpkins, Nicola Jones, Craig Williams, Mark Appleby		
Owner (SRO):	Jerry Clough/Carole Burgoyne		

Version	Date	Summary of Changes	Changes Marked
V2.0	04/07/2014	Final Version	CW

Approvals				
Name:	**Title**	**Signature**	**Date**	**Version**
Mark Appleby	Business Architect	Email	03/07/14	V2.0
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Hugh Van Wijk	Head of Business Architecture	Email	03/07/14	V2.0
Carole Burgoyne	Strategic Director of People	Email	03/07/14	V2.0
Cllr Tuffin	St Peter & Waterfront Ward	Scrutiny	04/07/14	V2.0
Jerry Clough	Managing Director, Western Locality, NEW Devon CCG	Email	04/07/14	V2.0

This document has been distributed to:

Distribution			
Name	**Title**	**Date**	**Version**

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An introduction to the Plymouth City Council's Transformation Programme and NEW Devon CCG Transforming Community Services Strategy

Context:

2002-12: A Decade of Improvement

The City of Plymouth has had an extra-ordinary journey over the past ten years. A decade ago, it had a reputation as a city of low aspiration with a lack of vision, weak financial and strategic planning, poor relationships between agencies, and service delivery arrangements that did not meet the needs of all of its citizens. An acknowledgement of the determined and sometimes inspired effort that was then made to improve the city came in 2010 when the Council was voted 'Highest Achieving Council of the Year' by the Municipal Journal. Behind that accolade, foundations had been laid by successive political administrations of a clear, ambitious vision for the city, sound financial management arrangements, the development of strong strategic partnerships and a determined focus on the improvement of service delivery. The Council has acknowledged and embraced its role as a key player in influencing the broader city and regional agenda, driving economic growth and making coherent contributions to broader policy-making.

Drivers for Transformation:

The Brilliant Co-operative Council with less resources

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

The Corporate Plan was developed using the principles of a Co-operative Council. It is a short and focused document, but does not compromise on its evidence base, and was co-developed with the Cabinet of the Council, before being presented in person by members of the Corporate Management Team to every member of staff throughout the council at a series of 74 roadshows. The positive results of this commitment to strong communications and engagement were evidenced by 81% of council staff responding to the workplace survey conducted in October 2013 agreeing that they understand and support the values and objectives set out in the Corporate Plan.

The economic, demographic and policy environment affecting public

services is accepted as the most challenging in a generation. At the same time as an aging population is placing increased demand on health and social care services, the UK is facing the longest, deepest and most sustained period of cuts to public services spending at least since World War II. The Council's Medium Term Financial plan identified in June 2013 funding cuts of £33million over the next three years which, when added to essential spend on service delivery amount to an estimated funding shortfall of circa £64.5million from 2014/15 to 2016/17, representing 30% of the Council's overall net revenue budget.

The Council has shown remarkable resilience in addressing reduced funding and increased demand in previous years, removing circa £30m of net revenue spend from 2011/12 to 2013/4 through proactive management and careful planning. However the Council has acknowledged that addressing further savings of the magnitude described above while delivering the ambitions of the Corporate Plan will require a radical change of approach.

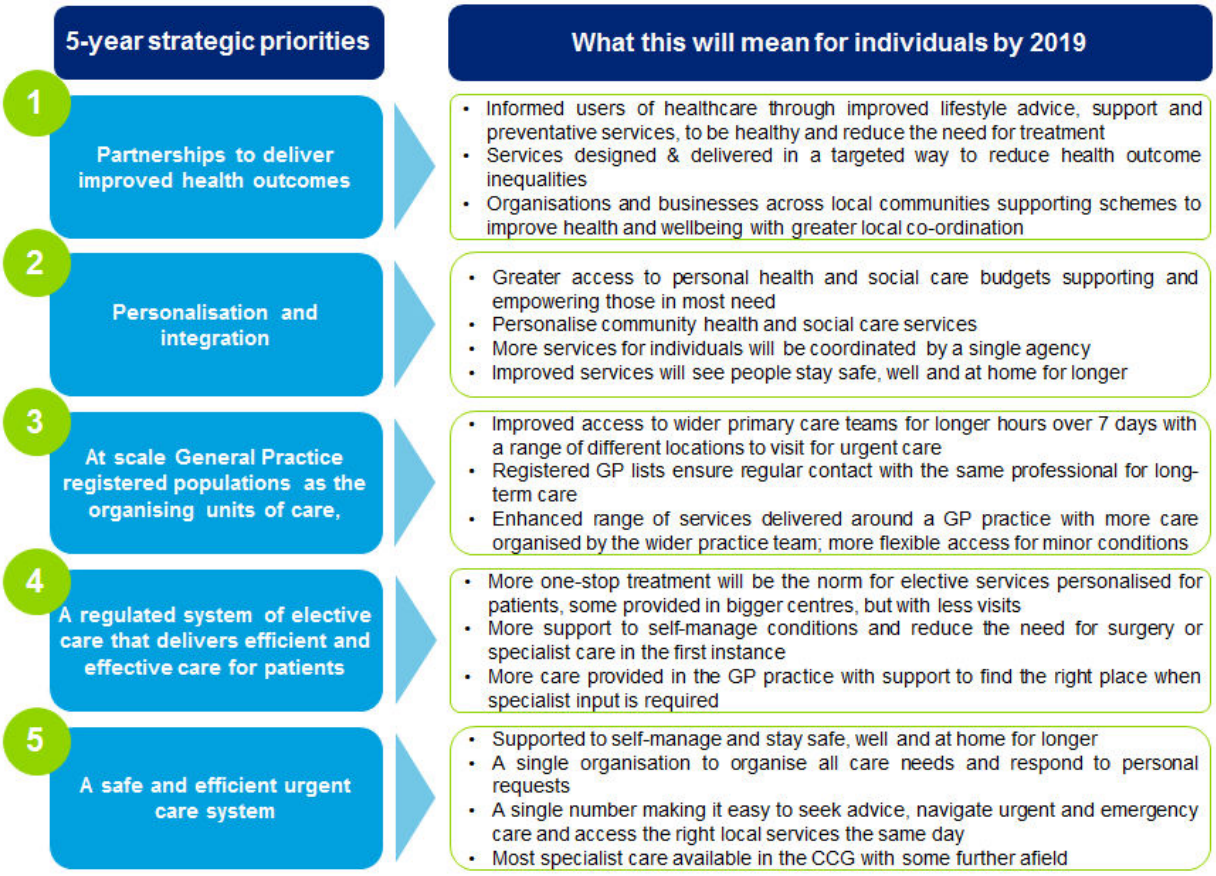
Transforming Community Services:

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 transforming communities consultation which has gathered feedback from people who use services and they described that they wanted 'Health care that does not stop at boundaries', services that see me as a person, not a condition', and 'safe and secure services with future proofing in mind'. This engagement has resulted in the establishment of the key priorities which are reflected in NEW Devon CCG's community services strategy (in draft). This features six key priorities – helping people to stay well, integrating care, personalising support, co-ordinating pathways, thinking carer and family and home as the first choice.

NEW Devon CCG' five year NEW Devon CCG's draft five year strategy features key principles as described below(draft):

The draft strategic priorities for the NEW Devon CCG are summarised below:



Review of existing transformation programmes

The Council commissioned Ernst and Young in June 2013 to:

- Examine the Council's financial projections and provide expert external validation of our assumptions about costs and income in the medium term
- Review the Council's existing transformation programmes and provide a view as to whether they will deliver against the Corporate Plan
- Provide advice as to how the council might achieve the maximum possible benefit through a revised approach to transformation

Ernst and Young validated the Council's current Medium Term Financial Plan based on projections and assumptions jointly agreed, and judged it to be robust, taking into account the complex financial landscape and changing government policy.

