Programme Name:	Integrated Health and Wellbeing		
Date:	27-10-2014	**Version:**	0.7
Project:	Integrated Commissioning		
Author:	Craig McArdle, Anna Coles, Nicola Jones, Jenni Doudoulakis, Alex Mehaffey		
Owner (SRO):	Carole Burgoyne & Jerry Clough		

Cabinet Recommendations

1. The new high level governance arrangements set out in Section two are approved
2. The scope of the integrated commissioning pooled budget is agreed and the indicative contributions are noted
3. The Risk Sharing principles are used as a basis to develop the Section 75 Agreement
4. The high level Integrated Commissioning Design is approved and is allowed to proceed to the design and build phase
5. The High Level Commissioning Strategies for Children's, Wellbeing, Community and Complex are approved for consultation and development.
6. The commissioning and contracting approach for the Integrated Health and Social Care Provider is approved.
7. The next steps are noted and the Contract Award report for the Integrated Health and Social Care Provider and the finalised Section 75 agreement is brought back to Cabinet before March 2015

DOCUMENT CONTROL

VERSION HISTORY: (VERSION CONTROL E.G. DRAFT V0.01, V0.02, V0.03 BASE LINE @ V1.0)

Version	Date	Author	Change Ref	Pages Affected
0.1		Craig McArdle	Original document	All
0.2		Anna Coles / Nicola Jones	Comments	All
0.3	15-10-2014	Jenni Doudoulakis	Additional information	Section 8
0.4	15-10-2014	Jenni Doudoulakis / Craig McArdle	Update	Section 8
0.5	15-10-2014	Jenni Doudoulakis	Update and formatting	All
0.6	16-10-2014	Craig McArdle / Jenni Doudoulakis	Minor amendments and formatting	All
0.7	27-10-2014	Alex Mehaffey	Update and reformatting	All

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REVIEW AND APPROVAL PROCESS:

Date	**Organisation**	**Meeting**
29/09/14	PCC	People JCC
29/09/14	Joint	IHWB Programme board
30/09/2014	PCC	CMT (for discussion)
07/10/14	PCC	Cabinet Planning and TPB
08/10/14	CCG	WL Board Seminar (Discussion)
08/10/14	CCG	SRG and UCP (Views)
14/10/14	PCC	CMT approval
15/10/14	CCG	CCG Executive (Views and support)
21/10/14	CCG	Finance Committee (Views and support re: financial models, risk sharing, benefit sharing)
21/10/14	CCG	WL SLT (Support pre WL Board)
21/10/14	CCG	Primary Care Strategy Group (Views)
29/10/14	CCG	Western Locality Board (Support ahead of GB)
06-07/11/14	PCC	Scrutiny Panels
05/11/14	CCG	Governing Body – private session (Support ahead of GB)
11/11/14	PCC	Cabinet (Decision)
18/11/14	CCG	Senior Leadership Team (Support ahead of WL Board)
26/11/14	CCG	Western Locality Board (Support ahead of GB)
3/12/14	CCG	Governing Body (Decision)

INTEGRATED COMMISSIONING

Building "One System One Budget"

Section	Sub Section
Introduction and Background	Background Wider Context Programme Approach Workstreams Communication Approach
New Governance Arrangements	What we mean by Corporate Governance Clinical Commissioning Groups Local Authorities Current Governance Arrangements Outcomes from Workshop Governance Principles Proposed Governance Model April 2015
Finance Arrangements	Background and Legal Context Scope and Size of Integrated Budget Costs and Benefits Developing the Financial Framework Risk Sharing Principles Managing the Pool Budget
Pool Budget Holder- Options	Hosting of the Pool Critical Decision Factors Summary
Integrated Commissioning Design	Introduction Key Outcomes Areas for Consideration Logical Organisation 2015 Integrated Commissioning Business Capabilities Capability Mapping Capability Change

High Level Commissioning Strategies	Children's Wellbeing Community Complex Acute
Commissioning the New Integrated Health and Social Care Provider	Integrated Provider High Level Design Target Operating Model Statutory Functions and Retained Client Protecting Social Care Contracting Process Specification Development and Contract Negotiations Verification Model
Project	Next Steps Communication Plan Risk Log
Recommendations	

Section One Introductions and Background

Background

Public Sector organisations across the country are facing unprecedented challenges and pressures due to rising demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities. Until recently the complexity and scale of our system-wide challenge has been difficult to understand and local organisations have, as a result, focussed mainly on meeting their own challenges. A lot of this work has been successful and this has delivered much that is good right across our system. Our local NHS trusts and other organisations provide excellent acute, community, and mental health services and many of the area's aggregated performance metrics are very good.

However we know that this existing good practice will not be enough to meet the current challenge. This means a new imperative for joint and collaborative working across all the organisations that commission and deliver health and wellbeing in our area.

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

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

Wider Context

It is important to recognise that integration sits with a wider context of system challenge and change. Devon and Plymouth are recognised nationally as a challenged health economy and this has led to the development of the NHS Futures Programme. This programme sets out how we will work together as a system to tackle the challenges we face and move forward to deliver changes in the way we meet the needs of people who use our services. The strategy describes a framework for system-wide action and detailed plans are currently being developed so that this can move forward with confidence and pace.

The overarching challenged health economy strategy has been developed with the active support of the following organisations: Devon Partnership NHS Trust; Plymouth Hospitals NHS Trust; Royal Devon and Exeter NHS FT; Northern Devon Healthcare NHS Trust; Devon Doctors; South