The council has initiated a number of far-reaching and ambitious change programmes over 2012-13 to address the twin aims of addressing financial constraints and improving service delivery. These include:

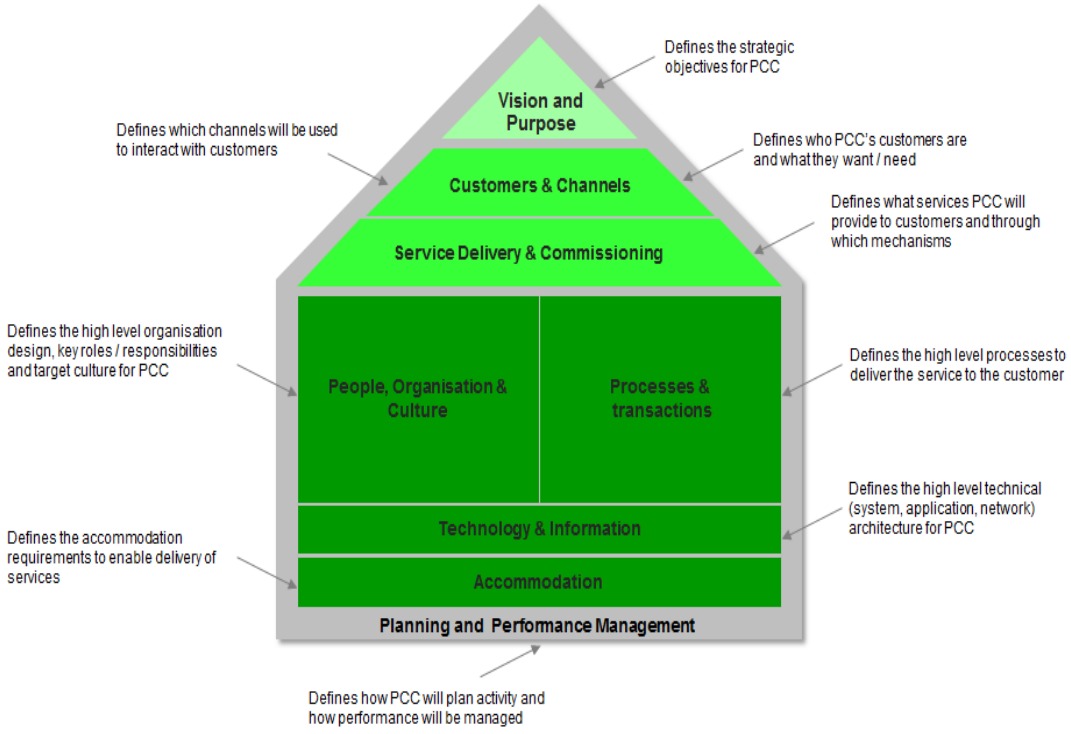
- Investment in Customer Transformation and Core ICT infrastructure (Cabinet approval September 2012)
- ICT Shared Services: DELT (Cabinet approval October 2013)
- Redevelopment of the Civic Centre and future accommodation requirements (Cabinet approval September 2013)
- Modernising Adult Social Care Provision (Cabinet approval January and August 2013)
- Co-location with Clinical Commissioning Group at Windsor House (Cabinet approval January 2013)

In addition to feedback and advice about individual programmes, the Council received advice that has been carefully considered, and which has informed the overall design of the Transformation Programme and the content of the business cases for the five programmes.

Vision and Direction: The Blueprint

The Council has responded to concerns that, despite strong support for the Corporate Plan from both officers and members, there was a lack of clarity about how the Corporate Plan translates into practical action and a danger that the council might be attempting to 'do the right things, but in the wrong way'. After significant consultation with Members and over 100

staff from all levels and disciplines within the organisation, the Council's vision for the Brilliant Co-operative Council has been translated into a Blueprint which describes the capabilities which the Council will need in the future. These capabilities will be commissioned by the council and will result in services being delivered by the Council and a variety of other organisations operating across the public, community and voluntary and private sectors. The components of the Blueprint are illustrated below:



To inform the development of the main components of the Blueprint, a number of principles have been developed co-operatively with Members, senior officers and staff to ensure that the values set out in the Corporate Plan guide how the Blueprint is developed.

There are 5 programmes to deliver the transformation:

Customer and Service Transformation: This programme will transform the way the council interacts with customers to meet their demands and preferences, and transform the services that the Council decides to retain in-house.

Co-operative Centre of Operations: Creating the business as usual strategic 'centre' for the Council, which uses the co-operative principles and intelligence to co-ordinate organisational decision making and activity.

Integrated Health and Well Being: The Council can engage with partners to deliver services at a lower cost, whilst also improving outcomes and customer satisfaction. The aim of

the programme is to achieve "One system, one budget to deliver integrated, personal and sustainable care".

People and Organisational Development: The programme will enable the Council to define and deliver the required workforce and accommodation capability change.

The **Growth, Assets and Municipal Enterprise** programme has been developed to:

- Contribute to the growth of the City and the move towards a brilliant co-operative council.
- Generate and accelerate additional income for Plymouth City Council from economic and housing growth across the Council
- Create a brilliant co-operative street service which will :
    - Make operational changes to enhance service delivery
    - Provide evidence to design and deliver new service delivery models
    - Identify and deliver new opportunities for commercialism, new income streams
- Realise opportunities to bring in additional income from the commercialisation and increased trading of services.

1. BACKGROUND AND OPPORTUNITY

1.1Background and Context

NEW Devon CCG is the largest in the country, serving a total population of 898,523. As we look ahead we are focussed on ensuring that our existing services providers develop joined up services which are sustainable to address our future demands across the Health and Social Care system. Through engagement with local people via the Transforming Community Services agenda, the need to ensure that community services are integrated and person centred is paramount. National policy and guidance sets a clear direction that the services of the future must be based on simple pathways of care and support, focusing on individual outcomes and quality of life indices. It is imperative that any new service delivery model can demonstrate how to support individuals to self-manage their health and social care needs with greater awareness of the voluntary sector, better use of assistive technology and an increased emphasis on education programmes and empowerment. In order to achieve this ambition, the role of statutory community services cannot be considered in isolation since the functions currently delivered by acute and specialist health care, voluntary agencies and general practice are co-determinant to improving health and wellbeing.

The draft strategic framework developed through transforming community services engagement will be used to describe the priority areas for a future integrated delivery vehicle.

These priorities are:

- Help people to stay well
- Integrate care
- Personalised support
- Coordinate pathways
- Think carer, think family
- Home as the first choice

PCC and NEW Devon CCG are facing significant financial challenges coupled with rising demand for services. The Integrated delivery project will establish a more integrated, strategic approach to how the organisation deliver services with the aim of ensuring excellent people experiences, improving outcomes for residents in Plymouth and reducing costs. This approach fits with PCC's ambition of being a co-operative council; the CCG's vision of 'Healthy People Living Healthy Lives in Healthy Communities'; Plymouth Community Healthcare's vision of 'Safe, Well and at Home', and Health & Wellbeing Board's vision of 'Healthy, Happy, Aspiring Communities'.

1.2 Overview of Existing Situation

Many users of health and social care services experience care that is fragmented, with services reflecting professional and institutional boundaries when it should be co-ordinated around their needs. This can result in duplication, inefficiency, gaps in care, feelings that 'no-one is in charge' and ultimately poor outcomes.

The current configuration of the statutory provider market in Plymouth provides an opportunity to specify how the one acute trust, one community health provider and unitary adult social care department deliver joined up services, with shared outcomes in the future.

The personalisation agenda acted as a catalyst to bring about significant changes to how the adult social care service delivered community care assessments and support plans. Traditionally these had been undertaken after a significant waiting time and resulted in the provision of a service led response. Through extensive remodelling the service now delivers its statutory functions via a single contact point, which affords callers timely access to social workers and occupational therapists who can provide advice and information, undertake assessments of risk, engage with partner agencies and arrange rapid support if required. The development of personal budgets for individuals who are eligible for financial assistance has enabled staff to work alongside individuals to develop holistic plans to meet needs, harnessing the wider community infrastructure in terms of voluntary agencies, families, friends as well as statutory services. This flexible approach has empowered individuals to have greater choice and control over how their care is arranged.

The Integrated Delivery Project will build upon the ASC Transformation and Care Co-ordination (CCT) approach. The new intermediate care service (CCT) was launched in September 2013. In this team staff from community healthcare and social services work alongside each other wrapping support around individuals at time of crisis or to expedite hospital admissions. Working from a single access point, the team have adopted the same values and principles as the ASC teams, focusing on putting the person at the heart of the care planning process, linking with existing support systems, ensuring wherever possible that individuals only need to describe their needs once. Both services have been subject to evaluations; feedback from people who have worked with the teams or been supported by them has been extremely positive and on this basis it is intended that the Integrated Delivery project will expect providers to utilise these existing platforms to develop a wider offer across all health and social care services; providing the right care at the right time in the right place. It is expected that whilst emphasis will be placed on those who would benefit most from person centred care, such as intensive users of services and those who cross organisational boundaries, organisations will assist in achieving the required shift from crisis to preventative support services.

Section 75 partnership agreements, legally provided by the NHS Act 2006, allow budgets to be pooled between health organisations and local authorities. It is anticipated that this arrangement will be used to allow for the transfer of staff and budgets. The future provider will then be contracted to deliver statutory functions in terms of community care assessments and to deliver an integrated response to other individuals across the city for examples those with long term conditions, end of life support needs and those requiring therapy support.