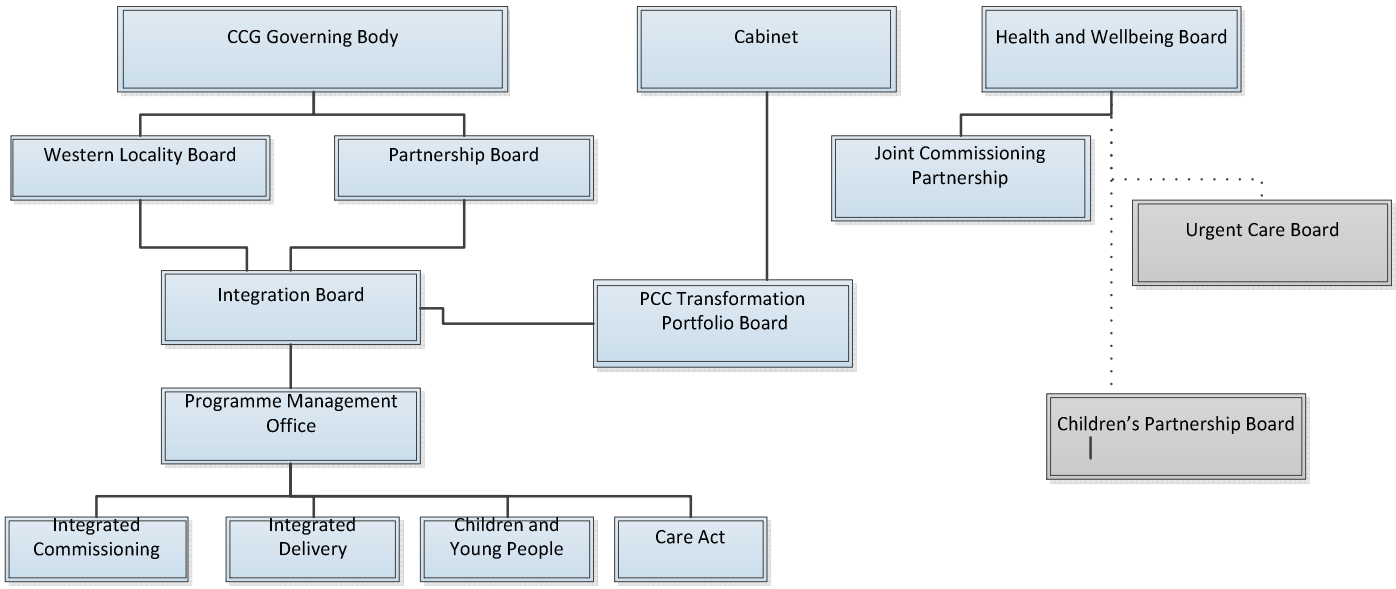
West Ambulance Services NHS FT; Devon County Council; Plymouth City Council; Virgin Care; NHS England, Monitor and Trust Development Authority.

It is recognised that if true system change is to be achieved then the role of Primary Care services is essential. Within this context NEW Devon CCG's has made an expression of interest in having delegated responsibility for co-commissioning of primary care (currently this responsibility sits with NHS England, Area Teams). Commissioning primary care supports the delivery of the Integrated Health and Wellbeing Programme.

Programme Management Approach

In order to meet the challenges facing Plymouth but also to support the wider challenged health economy work, New Devon CCG and Plymouth City Council have established a joint programme of work known as the **Integrated Health and Wellbeing Programme** (IHWB).

The IHWB programme is made up of four significant projects; Integrated Commissioning, Integrated Service Delivery, Children, Young People and Families and Care Act 2014 Implementation and has adopted the following overarching governance structure-



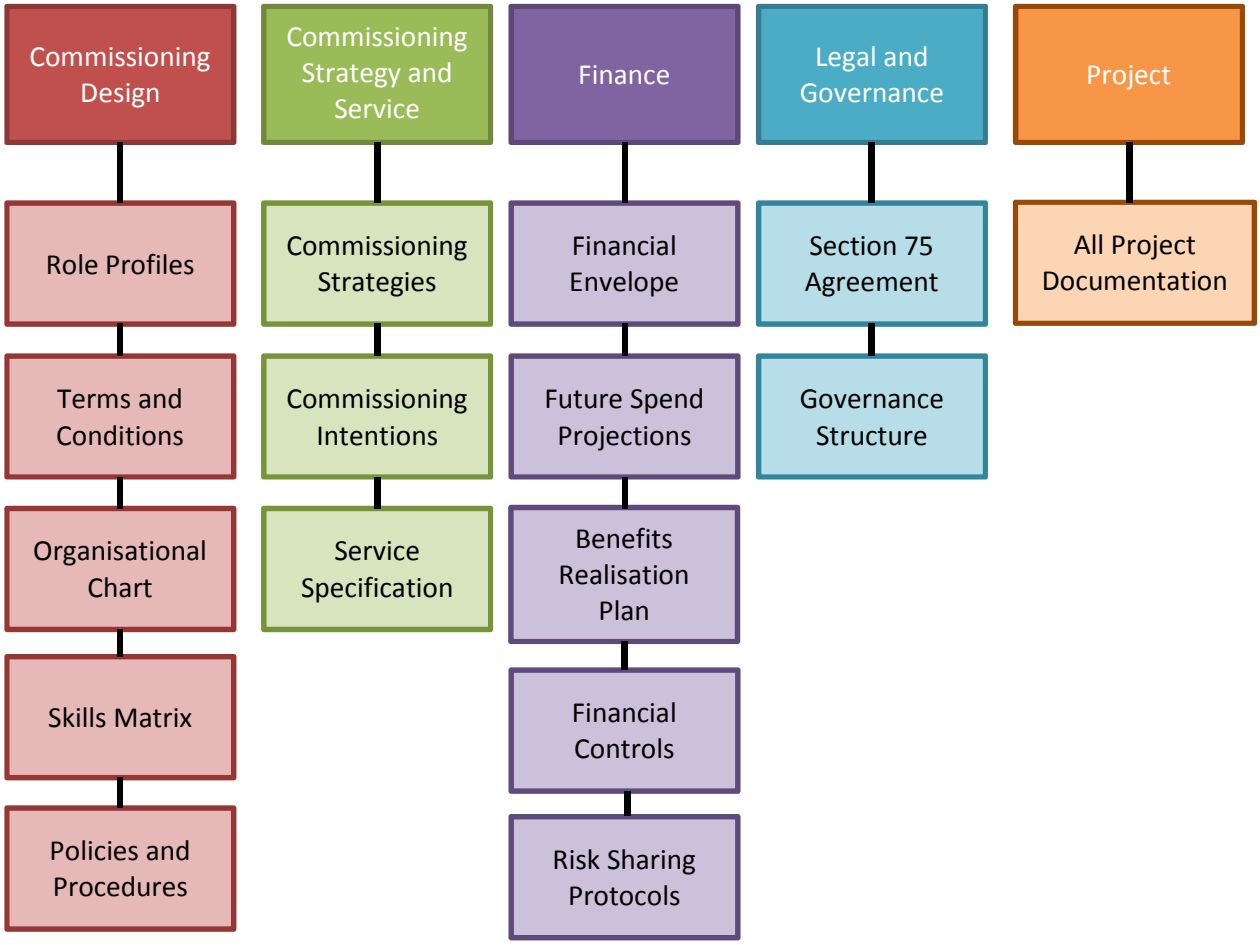
Both organisations recognised that if they were to make the step change in improving services and outcomes for individuals and communities, then achieving the largest scale of commissioning change possible is required. Consequentially in July 2014 New Devon CCG and Plymouth City approved the following recommendations:

- Plymouth City Council works collaboratively with NEW Devon CCG to achieve a fully integrated commissioning function new entity by Mar 2016.
- Plymouth City Council works with NEW Devon CCG to develop a section 75 agreement(s) by the end of March 2015 to pool budgets based around:
    - Wellness
    - Community Based Care
    - Complex / Bed Based Care (excluding acute)

- As a result, Plymouth City Council and NEW Devon CCG will work collaboratively to achieve an interim Commissioning function by Mar 2015
- Plymouth City Council works with NEW Devon CCG to develop single commissioning strategies based around the above.