1.3 Opportunities and Outcomes

PCC, the Western Locality of the NEW Devon CCG and Community partners propose development of an integrated model for the delivery of services for the City of Plymouth. This vision has been endorsed at the Plymouth Health and Wellbeing Board as an agreed work stream as a priority for 2014.

In order to promote integrated whole person care that improves outcomes it is recognised that an integrated approach to commissioning is a pre-requisite with commissioners being required to develop “one system, one budget”. There are already strong relationships between the CCG and PCC which can act as a solid foundation to support closer integration, through the development of a specification describing outcomes to be delivered by a joined up health and social care service.

These outcomes will serve to address the Better Care Fund requirements but also ensure that the delivery vehicle is able to respond to changing needs and demands across the system. Whilst the development of this specification will enable the providers to develop detailed plans of how best to configure their approach to respond to individual needs across the city it is anticipated that savings will be made through having shared management, systems, overheads, and via a reduction in duplication of effort. These areas will ensure an approach which delivers for now and the future.

The project creates a significant opportunity to fundamentally redesign how community services look in the future but with the current unsustainable pressures it is imperative that it achieves:

- An offer which places the person in the centre and arranges appropriate support when needed
- An emphasis on self-management including the use of assistive technology
- A reduction in bed based support and a shift to community assistance
- A single contact point for all incoming work
- It must be available 24/7 to offer assistance when a crisis occurs
- It will have an integrated IT system that delivers a single individual assessment which is accessible for primary and secondary care, the ambulance service and voluntary sector. It will allow people to describe their needs once and then using a unique identifier (NHS number) this can be shared.
- A workforce which is remodelled to ensure the right skills are in the right place, this will include significant investment in workforce development to increase generic skills, thus minimising duplication of effort.

What will local people see as a result?

- Widespread engagement in how services are designed
- More care delivered in the community
- Better access to condition management information
- Only needing to tell their story once
- Improved sharing of information to enable people to make their own choices
- Support from an well informed professional worker who can provide information or assistance at the time it is needed
- Opportunity to take a lead in the on-going shaping of services

The following 'I statements' have been developed nationally and approved by the Plymouth Health & Wellbeing Board, they describe the desired outcomes which people who use integrated health and wellbeing services will experience:

More than a condition

"I want services that support me to manage my situation in life not just my condition"

Existing services

"I want the services I value now to be strengthened"

Transport

"I want to be able to get to the services in my community"

Service Opening times

"I want to be able to get to my community services at times that are convenient for me"

Carers

"I want what my carer does to be recognised and for them to have the support they need to have a full, healthy life of their own"

Educate and inform

"I want the information I need to make healthy choices and stay healthy"

Work with others

"I want to be able to have services provided in lots of different places not just health centres"

Communication

"I want to be able to talk to healthcare providers when I need to."

Talk to each other

"I want to tell my story once - share my information with colleagues"


Technology

"I want to be able to use new technology to help me manage my own health"


The voluntary sector

"I want to continue to get the services I value that are provided by the voluntary sector"

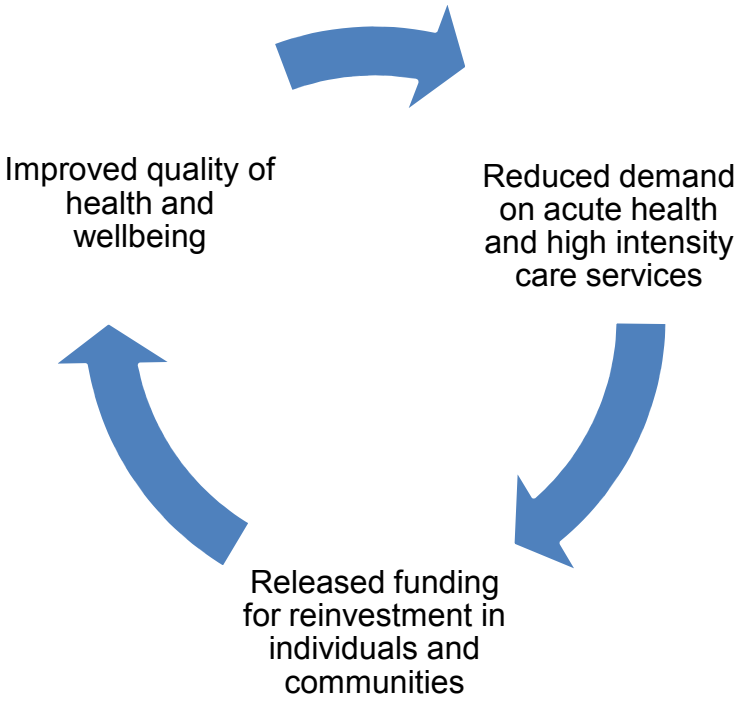
Boundaries

"I want a health care service that doesn't stop at the boundaries"

The overall outcome of the Integrated Health & Social Service Delivery Project will be alternative delivery models for health and social care services, and to facilitate the development of an integrated health and social care economy within Plymouth.

The results of this will be:

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



So what will it look like?

Scenario 1

Mrs X has respiratory disease and with her Long Term Condition (LTC) matron has developed a usual plan of care which describes how she manages her condition and the care she receives in the community. She also has a crisis care plan in the event that she becomes unwell.

As she becomes unwell she contacts the LTC matron who liaises with the single access point who are able to share information about existing support services and arrange for a temporary increase in care. The LTC matron retains the co-ordination, liaison with primary care and is responsible for reducing the care when Mrs X stabilises.

Therefore in this scenario the LTC Matron is providing the clinical support and the centralised team provide access to advice, information and short term reablement support.

Scenario 2

June a homecare worker attends Mrs A at her normal time. Mrs A appears listless and unwell, June contacts the GP. The GP is unable to attend immediately but rather than advising her to call the ambulance he asks June to contact the centralised service for an assessment. The rapid team arrange to visit Mrs A and complete an assessment, arranging support to assist her through this short term illness.

The GP retains clinical responsibility for Mrs A and visits later that day to prescribe a short term course of antibiotics. Once Mrs A has stabilised the additional care is stepped down but the support worker assists Mrs A to develop a contingency plan for the future, the draws together information about her family, friends and neighbours who support her.

2. PROJECT CATEGORISATION/STRATEGIC FIT

2.1 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. PCC and NEW Devon CCG are looking to seize the opportunity created by sector wide reform, to create a vision for integrated delivery 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.

2.2 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.

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.

Recent winters have seen significant pressure on Derriford Hospital. 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.

NEW Devon CCG is the largest CCG in the country, spanning 2,330 square miles and serving a population of almost 900,000 people. It spends £1.1bn each year commissioning services on behalf of that population. This equates to approximately £1,220 per resident.

The CCG commissions services across a complicated footprint. It is a membership organisation of 126 GP practices, spans three acute trusts, two local authorities, two organisations providing mental health services, and is part of a broader specialised commissioning footprint that spans the peninsula. As a result, it has huge volumes of change to deliver. Given the size of the CCG and its current locality focus, strategic planning is especially challenging because it has to be carried out simultaneously at several different levels

Therefore of key concern for both organisations is the on-going sustainability of the services, outcomes for individuals and communities 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.

Health & Wellbeing Strategy

The Health and Wellbeing Board's aim is to "promote the health and wellbeing of all citizens in the City of Plymouth". The vision "Happy, Healthy, Aspiring Communities".

The Health and Wellbeing Board has set out a core programme to promote integration of Health and Social Care delivery. The focus is 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.

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.

PCC Transformation Programme

Although PCC's adult social care service has gone through a major transformation, it has not integrated with health provision to ensure services are wrapped around customer. By removing duplication, profiling existing and future demand, developing a culture of trust between various professional groups, it is clear that service delivery can develop further to best address the needs of the population of Plymouth.

The development of joined up services will be one mechanism to address the significant funding gap across health and social care services which early indications suggest has the potential to further increase over the next three years without significant intervention.

2.3 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 out-dated 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.

Below details a number of national drivers for integration;

- **Health & 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 (improved collaboration, partnership working and integration).
- **The Care Act**; aims to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. The Bill makes it clear that this refers to housing, health and social care delivery/commissioning and not just health and social care.
- **The Better Care Fund**; creates a substantial ring-fenced budget for investment in out-of-hospital care to target a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge.
- **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.

- **Public Health Outcomes Framework 2013-1016**; aims to address two key outcomes: Increased healthy life expectancy and 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 using a whole system approach.
- **Adult Social Care Outcomes Framework (ASCOF)**; used to demonstrate the achievements and strengths of adult social care in delivering better outcomes through describing a set of outcome measures.
- **NHS Outcomes Framework 2014/15 (NHSOF)**; describes a set of outcome measures to highlight risks and report success.
- **NHS Call to Action**; 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.
- **Closing the NHS Funding Gap**; This report details ways in which NHS commissioners and providers may close the anticipated funding gap in the NHS (by improving productivity of existing services, delivering the right care in the right setting, developing new ways of delivering care and allocating spending more rationally).
- **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.

In response to 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. PROJECT SCOPE

3.1 Integrating Delivery

The project will facilitate the development of an integrated health and social care system within Plymouth. This will be achieved through the development of a commissioning specification that sets out the delivery of key outcomes and targets.

The commissioning specification will be based on the clear "customer" requirements recorded in the work carried out by NEW Devon CCG's initiative Transforming Community Services. The diagram below providing examples of the services that customers expect.

The outline business case stated that this workstream should, "*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*".

With the customer requirements combined with key drivers such as the Better Care Fund, Care Closer to Home, NEW Devon CCG strategy and initiatives such as Admission Avoidance the emphasis in setting up the integrated function requires a significant focus on services based in the Community.

Services in scope

The PCC services impacted by this project are those within the Adult Social Care part of the People Directorate. The specific teams that are to be considered for this transformation are:

- Social Care Assessment and Support Planning Service, including Social Workers, Occupational Therapists and Community Care Workers
- The services in scope of the project are those available in the community including District Nursing, Long Term Condition Management, Intermediate Care, Therapy Services, Continence services, Falls Provision. (Note: This is list is not exhaustive and it is anticipated that through the redesign process other services may achieve efficiencies once the points of duplication are removed.)

To develop and deliver a community based approach requires the following:

Business Analysis and Design

- capturing of existing demand data and access points for referrals
- the identification of areas of duplication
- the evaluation of existing workforce,
- the completion of skills gap analysis
- the development of workforce development plans
- the reconfiguring of existing teams
- the redesign of the IT infrastructure and performance reporting
- the development of the Section 75 arrangements, the development of the appropriate governance arrangements to ensure robust procedures to manage areas which are not delegated.

3.2 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, however consideration will be required to ensure detailed pathways for individuals moving through transitions are in place.

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 delivery. It is anticipated that these key stakeholders will have an active role in the redesign of community. The scope may be widened to directly include these services if a change in commissioning responsibilities for these (e.g. co-commissioning of primary care with NHS England) takes place within the timescale of this programme.

4. OPTIONS APPRAISAL

4.1 Overview of Options

Integrating Health and Social Care service delivery is a complex activity and results in a number of options. The business case has previously discussed horizontal versus vertical integration

4.2 Community Service Delivery or Acute Service Delivery

In developing the project, two options were considered:

- Integration with Community Provider – PCH (Horizontal integration)
- Integration with Acute Provider – Derriford Hospital (Vertical integration)

During the options workshop (see Section 4 below), significant consideration was made in relation to the adoption of a horizontal (Community based) or vertical (Acute) model of integration. NEW Devon CCG's preferred option following the Transforming Community Services engagement is for horizontal integration in the Western Locality.

With health, public health, primary, community health and social care all moving towards an outcome focused approach, they can design and develop pathways which prevent crisis, minimise delays and meet increasing demands. This can be done best from the person's own home.

It was acknowledged the provision of bed based acute care is expensive and delivers poor outcomes for many individuals, particularly older people who experience lengthy hospital admissions. In order to address this challenge services need to be configured close to people's home, supporting individuals at the onset of their needs through prevention and early intervention, it was agreed that a horizontal approach who best achieve this. The historical approach of uncoordinated multiple assessments by health and social care not only leads to duplication but creates delay in provision of support, often tipping individuals into secondary care arrangements where the outcomes are frequently poor as pathways and transfers are unreliable at best.

4.3 Community Based Approach

The agreed approach to be taken with service delivery is to horizontally integrate with the community based health provider. This will deliver the best whole system approach to joined up care, since creates flexibility and enables a range of services to be brought together to wrap around individuals. The option of vertical integration was discounted as the preferred choice since it was unlikely to achieve the community focussed outcomes described through the Transforming Community Services consultation.

The current community services provider is Plymouth Community Healthcare (PCH). The community services are mainly commissioned by NEW Devon CCG. A further option appraisal was undertaken to determine the level of integration with PCH (see Section 4 below).

4.4 Extent of Integration

Having determined that the current priority for Plymouth is to integrate service delivery in the community, the next option appraisal undertaken was determine the degree of integration to be undertaken.

The table below describes the four levels of potential integration from minimal (option 1) to maximum (option 4).

Option	Description
1	Delivery workforce remains in existing structures. Pathways for people requiring support are reviewed and streamlined. Budgets are re-profiled to follow individuals
2	Delivery workforce is re-configured to sit with shared line management arrangements linked to individual pathways. Staffing budgets are aligned accordingly
3	Delivery services staff come together under single management with some provision budgets joined to support specific pathways
4	Delivery services staff come together under single management structure. Budgets across the system are transferred to delivery service

These options have been appraised through workshops with the Programme Board and an options workshop with key stakeholders from PCC, NEW Devon CCG and PCH.

In that workshop members were provided with a matrix detailing the 4 options with a list of factors to consider (a copy of the matrix can be found in Appendix).

These topics were discussed and the highlights were as follows:

- Agreement was made that the first two options would not generate the customer benefit or financial savings that we are aspiring to achieve, and so were discounted as options.
- Option 3 raised concerns regarding achievable benefits, which would only be achieved through pooling budgets in option 4.
- Consistencies between options were identified, such as strategic and operational oversight of budgets and associated costs.
- Operationally option 4 would place more focus on the individual, provided opportunities and scope for staff. For consideration; working hours, recruitment processes, TUPE, the impact of the care bill, pay scales and early communications.
- Discussions centred on creating a delivery vehicle/partnership versus TUPE. It was agreed that TUPE would be preferable and for adult social care to be delivered via PCH and governed through a commissioning structure. This will be influenced by the commissioning outcome. Councillors would require represented on the board to monitor the Local Authority statutory responsibilities and have direct access to address any constituent issues. Discussion continued around the roles and responsibilities of the ASC Director role and how this is monitored and possibly a strategic lead to have oversight of budgets, quality and performance. Option 4 is the logical place to go with any further work.

- Discussions made to create savings through mapping across work streams, to review lessons learnt from others and not repeat.
- SystmOne or the new system and how this could be promoted to GPS and the existing localities and structures against a citywide model of operation and how this will need to be teased out along with the vision of what the future organisation will look like.
- Discussions around commissioning and what this means. Point added that this would need further discussions around local authority responsibilities and how they could be delivered.

4.5 Recommended Option

Option 4 above received the greatest level of support as an accepted model of co-design. This will establish a single integrated provider of community health and social care.

The delivery of an integrated system will have a positive impact ensuring people feel more confident to manage their condition and ensure that risk stratification is used to identify those at highest risk. This approach needs to be developed within the community, preventing acute admissions but also pulling people out and ensuring timely access to support services.

The current community providers propose to develop options to horizontally integrate in order to meet the desired outcomes. This is supported by the Transforming Community Services agenda, the Better Care Fund requirements and members of the community. Business Architecture support will be required in how two disparate systems come together so we can achieve the outcomes that our customers require of a single approach assessment and planning of care and subsequent storing and sharing of information. Work has started to develop a blueprint for a technology solution to support this.

To further explore option 4, the following operational models have been considered for a preferred model to be used to deliver a single integrated provider:

Description	Benefits	Risks
Providers come together (legal construct unspecified) into a single entity	• Fully integrated processes for finance, performance management and governance • Full integration/ centralisation of back office and business functions (HR, IT, medical records and assessment) • Legally binding arrangement, restricting opportunities for entry /exit • Integrated budget avoids cost shunting • Seamless organisation from patient perspective • Staff within one organisation • Opportunity to create single organisational culture, vision and strategy • 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 • Increased risk on a single provider, posing a threat to local economy and required savings • Divestment – may lose core areas of provision to integrating organisation • Regulation (transitional) – meeting service standards during protracted period of integration.