Workstreams

To deliver Integrated Commissioning a number of workstreams have been established that aims to deliver a number of core products:



Each workstream has a designated lead who reports in to the Project Team.

Communication approach

A Communications Plan for the Project and Programme has been developed jointly by NEW Devon 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 and GPs
- Communication Sessions, with Staff, Stakeholders and Partners
- Regular written and face to face briefings
- Co-design workshops with staff

Section Two New Governance Arrangements

What we mean by Corporate Governance

Corporate governance is about how an organisation ensures that it is doing the right things, in the right way, for the right people, in a timely, inclusive, open, honest and accountable manner. It comprises the systems, processes and cultures and values by which the organisation is directed and controlled and through which it accounts to, engages with, and leads its communities.

Clinical Commissioning Groups (CCGs)

Clinical Commissioning Groups (CCGs) were established on 1st April 2013 under the National Health Services Act 2006 as amended by the Health and Social Care Act 2012. CCGs are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are NHS Bodies for the purposes of the National Health Services Act 2006.

CCGs are clinically led membership organisations, members being GPs in local general practices. The members of the CCG are responsible for determining the governing arrangements for their organisations, which they are required to set out in a Constitution.

The Constitution document for NHS Northern, Eastern and Western Devon CCG contains arrangements, as agreed with NHS England, for membership, vision and mission, functions and duties, decision making, roles and responsibilities, standards of business conduct and managing conflicts of interest, general arrangements including confidentiality and Freedom of Information, transparency, ways of working and standing orders.

The geographical area covered by NHS NEW Devon CCG is the city of Plymouth and the county of Devon excluding South Devon and Torbay.

Local Authorities

Plymouth is a unitary authority, which means it is responsible for all local services including transport, social care and education. Many of the services we provide are statutory responsibilities and we have identified others as priorities. For example, we have a legal duty to dispose of the city's waste while we are not legally obliged to provide public toilets.

Councillors

Plymouth City Council has a Labour administration.

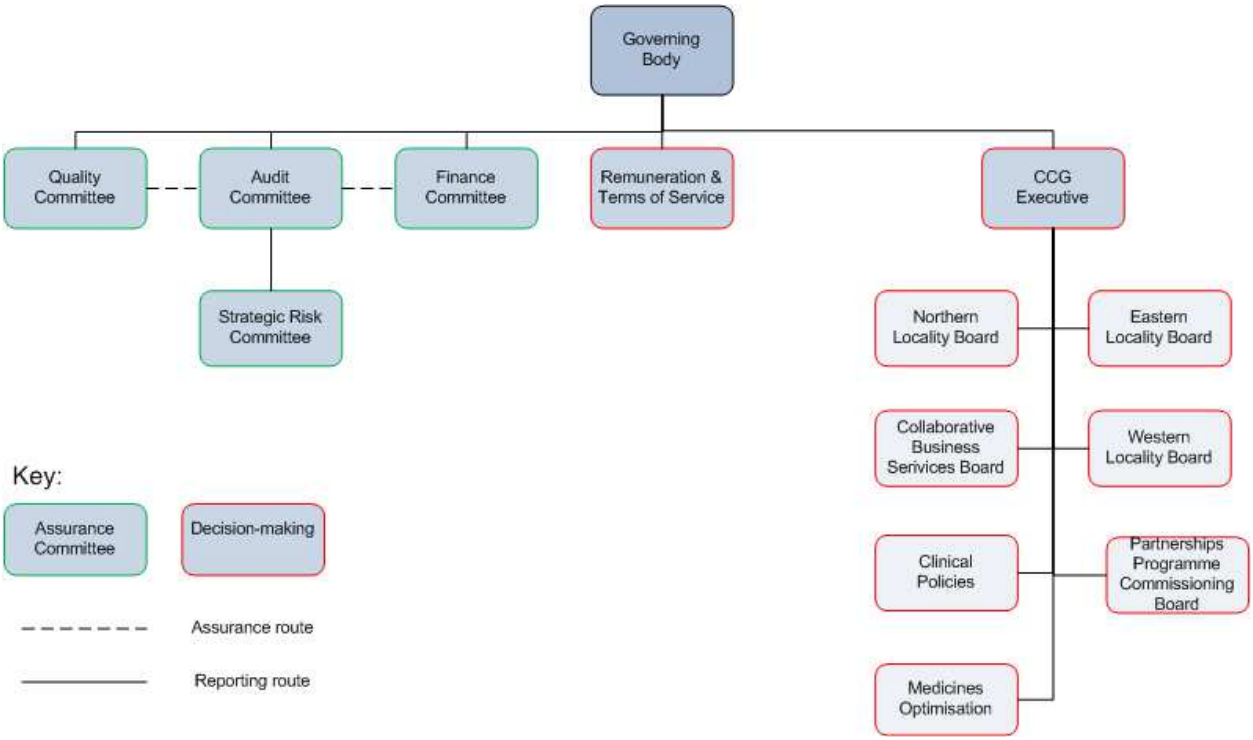
- Labour - 29 seats
- Conservatives - 24 seats
- UK Independence Party (UKIP) - 3
- Independent - 1

A Cabinet is selected by the ruling group. The Cabinet meets in public every four weeks to make key decisions. Each Cabinet member has a special area of responsibility or 'portfolio'. Cabinet members are also given the authority to make detailed decisions that affect their area of responsibility.

The Leader and Cabinet make most of the key decisions about how the Council is run and how the budget is allocated.

Current Corporate Governance Arrangements in NEW Devon CCG

The diagram below shows the Corporate Governance structure of NEW Devon CCG:



As at October 2014, the CCG's Governing Body has the following functions:

- Ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the group's principles of good governance
- Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the Group, including pensions
- Approving any functions of the Group that are specified in regulations
- Providing strategic direction and focus on the organisation's purpose and on outcomes for patients and the population
- Ensuring an assurance framework is in place linked to strategic objectives and risks
- Approving the Group's Code of Conduct
- Determining the Group's risk tolerance limits
- Monitoring the management of significant risk and seeking assurance on management decisions
- Creating a culture of openness, transparency and continuous improvement
- Understanding the wider implications of risks taken by Locality Boards and management in pursuit of better outcomes

Decisions reserved for the Governing Body are:

- Approving the Standing Orders
- Establishing terms of reference and reporting arrangements for all committees
- Agreeing the Scheme of Delegation
- Approving the Strategic and Annual Operating Plan
- Approving the group's assurance framework
- Approving Standing Financial Instructions
- Appointing the Governing Body's Vice Chair
- Defining the group's strategic aims
- Approving business cases for capital investment if it affects more than one locality
- Approving budgets
- Receiving and approving the annual report, annual accounts and quality account
- Receive and approve periodic financial performance and quality performance reports
- Resolve disputes and conflicts of interest between localities

The Governing Body has appointed the following committees:

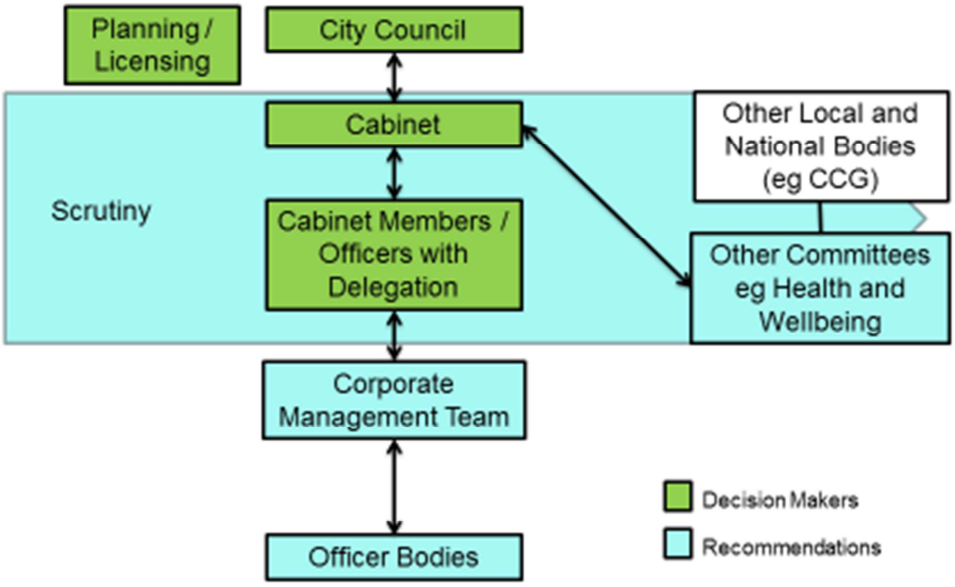
- Audit committee
- Remuneration and appointments committee
- Quality committee
- Finance committee
- Locality Boards.

The Locality Board with responsibility for Plymouth as well as parts of South Hams and West Devon is the Western Locality Board.

Through a scheme of delegation the Governing Body delegates responsibilities and decision making authority for certain matters to the Western Locality Board.

Current Governance Arrangements in Plymouth City Council

The diagram below shows the Governance structure of Plymouth City Council:



Plymouth City Council is made up of 57 members who collectively make budget and policy decisions in addition to scrutinising the work of the organisation.

Under the Constitution, the Council operates under executive arrangements using a Leader/Cabinet model where the Leader is elected, from and by the Members of the Council. Under this arrangement all executive functions are vested in the Leader who can then delegate those functions as seen fit. The Leader is responsible for appointing members of the Cabinet and delegating executive responsibilities to Cabinet Members. Currently Plymouth City Council's Cabinet is made up of nine members including the Leader.

Outcomes from Workshop

In order to build integrated system leadership, an Elected Member and Clinical Leads workshop was hosted to discuss shared governance principles, the outcomes from this workshop agreed the following next steps:

- Learn from the collaborative approach of the Health and Wellbeing Board
- Design a distinct set of governance processes that fulfil the requirements of both PCC and CCG
- Agree the narrative and agree the options
- Learn from one another through sharing of knowledge
- Agreeing the needs and outcomes first should more easily bring about consensus
- Aggregate all pieces of feedback to really learn
- Scheme of delegation will need to be drafted
- Need to achieve a level of agreement across the whole system

- Share Information and Intelligence across the whole system
- Structure Options
- Need to do scenario planning/examples to work through
- Keep sighted on the vision and principles
- Shared governance
- Shared policies to be reviewed regularly due to changing circumstances

Governance Principles

In order to move forward at pace both organisations have agreed the following governance principles that will guide future behaviours and decision making:

- "One system, one budget to deliver the right care, at the right time in the right place"
- The Health and Wellbeing Strategy will guide our future commissioning activity
- Commissioning and services should be integrated and seamless wrapped around people not structured around organisational convenience
- Decisions taken should not be done in such a way to destabilise the other organisation

The IHWB Programme is utilising a cooperative commissioning approach. This means that the programme has adopted the following cooperative commissioning principles:

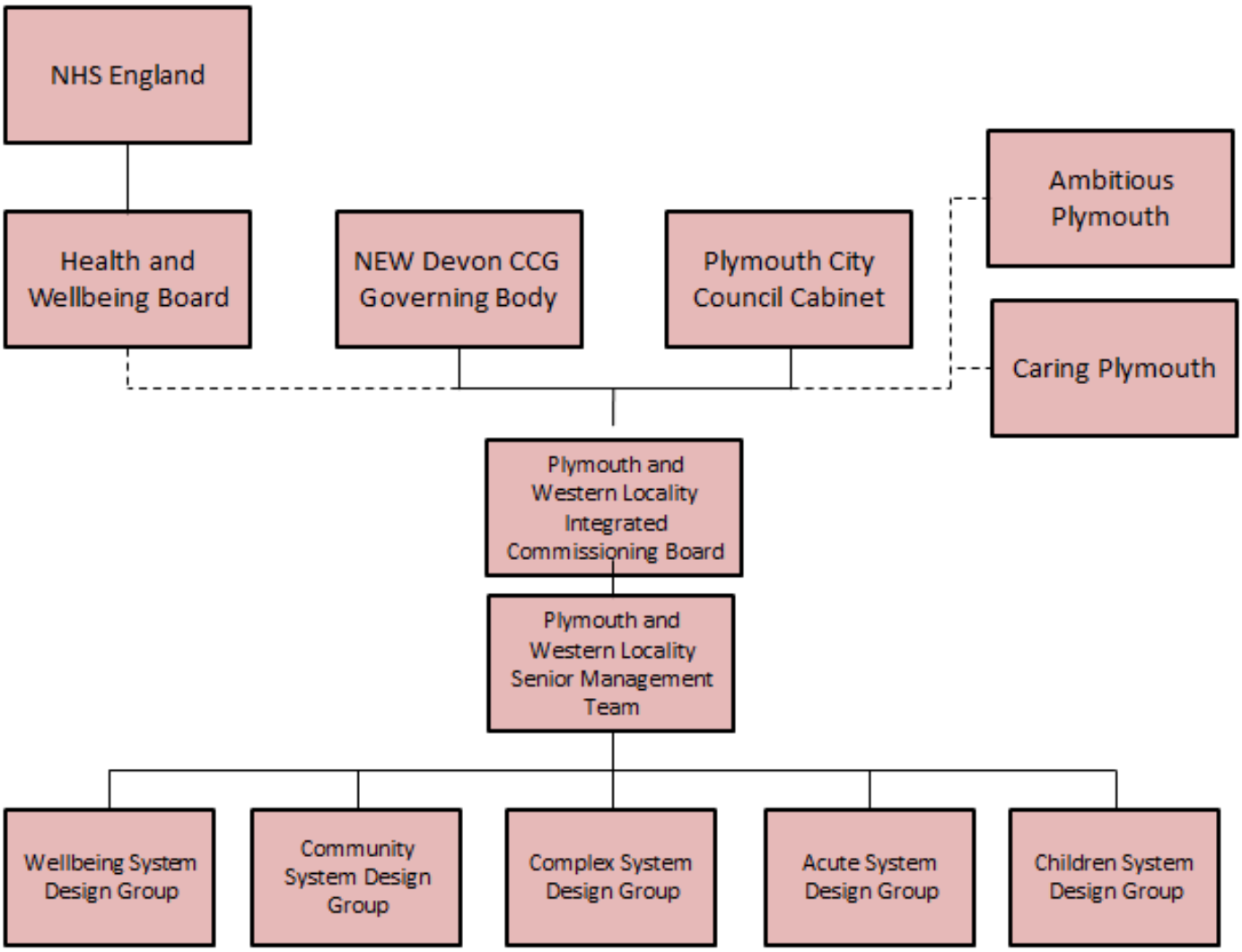
• Citizens and communities will be at the heart of all commissioning activity • Commissioning decisions will be open and transparent • Commissioning will seek to promote civic responsibility
• We will commission for sustainability by prioritising early intervention and prevention • We will commission for quality and outcomes • Commissioning decisions will focus on delivering VFM and promoting social value
• Commissioning will focus on reducing inequalities and making Plymouth a fair City • Commissioning activity will be needs and evidence based • We will develop local, fair and sustainable markets • We will work with organisations that pay their staff a "living wage" as a minimum.
• We will commission with a range of partners regardless of organisational form • We will work collaboratively and coproduce public services • We will promote citizen commissioning