Providers come together (legal construct unspecified) but not into a single entity	• Shared commitment to common vision and goals • Separate statutory bodies – retain autonomy and identity • Finance, performance and governance arrangements stabilised by e.g. S75, SLA • Multiplicity – simplified partnership arrangements, with lower barriers to entry, mean opportunities for integration with a greater number/ range of partners • No staff transfer – continuity of pensions and job specifications, and avoidance of TUPE liability • 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 • Continuation of operational status quo – i.e. executive sponsorship but partner organisations view themselves as separate and distinct • Planning of which organisational departments will integrate, and organisational management of integration process is both time consuming and has additional costs associated
Accountable lead provider model	• Centralised governance and management • Single point of responsibility to improve care and deliver better outcomes and better health • Incentives to invest in 'upstream' disease prevention and health promotion as well as diagnosis/treatment • Promotes 'make or buy' decisions, hence creating opportunities to align clinicians across traditional boundaries and to encourage clinical collaboration • Greater incentive and freedom to innovate • Stronger accountability for patient-oriented outcomes • Commissioning of individual services shifts from commissioner to lead provider hence giving the principal provider greater autonomy and lower resource requirement for the commissioner to manage contracts • 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	• Require extensive reconfiguration of services, contracts and payment mechanisms , especially for the lead provider and therefore has its own cost and risk implications • Increased financial risk on lead provider • Risk of creating new silos centred on conditions and diseases in place of existing silos • Staffing transition costs and implications where lead provider chooses to 'make' the service – potential TUPE

It is recognised that following the options appraisal undertaken so far, further work will be required between NEW Devon CCG and PCC as the commissioners further develop the options and evaluation of the preferred delivery model. This will be co-developed with PCH as the incumbent community based provider and PCC (Adult Social Care). Once a preferred option has been developed it will be subject to due diligence and governance approval and this will be presented to Cabinet and NEW Devon CCG Governing Body for final agreement in November 2014.

Extensive legal input will be required during the next phase of the project.

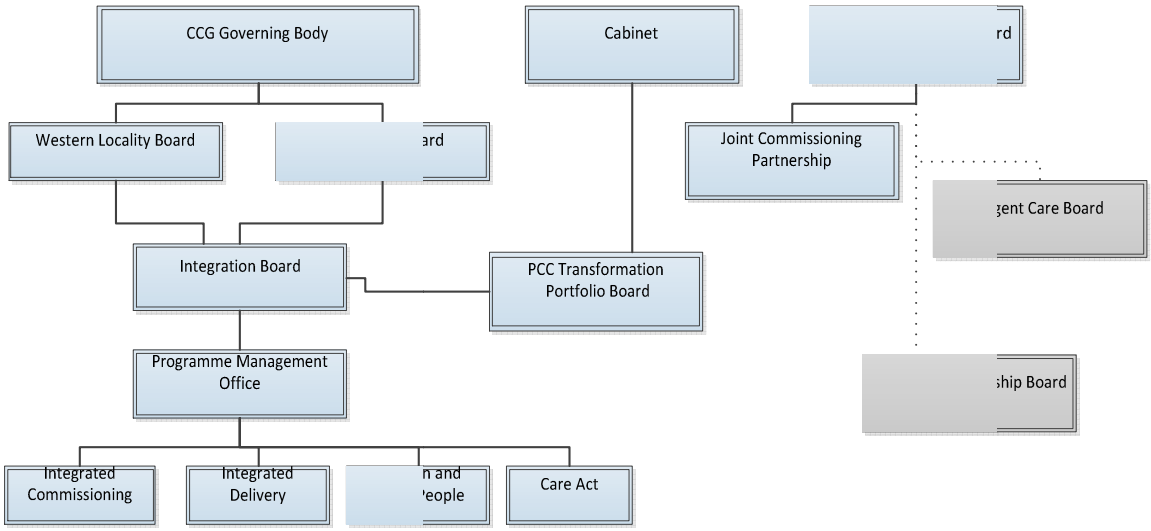
Transformation Portfolio Assurance and Enterprise Architecture

Formal sign off to the project will be granted in November 2014 following detailed design and project plan development.

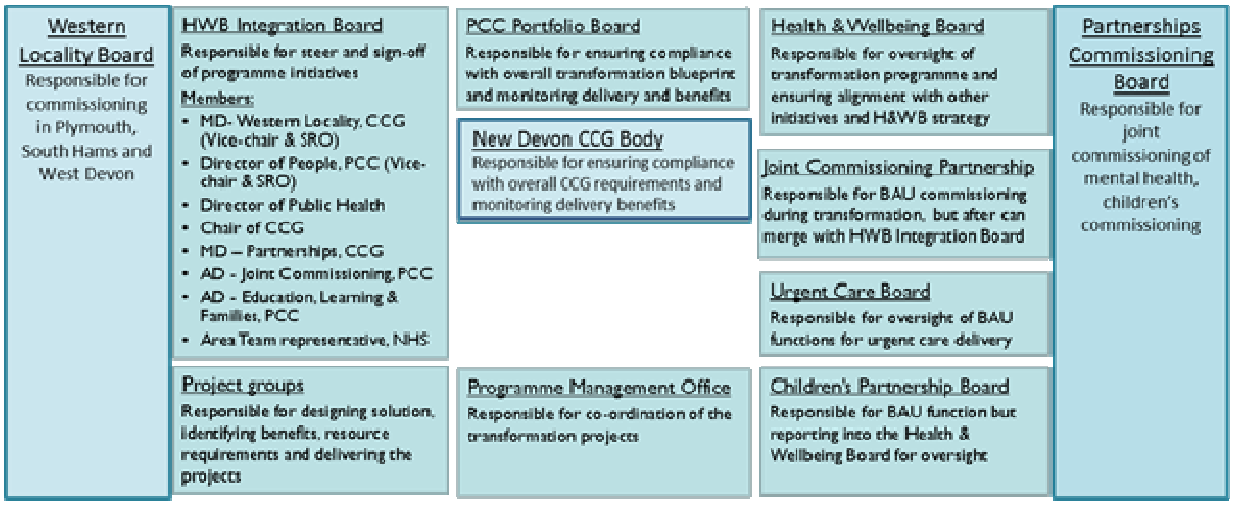
5. PROJECT APPROACH

5.1 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:



Proposed Governance & Structure

Senior Responsible Officer: Carole Burgoyne (Plymouth City Council), Jerry Clough (NEW Devon CCG)

Project Executive: Dave Simpkins, Nicola Jones, Michelle Thomas

Chair of Delivery Board: Steve Waite

Programme Manager: Craig Williams

Project Manager: Anna Coles (Lead), Paul Walshe, Lee Grant, Jacqui Wagner

Project Support: Jenni Doudoulakis

Finance: Paul Hardwick, Helen Foote, Dan O'Toole, Ben Chilcott

Business Architect: Mark Appleby

Communications: Nicola Morgan, Sam Sposito

Business Change: Lisa Woodman

Legal: Linda Torney

HR: Emma Rose

5.2 Governance arrangements:

The development of a Section 75 arrangement between the Local Authority and CCG will enable the establishment of a single health and social care community, with the contract then being jointly managed via the Integrated Commissioning Hub. This will be evaluated and presented back to PCC and NEW Devon CCG for final approval.

A detailed target operating model covering governance, staffing, finance, operational systems, funding and contracting will need to be developed in partnership with the proposed provider.

Staff Engagement and Development

The integrated service delivery project will continue to build on the existing ASC transformed service model and the CCT model to engage with users of services, stakeholders and staff currently delivering services to co-design the future operational model.

In order to support the new integrated model of service delivery there will be a requirement that the delivery workforce is remodelled to support the new operational framework. The intention is that staff are aligned in a way that ensures the right skills are in the right place to achieve this.

The current delivery offer structure consists of Plymouth City Council Adult Social Care's 167 individuals (149.24 FTE) not including vacancies. This is split across a range of professional, semi-professional, clerical and management staff.

The new operating model will be co-designed with current and future users of services along with frontline staff who will be affected by the changes.

As part of the operational design process work that will take place there will be an emphasis on identifying areas of duplication and cross over removing these to maximise efficiencies throughout the process. Once the redesign work is complete then the project will progress to consultation stage with staff.