The integration will aim to achieve the following outcomes:

- Provide and enable brilliant services that strive to exceed customer expectations
- Use resources wisely.
- Prioritise prevention.
- Help people take control of their lives and communities.
- Children, young people and adults are safe and confident in their communities.
- People are treated with dignity and respect.

Proposed Governance Model: April 2015

Much of the Governance arrangements are in place and these should not be diluted. Cabinet and the CCG Governing Body will remain the statutory and most senior decision making bodies. To help support GPs and Members, the following approach is being considered:



Scrutiny	• Statutory powers to scrutinise external health bodies • Duty on Commissioners and Providers to consult committees on significant changes • Retained power of referral to the Secretary of State for review of substantial changes in service provision
Plymouth City Council Cabinet / NEW Devon CCG Governing Body	• Executive function to take decisions on Budget, Policy and Strategy
Health and Wellbeing Board	• Strategic Leadership and Direction Setting • Holding Commissioning to account development of JSNAs and JHWSs • Promote Integration & Make recommendations
Plymouth and Western Locality Integrated Commissioning Board	• Senior Leaders/Clinicians from CCG/PCC & DPH • System Oversight • Approval of Commissioning Plans
Plymouth and Western Locality Senior Management Team	• CCG/PCC Commissioning/Performance/Finance Managers • Development of Commissioning Intentions • Provide assurance to the PWLICB on performance and delivery
System Design Groups	• Providers, Stakeholders, Commissioners & Users collaborating to design, operationalise and provide system resilience

In this scenario the Plymouth and Western Locality Integrated Commissioning Board (PWLICB) would oversee the strategic direction and spend of the Integrated Commissioning Unit and ensure the effective delivery of key objectives. The PWLICB will ensure compliance with both organisations' clinical and corporate governance and standards and an equal focus on delivering what is required under both the CCG and PCC's outcome frameworks.

It is important to recognise that each party will remain ultimately accountable for its respective organisational functions, statutory obligations and budgets and therefore key decisions will need to go through the parallel Cabinet and CCG Commissioning Body processes for approval.

Section Three Finance Arrangements

Background and Legal Context

Section 75 of the National Health Service Act (2006) (formerly Section 31 of the 1999 NHS Act) provides the framework for health bodies and local authorities to pool money, delegate functions and integrate resources and management structures. The framework allows for the commissioning of existing or new services and provide for arrangements for working together.

A pooled fund is a single, common fund set up by partner organisations in order to meet an agreed list of partnership objectives. The partners decide which is to be the host body, which then manages the pool on behalf of both partners, through agreed delegation arrangements.

Scope of Pool Budget and System Benefits

The CCG and the Council are carrying out detailed work to identify an equitable and deliverable scope to the pool. Both organisations agree that the maximum scope of services that are provided to the Plymouth population should be included in the pool. The original decision by both organisations, that acute expenditure remained outside of the scope of the Pooled Budget, has therefore been reviewed. Further analysis concluded that this would limit a whole system approach and it is now recommended that acute expenditure is put into the pool. This means that the working assumption is that the CCG would transfer its whole budget for commissioning services for patients registered in Plymouth, based on 14/15 outturn (adjusted). The Council is seeking to include commissioning funding for those services that are likely to have an impact on the effectiveness of the outcome of the services commissioned. As such the Director of Public Health has made the decision to commit the entire Public Health Commissioning Budget covering both mandatory and non-mandatory services. On this basis the scope of the pool budget, and associated benefits, has been drafted.

Significant modelling has been undertaken to quantify the impact of planned interventions on future client/patient trends and associated financial benefits. Each separate organisation has plotted the 'as is' position on client/ patient cost and volume data as an initial baseline. An informed judgement has then been applied to each separate intervention to articulate its impact on future data and associated costs.

A systems-based approach has been applied to this financial modelling to best reflect the 'journey of care' under the new operating model. Integrated financial benefits from this modelling have then been apportioned to each separate organisation to provide clarity on how changes will impact on existing budgets.

Combined net revenue budgets that are currently deemed as being 'in scope' for the IHWB programme are £421m for 2015/16, increasing to £429m by 2017/18 (factoring in the planned interventions). In broad terms, the level of investment in terms of the budget input to the pool is 75% CCG (£321m in 2015/16) and 25% PCC (£100m in 2015/16).