6. Communication Approach

A Communications Plan for the Project and Programme has been developed jointly by The CCG and PCC. This will form the basis of the overarching communication strategy for this project, which will be continuously developed. Key activities in relation to this project include:

- Briefings and workshops with Members, GPs, Delivery Providers
- Communication Sessions, with Staff, Stakeholders and Partners
- Co-design workshops with current and future users of services
- Co-design workshops with frontline staff
- Co-design sessions with voluntary sector
- Regular written and face to face briefings

7. High Level "Stage" Plan

Activity	Timeframe
Review of access points across the Health and Social Care system to understand current demands, potential points for join up and facilitate future demand trend analysis	End of July 2014
Review of existing team configurations, locations and assessment frameworks to identify points of potential duplication and areas of efficiency for integration	End of July 2014
Arrange staff workshops to shape workstreams (such as IT, accommodation) to identify duplication, develop best practice and redesign pathways.	End of September 2014
Consultation and Engagement with staff and partners to support remodelling work	End of July 2014
Develop New Integrated delivery governance architecture	End of August 2014
Design function and form of new Organisation	End of September 2014
Plymouth City Council Cabinet and CCG Governing Body	11th November 2014
Staff consultation	Beginning of October 2014
Due diligence process	Beginning of November 2014
PCH / CCG contract update	Beginning of November 2014
Develop Section 75 agreement	End of November 2014
New Integrated delivery structure in place	End of April 2015

7.1 Activity Management:

Activity will be managed through a project management office and underpinned by a number of enabling workstreams:

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 target areas and assumptions	Agreed parameters and identify capacity requirements
Develop or modify approach to ensure required information is gathered	Demand and capacity model to be utilised to develop future service requirements
Understand and assess national policy initiatives and relevant legislative changes	Activity projections linked to primary, community and social care services

Finance	
Purpose: To work with service areas to inform the service reconfiguration and develop the Financial business case	
Key activities	**Key outputs**
Detailed financial analysis to define costs of new operating model.	FBC Financial Case including: • Cost benefit analysis • Transitional costs • 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
Identify resources required to deliver the implementation	Workstream implementation plan including transitional costs and benefits
Develop benefit realisation mechanism	Ensure relevant efficiencies are tracked

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 system assumptions underpinning the development of an integrated	Updated, consistent and tested assumptions underpinning operational redesign and

Health and Social Care response	information gaps added to workstream plan
Working with Activity workstreams, analyse existing pathways and redesign the service for each person pathway As the service redesign component of this project begins there will be involvement of business architecture to ensure the options design achieves the outcomes required.	Complete analysis and inform future service specification based on a modernised, sustainable and integrated approach
Develop cost benefit analysis of the new operational model	Detailed cost and benefit analysis
Contribute to the development of final business case	Relevant technical input to: - strategic content - option appraisal - preferred option.

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
Ensure employment issues e.g. (TUPE, Redundancy) are planned for correctly	Legal compliance with employment law requirements

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 relevant communication and Engagement Teams	Coordinated communication and engagement activity

Work with HR where appropriate, to support and enable communication and engagement with internal stakeholders (e.g. staff)	Newsletters, intranet, email bulletins, workshops, roadshows, documented meetings

8. VALUE ANALYSIS – COSTS, BENEFITS & RISKS

8.1 Financial schedule

1) Figures detailed in the outline business case for integrated adult service delivery were indicative figures based on the evidence and research provided by Ernst Young. The financial benefits envisaged over the three financial years of 2014/15 to 2016/17 are detailed in the table below and have been built into the council's three year balanced budget (as approved by Full Council in February 2014).

Financial benefits as detailed in 3 year balanced budget

	2014/15 £000	2015/16 £000	2016/17 £000	Total for 3 years £000
Integrated Health & Wellbeing budget savings (PCC element only)	1,500	5,900	9,500	16,900
Planned savings attributable to 'integrated adult service delivery'	525			

2) Financial benefits from this programme clearly accrue for both Plymouth City Council and the Clinical Commissioning Group in terms of how we join up our services and focus on the combined right outcomes for people. Savings mainly relate to two key areas:

(a) Staffing and administrative savings through integrating all relevant delivery staff within a single entity, adopting standard systems, procedures and practices. We will drive savings by rationalising management, streamlining processes and improving operational efficiencies and;

(b) Adopting a unique care approach where health and social care staff work alongside one another focussing on a client's needs around early intervention and prevention – hence reducing demand on higher cost placement services.

3) We are planning to implement an integrated service delivery model with effect from April 2015. However, it will take a longer time period to optimise the full extent of savings from this transformation project. Within this financial summary we have detailed a range of savings that could be realised. Savings are calculated using 2014/15 approved revenue budgets as a base. It is difficult at this stage to determine the exact split of financial savings between PCC and CCG. For modelling purposes, we have applied a standard percentage range for each organisation until the future shape of the delivery vehicle is better defined. These percentages will be tested and updated as we progress through the implementation.

4) Clearly, the level of combined spend on integrated health delivery offers an opportunity to drive significant financial and non-financial benefit. However, it should be noted that both organisations are facing considerable financial pressures whilst operating as single entities. These pressures will remain under close scrutiny to ensure that financial savings are fully delivered against 2014/15 base budgets as opposed to just absorbing spend from increased demand.

5) Staffing rationalisation and driving efficient operations. The integration between the two organisations will be implemented from April 2015. Within 2014/15, the new vehicle will refine and re-align existing practices and structures which will further develop over time.

Integrated Adult Provision – estimated staffing savings

Staffing	Existing spend £000	2014/15		2015/16		2016/17	
		Lower @ 1% £000	Higher @ 3% £000	Lower @ 2% £000	Higher @ 5% £000	Lower @ 3% £000	Higher @ 7% £000
PCC 14/15 base	11,028	110	331	221	551	331	772
CCG 14/15 base	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total savings	11,028	110	331	221	551	331	772

6) The biggest bulk of spend, and therefore associated savings, are the actual services in scope for the newly formed integrated delivery function. For PCC, our base budget for 2014/15 amounts to £44.3m with a further XXXm attributable to the CCG.

7) There are a range of planned activities that will deliver financial benefit through integrated adult service delivery. At this stage, we have not assigned a financial value to each specific activity, but have specified a range of potential savings based on phased implementation of all of the planned actions across the three years. The core activities that will deliver the savings are:

- In 2014/15 both organisations will constructively review and challenge existing service delivery arrangements – mainly focussing on those with long term care needs;
- Out of area placements will be reviewed to evaluate more local, cost effective solutions whilst focussing on improving the level of care provided;
- Develop and adopt integrated strategies reflecting a different operating model;
- Adopt a single assessment process;
- Process re-design and adoption of integrated ICT systems;
- Introduce a single point of client contact;

- Undertake service and pathway reviews – admission prevention, discharge and out of hours rapid response;
- Adopt a fully integrated case management system – significantly reducing the number of client visits required;
- Implementing fully combined, blended packages of care around the client's needs
- Integrated strategies will retain a focus on reducing demand for high cost residential, nursing and hospital placements – placing a greater share of resources to early intervention, preventative services and enabling support;

8) A key initiative that will be considered is one known as Unique Care Approach. This approach is considered to be a best practice example and is based on the Integrated Care Model, based in Castlefields Health Centre in Runcorn, Halton PCT (Lyon et al. 2006). At Castlefields, a social worker was introduced to work alongside a district nurse to introduce an integrated case management approach for patients who have been identified as potentially high users of hospital services. Over 4 years, hospitals saw a 15% fall in unplanned hospital admissions from a baseline in 1999. A&E attendees and GP visits fell by 30% and there was a 41% drop in bed days, which has led to approximately £1million of savings

9) Our estimated range of non-staffing savings attributable to the integrated adult service delivery are detailed below:

Integrated Adult Service Delivery – estimated integrated delivery savings

Commissioning function	Existing spend £000	2014/15		2015/16		2016/17	
		Lower @ 1% £000	Higher @ 3% £000	Lower @ 4% £000	Higher @ 7% £000	Lower @ 8% £000	Higher @ 12% £000
PCC 14/15 base	44,336	443	1,330	1,773	3,104	3,547	5,320
CCG 14/15 base	85,000	850	2550	3400	5950	6800	10200
Total savings	129,336	1293	3880	5173	9054	10,347	15,520