Integrated Commissioning Combined Pool 3 Year Plan

	15/16		16/17		17/18
Integration Groupings	**Total (£000`s)**		**Total (£000`s)**		**Total (£000`s)**
Wellbeing	£17,158		£17,158		£17,158
Community and bed based	£184,408		£183,254		£186,349
Bed Based	£109,829		£112,820		£114,894
Acute	£151,414		£150,421		£148,768
Staffing	£18,142		£18,240		£18,313
Income	(£32,728)		(£32,730)		(£32,733)
Support costs	£0		£0		£0
Total Planned Spend	**£448,223**		**£449,161**		**£452,749**
Revenue Resource Limit	**£421,481**		**£424,196**		**£428,965**
Over Spend vs Rev Resource Lim	**£26,742**		**£24,965**		**£23,784**
Planned Deficit	**(£12,442)**		**(£12,442)**		**(£10,887)**
IHWB Benefits	**£14,300**		**£12,523**		**£12,897**

Integrated Commissioning Combined Benefits

	2015/16 £'000s	2016/17 £'000s	2017/18 £'000s
Integrated Provision	-	500	1,000
Integrated Commissioning	4,276	7,901	11,608
Cooperative CYPS *	234	234	234
Care Act	-	-	-
People Directorate review *	200	200	200
Further QIPP savings	9,590	3,687	(146)
	14,300	**12,522**	**12,896**

Integrated Health & Wellbeing Programme Costs

	14/15	15/16	16/17		Total
Cost type	£'000s	£'000s	£'000s		£'000s
Resources	326	232	38		596
Other	800	405	225		1,430
Total	1,126	637	263		2,026

System Performance Benefits

- Reduction in the rate of admissions to long term care homes by 6% achieved via the provision of good quality preventative services
- Reduction in number of non-elective admissions by 3.5%
- Reduction in the rate of Delayed Transfers of Care days by 46%, from 1,572/100,000 to 843.3/100,000 by the end of March 2016

Developing the Financial Framework

The pooled arrangement needs to be underwritten by a clear set of principles and rules that lay down the way that the host and the partners to the pool will manage their roles and responsibilities. This agreement is set out legally, in the section 75 agreement. Setting a clear framework of understanding of the financial rules underpinning the partners' relationship with the pooled fund will improve the future resilience of the pooled fund.

The detail of the agreed approach to managing the governance, regularity and financial management of the pool will be set out in a jointly owned Financial Framework, which is currently being drafted. The scope of the framework addresses:

- adopting the framework
- scope and objectives of the pool
- partners' responsibilities
- pool's responsibilities
- governance of the pool, including the structure of governance
- corporate and annual plans and annual budget setting
- managing the pool and the pooled budget
- monitoring performance
- managing risks.

The framework sets the rules for both partners to the pooled fund. Recognition of the key likely financial risks and challenges; and how these will be addressed, is a critical element of the framework.

Risk Sharing Principles for Health Integration

Both organisations start with the premise that the pool will be managed in such a way that allocative efficiency is achieved; it will not overspend and commissioning intentions and activities will be directed towards achieving this. However it is also recognised that significant elements of the pool are demand led and along with the current and forecast pressure on resources, there needs to be clear risk sharing principles in place from the start. A suggested basis for our principles is:

- The pooled budget arrangements will be managed in such a way as to avoid destabilising either organisation;

- Each partner will retain responsibility for dealing with any deficit it has at the start of the pooled budget arrangement.

- The contribution each partner makes to the services funded from the pooled budget will be the same contributions that would be made if the services were funded within its own agency.

- The partners will strive to achieve a balanced budget within the pooled budget.

- The statutory requirements of each organisation must be maintained

- The pooled budget will contain a mechanism for dealing with significant changes to the funding or statutory responsibilities of either partner that affect the areas in scope of the pooled budget arrangement. This will include limits around materiality and apply where changes have a cumulative impact of less than£500k a year.
  Changes with a cumulative impact of more than £500k per year will be dealt with as a material change to the pooled budget arrangement that requires renegotiation and amendment to the s 75 agreement.

- The mechanism should be transparent and as simple as possible

- These risk sharing principles need to be revisited on an annual basis at the same time as the S75 agreement is reviewed to ensure there have not been any significant changes. Arrangements must be flexible enough to respond to changes in funding frameworks

- Current reserves will remain within existing organisations and a portion of any pooled budgets need to held as a contingency to allow scope for delivering either new innovations or supporting unforeseen demands in the system until a planned approach can be developed.

- Both organisations will meet on a quarterly basis to update each other on indications from central government in terms of priorities and funding.

- The partners will develop appropriate financial management agreements which feed into the corporate governance arrangements of each partner agency and provide robust management information.

- Both organisations through joint working on integration will move towards redressing existing underlying overspends

- The partners will agree a clear mechanism for setting annual operational and financial forecasts that meets each partner's timeframes for budget setting

- The partners will agree a mechanism for the early identification of potential in-year under or over spends and for the evaluation of any potential remedial actions

- Risks and benefits will be apportioned in the same proportion as contributions to the pooled budget arrangement (currently assumed to be on a 75%/25% split for working purposes)

- Maximising income generation through treasury management is a priority for both partners with benefits shared on 75/25 % split.

Managing the Pooled Budget

In order to supplement the risk sharing arrangements and to provide appropriate levels of assurance and ensure rigorous and robust management of the pool a series of structures and systems are required to be put in place. As such it is proposed that the following arrangements be further scoped, designed and then implemented.

Development of Integrated Management Structure (IMS)

- Consists of Finance, Performance and Finance Leads
- Responsible for the day to day management of the services within the pool

Appointment of Pool Manager

- Responsible for managing the budget of the pooled fund
- Responsible for forecasting and reporting to (IMS)
- Providing quarterly reports to each partners and annual report
- Arranging for auditing of accounts

Managing Over/Underspends

- Pool Manager notifies partners within 10 working days
- IMS prepare joint action plan

Annual Reviews of Pool Budget

- An annual review of the section 75 will be undertaken to include operational arrangements, demand issues and funding sources

Exit Arrangements

- Each party will be able to serve 3 months-notice

It is proposed that the final version of the Section 75 is presented to both governing bodies in early 2015. Before this the Section 75 will be subject to independent legal scrutiny to provide assurance to both organisations that the appropriate levels of due diligence are in place.

Section Four Pool Budget Holder- Options

Hosting of the Pool

Bevan Brittan has been commissioned, by the Department of Health to draft a template section 75 agreement for clinical commissioning groups and local authorities for jointly commissioning services to deliver the objectives of the Better Care Fund. Paragraph 7 of this model reflects the Regulations to the Act that require a host partner to be appointed. It states that:

> "…the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:
>
> - holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;
> - providing the financial administrative systems for the Pooled Fund; and
> - appointing the Pooled Fund Manager;
> - ensuring that the Pooled Fund Manager complies with its obligations under this Agreement."

The Healthcare Financial Management Association (HFMA) suggests that either party to the s75 agreement may act as the host partner (Pooled Budgets and the Better Care Fund, HMFA, October 2014). One of the key factors specific to the choice of host for the Plymouth pooled fund is the need to clarify the respective ability to set up the contracts that will be necessary for commissioning the range of services covered by the Pool, including the requirement to ensure that commissioning for prescribed NHS services is delivered through the NHS standard contract; and any differences in the scale of re-drafting, or novating of contracts that will be required at the start of the pooled fund hosting arrangements.

Whichever organisation is chosen to host the pooled fund(s) will need to ensure that governance and management arrangements are sufficient to deliver the statutory, regulatory and local requirements of both partners, including:

- staffing the pooled fund administrative team, including arrangements for sharing staff between the two organisations
- VAT management differences in NHS and local government
- statutory financial reporting regimes, including annual accounts closure and reporting requirements
- ledger management arrangements
- income charging arrangements
- external and internal performance monitoring and reporting requirements.