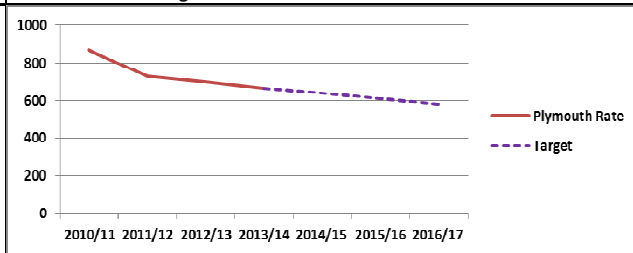
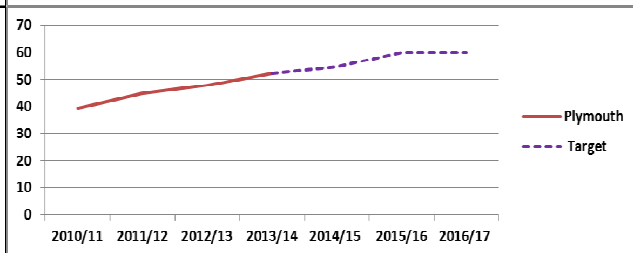
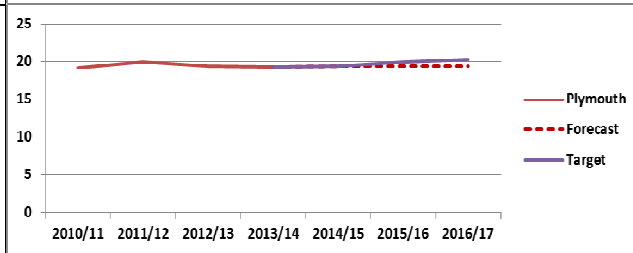
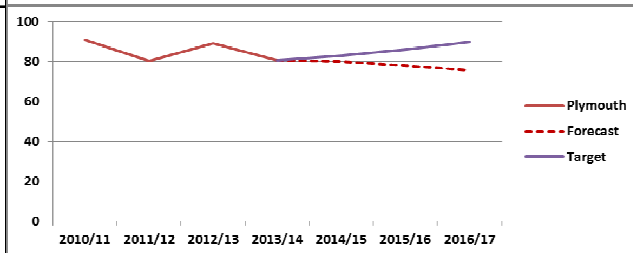
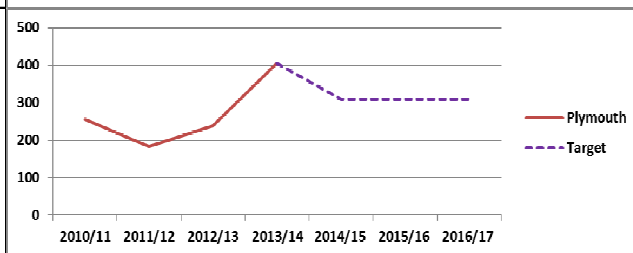
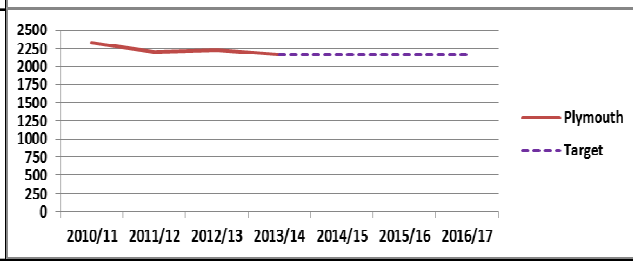
10) The combination of the potential savings across the integrated adult service delivery project and the wider health and wellbeing transformation programme has the potential to exceed the transformation benefit figures stated in PCC's 3 year balanced budget. However, based on existing increasing trends and complexity in client demand, it will be essential for the programme to over-achieve in order to offset escalating spend in both health and Adult Social Care. Resource assumptions and re-profiled client trend data will be fed into a refresh of the council's medium term financial strategy in September 2014.

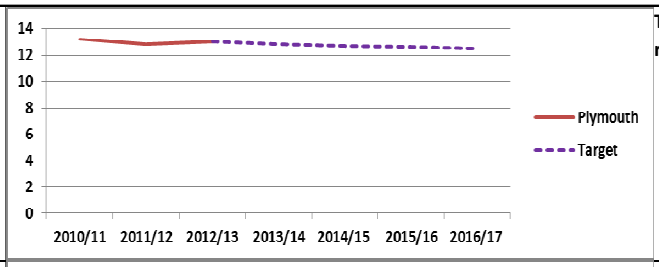
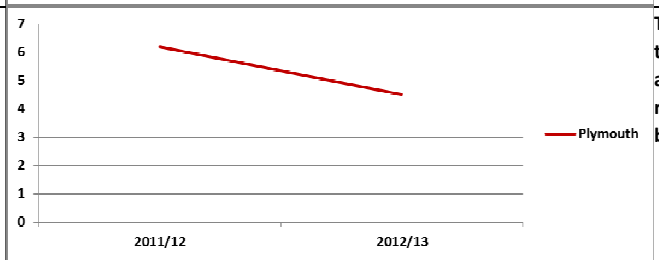
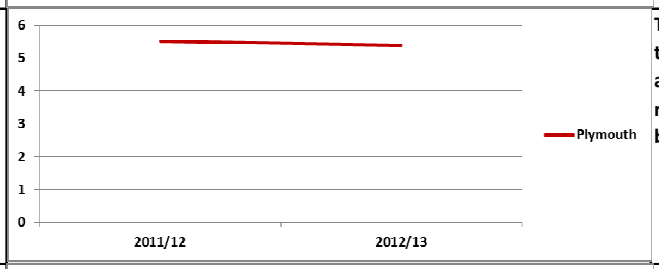
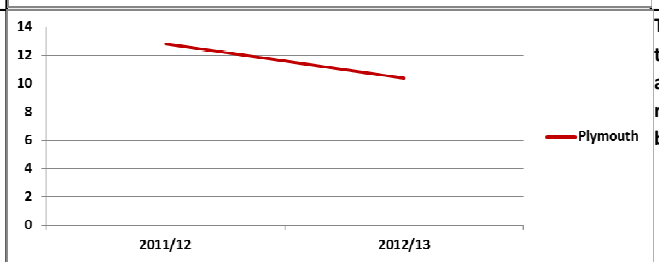
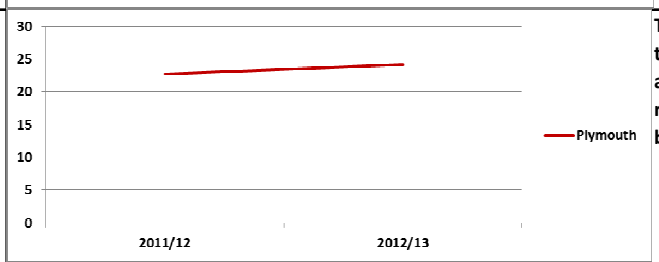
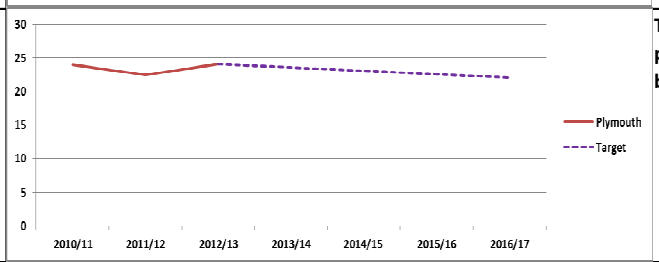
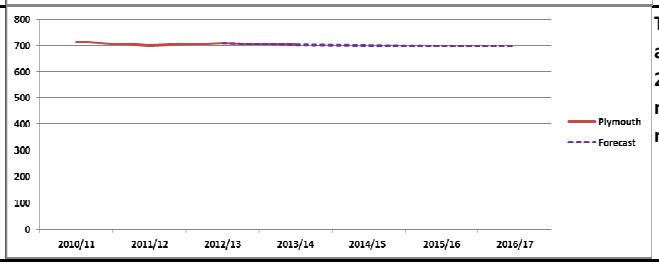
Assumptions

1) This is the existing adult social care staff based in the operational area of the service. This excludes co-operative commissioning and the provider area covering residential, day care and bespoke care services provided by the council. There are no figures in here because the budget costs based in Plymouth Community Healthcare and are part of CCG's commissioned contract with PCH.
2) Savings associated with service delivery for CCG would be reflected in the commissioning spend.
3) These budgets are the community based commissioning spend and are a sub-set of the total in the commissioning detailed business case.
4) These budgets are the CCG Plymouth facing spend contained in the contract with PCH and in community based commissioning spend. Further work will be undertaken during the due diligence phase.

8.2 Benefits- Improved Health and Wellbeing Outcomes:

The performance measures detailed below will form part of the contract for the Integrated Delivery Provider and are in line with our priorities to address the health and social care needs across the city. It is anticipated that additional key performance indicators will be developed by the Integrated Commissioning Hub and added to the integrated provider specification.

Category	Performance Measure	Baseline data and target	
Community	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population		To achieve the forecast reduction by 2016/17 equating to a 13% reduction in the rate per 100,000
Community	Estimated Diagnosis rate for people with Dementia		To achieve the national target of 60%
Community	Social Care related quality of life		To achieve a 5% improvement in quality of life score
Community	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services		To achieve Better Care Fund targets and return to 90% rehabilitation success
Bed Based	Delayed transfers of care from hospital per 100,000 population (average days per month)		Target - To reduce and return to national average by 2016/17
Bed Based	Avoidable emergency admissions		To maintain performance

Bed Based	**30 day readmissions**		**To achieve a 4% reduction**
Wellbeing	**Self Reported Wellbeing - People with a low satisfaction score**		**To decrease and better the national and regional averages based on responses to ONS well-being survey.**
Wellbeing	**Self Reported Wellbeing - People with a low worthwhile score**		**To decrease and better the national and regional averages based on responses to ONS well-being survey.**
Wellbeing	**Self Reported Wellbeing - People with a low happiness score**		**To decrease and better the national and regional averages based on responses to ONS well-being survey.**
Wellbeing	**Self Reported Wellbeing - People with a high anxiety score**		**To decrease and better the national and regional averages based on responses to ONS well-being survey.**
Wellbeing	**Smoking prevalance in adults**		**To decrease smoking prevalence in Plymouth by 24.4% by 2021/22**
Wellbeing	**Alcohol related admissions to Hospital**		**To reduce admissions and achieve target set in 2014/15 using new national recording methodology**

8.3 Benefits – Organisational

For the workforce	• Providing greater and more flexible career opportunities and ability for up skilling/ skills transfer between professionals • Integrated workforce plan designed to deliver service strategies • Fewer barriers to effective decision making • Ability to focus on delivering support to citizens • 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 • A system that is accountable to users and has been designed with their involvement • Joint investment in early identification, prevention and early intervention to prevent escalation of needs • Financial risk sharing arrangement to ensure value for money • Transparent performance and financial framework supported by joint governance to ensure robust management of quality and costs • 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 • Opportunity to invest due to greater financial certainty and delivery flexibility • Increasing productivity and accelerating improvements in service quality through working with all stakeholders to redesign services. • Reducing waste in the system through eliminating the amount of duplication • Making better use of community assets due to flexibility and removal of organisational boundaries • More integrated back-office and support function to provide seamless support and enable efficiencies • Simplified contracting arrangements and more focus on effective delivery

9. RISKS AND DEPENDENCIES

9.1 Risks & Impact

Risk Description (A short summary of the event)	Current Risk Rating	Actions to reduce risk to target
Savings delivered from the integration are not sufficient to meet the funding gap	Red	Scrutiny and validation of the business case, and the projected benefits in further phases Account for optimism bias in financial model when developed
Disruption to service delivery with an impact on service quality and reputation	Red	1. As part of business case phase contingency planning undertaken as part of implementation planning 2. Key scenarios identified and mitigation plans developed
Staff/union resistance to the proposed changes and service redesign	Amber	1. Early consultation with Unions 2. 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	Amber	1. Areas of potential disagreement highlighted and discussed early in the process 2. Identification of key decision makers and a dispute resolution process 3. Formal agreements and protocols in place to enable teams to work together
Multiple parties involved leading to partial support for business case or different decisions being made, which delays implementation	Amber	1. Key stakeholders identified at the start of the project and engaged regularly 2. Communications plan in place and key stakeholders provided with regular updates
Assumptions made will be wrong due to baseline data not being robust and so the business case is undermined	Red	1. Validation of the baseline data finance, the savings opportunities by service professionals2. Validation and ownership of the financial model by finance and service areas
Statutory, regulatory or political differences between Health and Social Care or partners lead to tensions (e.g.footprint of NEW Devon CCG will delay approval of business case and implementation)	Red	1. 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)	Red	1.Remain well-informed of policy and legislative developments and build in necessary changes early and challenge solution development
Negative impact of procurement or tax requirements on new delivery mechanism, for example VAT regulations	Amber	1. Consider likely impact of during the Options Appraisal process if new delivery vehicles/alternative structures are considered
Legal challenge regarding competition, contracting and procurement	Amber	1. 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	Amber	1. Develop programme delivery plan and get cross party sign up to this

		2.Cross- party investment planning meeting to agree resource commitment
Transforming Community Services programme does not support this level of integration or procure an integrated suite of community services	Red	1. Prioritise certain aspects of full business case development that provide a view on what services should be procured along with those provided by PCH
Failing to reach agreed terms that are compliant with Teckal criteria, due to differing legal opinions	Amber	1. 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) 2. Regular compliance checks and discussions
CCO objectives may not be achieved in time to support planned 2014/15 service improvements in People & Place directorates (e.g. finance, HR, ICT, FM, business support). This has the potential to delay achieving cashable savings for the IHWB programme if not resolved	Red	1. PCC / Portfolio guidance needed on what flexibility and freedom business areas have to determine what it can change independently and where it must follow the corporate line. Clarification over attribution of benefits: savings in support services are attributable to CCO irrespective of origin of the saving (in the same way as all premises savings are P&OD's)
Requirement for Corporate Support (Legal, HR, Finance etc) needs to be managed as there will be a lot of requests for their support and the Transformation 'pot' should be equally split between CCG and PCC.	Red	Early identification of work streams, careful profiling of resources, identify duplications of effort and mitigation accordingly

9.2 Dependencies

NEW Devon CCG has 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.

The CCG are exploring different models of community health provision through its community services strategy.

Organisational dependency with NEW Devon's relationship with Kernow CCG as an associate commissioner e.g. the contract held with Plymouth Hospitals NHS Trust.

Another key interdependency is with the Better Care Fund (BCF) 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).

Within PCC, there are key dependencies 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 are compliant with this document.

9.3 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 a decision will be needed by the CCG Governing Body as well as support from the Western Locality Board.

As part of the project plan for achieving integration there will be work stream leads covering the following areas to ensure that any constraints that arise can be resolved by the end of Oct14 to allow for a decision to progress with integration in Nov 2014:

- Legal
- HR and Pensions
- Finance
- Business Intelligence
- Contracts and Commissioning
- Operations
- Communications
- Assets
- Risks
- IT
- Governance
- Clinical Governance and Quality

Current known constraints include the options and evaluation of the recommended approach of using a Section 75 agreement with CCG to consider the integration of the Adult Social Care delivery service with Plymouth Community Healthcare. In these agreements there are known challenges such as TUPE, staff pensions, the need to develop an integrated IT solution and to ensure the financial systems between Plymouth Community Healthcare and Plymouth City Council can be put in place. Based on experience of other sites that have integrated in this manner this is achievable in the time scales proposed.

There is a concern that there may be procurement issues with the adopted approach. This is being tested out with external legal advice.

A comprehensive human resource process and plan will be available and the relevant unions will be consulted with prior to the commencement of consultation with staff. Plans will set out in detail each step of the process, the timeframes involved and all the support and information staff will receive during the process. Our intentions are to support staff through the proposed changes if this decision is made following the consultation process.

10. Appendices

Integrated Delivery Criteria	Options			
	Delivery workforce remain in existing structures. Pathways for people requiring support are reviewed and streamlined. Budgets are re-profiled to follow individuals	Delivery workforce are re-configured to sit with shared line management arrangements linked to individual pathways. Staffing budgets are aligned accordingly	Delivery services staff come together under single management with some provision budgets joined to support specific pathways	Delivery services staff come together under single management structure. Budgets across the system are transferred to delivery service
	Strengths/ Weaknesses	**Strengths/ Weaknesses**	**Strengths/ Weaknesses**	**Strengths/ Weaknesses**
Person-Centred / Individual at Centre				
Improved customer experience - Person to receive seamless provision of care				
Co-ordinated care around the individual leading to improved customer outcomes				
Single point of contact				
Finance				
Influence over all spend to ensure resources are allocated effectively				
Ability to manage integrated spend strategically				
Achievement of savings target				
Strategic and operational oversight of complete integrated budget				
Set up costs (procurement, moving staff, etc.)				
Sustainability				
Stability (Future-proof) (low risk of trust breakdown or organisations still acting independently)				
Shared commitment to common vision and goals				

Potential to expand and improve services				
Meets the strategic objectives of the programme and organisations				
Human Resources				
Employer of Choice - e.g. staff benefits, staff decision making, opportunity for progression, etc.				
Potential issues around training , experience, recruitment, retention				
Clarity for staff of HROD process/terms and conditions/benefits, etc.				
Skills/expertise sharing				
Governance				
A clear governance structure that Council members support				
A clear governance structure that GPs support				
Appropriately managing risks				
Operational				
Information Management and Technology available to support this option				
Clear Leadership				
Full integration/centralisation of back office and business functions (HR, IT, medical records and assessment)				
Reduced Duplication				
Single organisation for providers to deal with				
Legal				
Is the option legal?				

Risk of challenge (TUPE, state aid, political (e.g. if seen as outsourcing), etc.)				
Miscellaneous				
Fit with national policy direction for local authorities and NHS				
Commissioner/Provider relationship				
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				
Incentive and freedom to innovate				