The HFMA guidance also identifies that both partners will need to be aware of the cultural differences between NHS and local government.

Critical Decision Factors Summary

To support the decision making process the following decision matrix has been developed.

Category	Decision Factor	PCC Considerations	CCG Considerations
Finance	VAT Regulations	Able to reclaim VAT	Health care spend is VAT exempt
	Budgetary Management Practises	Obligation to achieve balanced budget	Obligation to achieve balanced budget although some history of agreed deficit
	Spend profile	Spend distributed across multiple contracts	Spend largely distributed across two major contracts
	Budgetary Scale	Budget is approximately £100mil	Budget Approximately £400mil
Legal	Contractual Obligations	Mostly locally determined through prioritisation with some nationally prescribed obligations	Nationally mandated and locally determined through prioritisation
Corporate Governance	Management structure	Political hierarchy	Clinically Lead
IT	Budgetary support systems	Challenges around robustness to support joint budget	Challenges around robustness to support joint budget
Operations	Ease of business migration	Difficulty is segregating shared centrally held budgets	Part of integrated commissioning function will serve wider geography; must be mutually permissive with wider CCG
	Existing Practises in joint commissioning	Already holds contracts for CCG/makes payments	Historically in Plymouth often does not assume lead commissioner role in joint commissioning

Further work on who will host the pool budget is ongoing and will be finalised as part of the section 75 development. Once the decision as to which organisation should host the pooled budget has been made, it will be important to establish the pooled fund management arrangements promptly, so that the plans for administering the pool can be agreed.

Section Five Integrated Commissioning Design

Introduction

The ultimate Goal of the Integrated Commissioning Project is to create a single integrated Health Care and Social Care Commissioning organisation to serve Plymouth and, for health care commissioning, the remainder of the Western Locality (i.e. South Hams and West Devon).

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

Key Outcomes

Outcome	Benefit
A single, integrated and coordinated approach to commissioning across the social care and health system	Targeted investment
Established protocols and pathways with clear governance agreements	Increased efficiency
Transparent performance framework	Robust quality management
Transparent financial framework	Robust cost management
Shared services	Resource savings
Financial risk sharing	Value for Money
Removed Organisational Boundaries	Increased Flexibility
	Increased Efficiency
	Financial certainty for providers
	More integrated back-office support

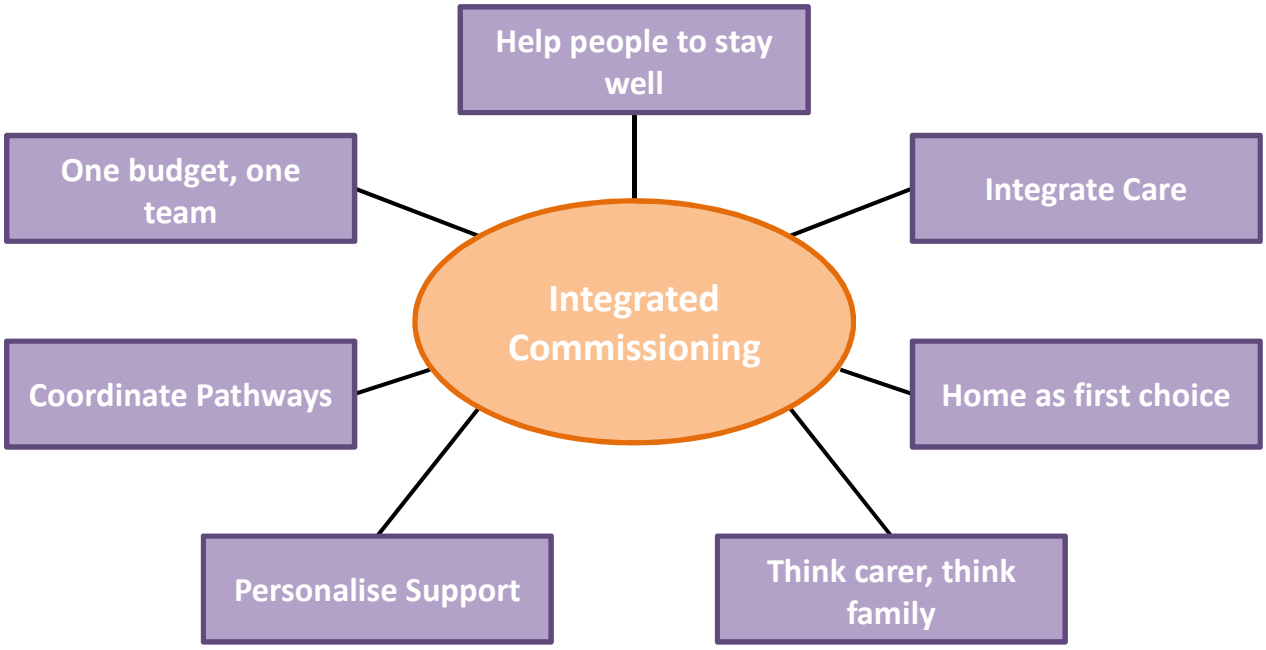
Areas for consideration

The following areas are what have been listed as under consideration by both PCC and CCG for delivery of Integrated Commissioning by 1st April 2015

Area	Under Consideration		Out of Consideration	
	PCC	CCG	PCC	CCG
Finance	✔	✔		
IT	✔	✔		
HR	✔	✔		
Legal	✔			✔
Operations	✔	✔		
Governance	✔	✔		
Organisation	✔	✔		
Information and Intelligence	✔	✔		
Quality and Patient Safety and Safe Guarding	✔	✔		
Market Management and Procurement	✔	✔		
Contract Monitoring	✔	✔		
Communications	✔	✔		

Design Principles

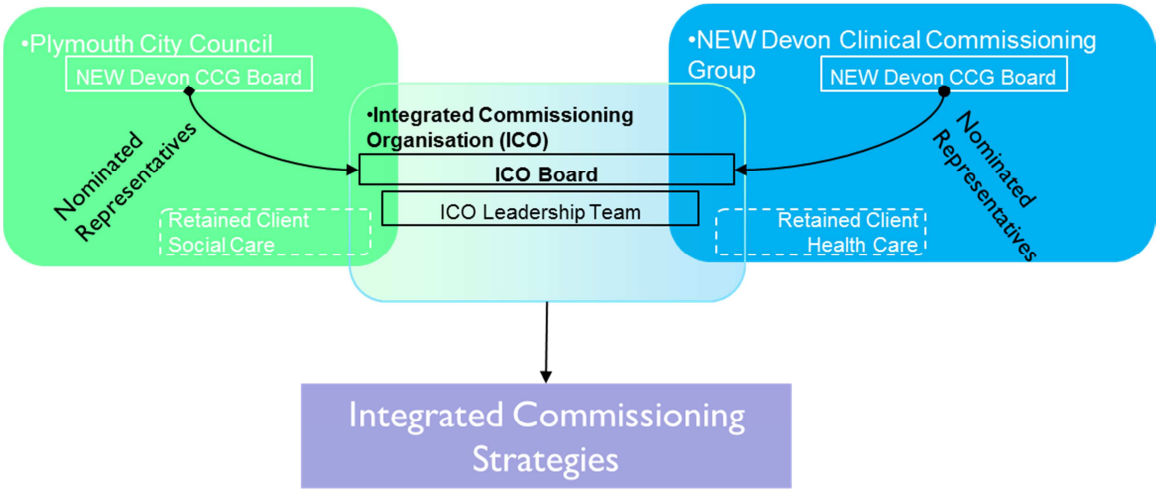
The integrated commissioning function will work to the agreed vision and strategies. Some current features of the strategies of both organisations include the following:



Logical Organisation April 2015

Key features of this structure are:

1. Health care and Social Care Budgets will be pooled under PCC or CCG
2. Commissioning staff associated with each form of care will be working according to the new Integrated Commissioning Strategies
3. Both PCC and NEW Devon CCG will devolve commissioning responsibilities and make resource contributions to the "shadow ICO" whilst retaining their individual statutory accountabilities



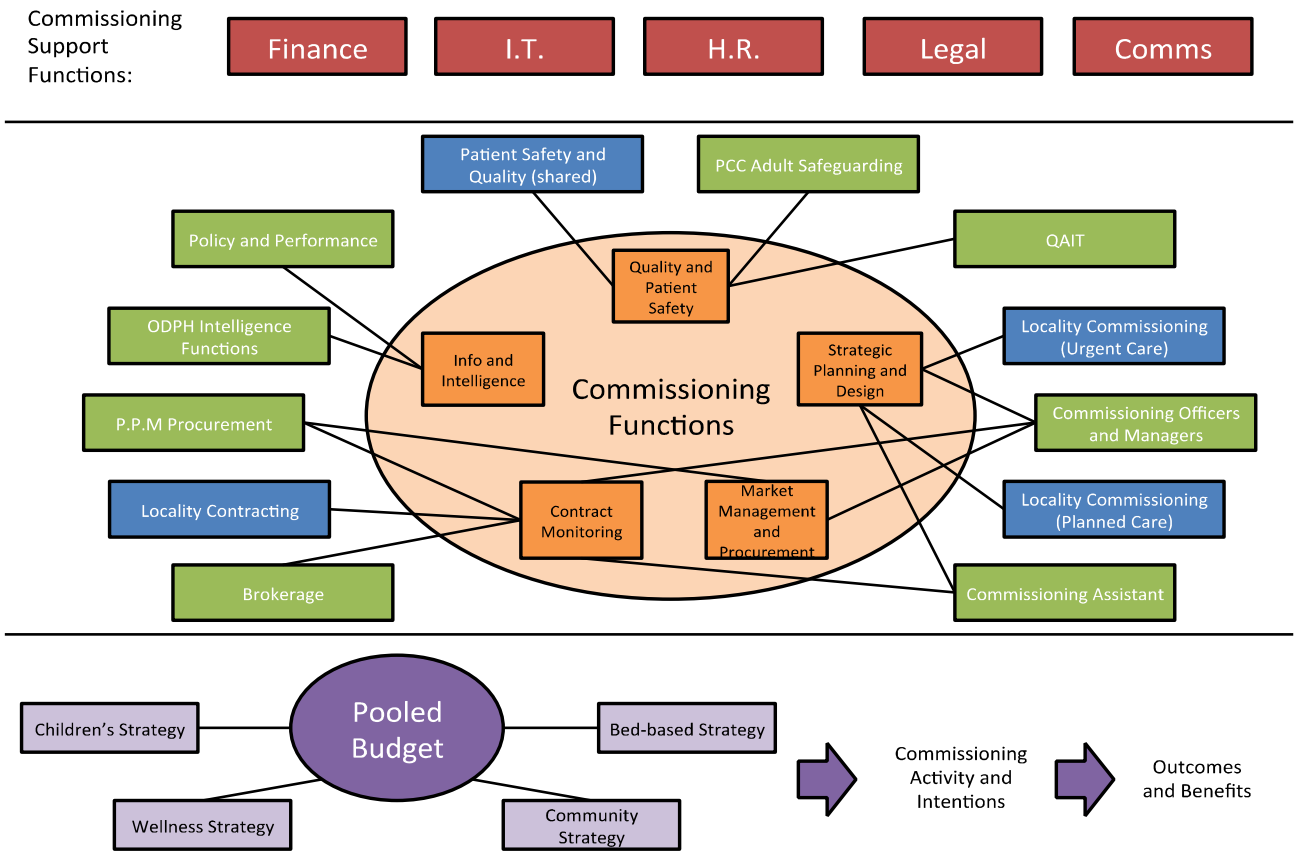
Integrated Commissioning Business Capabilities

Feedback from workshops and discussions with key personnel have identified the following core capabilities

Integrated Commissioning Core Capabilities				
Information and Intelligence	**Quality and Safety**	**Strategic Planning and Design**	**Market Management and Procurement**	**Contract Monitoring**
Population Needs Assessments	Quality & Patient Safety	Service User Engagement	Market Management and Development	Performance Monitoring
Operational Intelligence	Safeguarding	Commissioning Strategy Development	Strategic Procurement	Contract Reviews
Evidence Based Advice	Quality Assurance and Improvement	Resource Prioritisation	Brokerage/Individual Placements	Quality Reviews
Outcome Setting		Service Design and Spec Development	Decommissioning	
Research				
Monitoring and Evaluation				
Support Capabilities				
Finance Management	IT Management	HR Management	Legal Management	Communications Management
Business Administration	Change Management	Partner Management	Medicines Management	

Capability Mapping

Capability	PCC Organisation	CCG Organisation
Information and Intelligence	Policy and performance	
	ODPH Intelligence Functions	
Quality and Patient Safety and Safeguarding	PCC Adult Safeguarding	Patient Safety and Quality (Shared)
	Quality Assurance Improvement Team (QAIT)	
Strategic Planning and Design	Commissioning Officers	Locality Commissioning (Planned Care)
	Commissioning Managers	Locality Commissioning (Urgent Care)
	Commissioning Assistants	
Market Management and Procurement	P.P.M. Procurement	
	Commissioning Officers	
	Commissioning Managers	
Communications	-	Locality Communications (Shared)
Contract Monitoring	P.P.M. Procurement	Locality Contracting (Shared)
	Brokerage	
	Commissioning Assistants	
	Commissioning Officers	
	Commissioning Managers	
Finance		Locality Finance (Shared)
Partnerships		Locality Partnerships (Shared)
Medicines		Medicines Optimisation (Shared)
Business Administration		Locality Office
Change Management		Locality Programme



Capability Changes

<table>
<tr>
<td>IT

The following changes will be made to the IT Management Capability:
▪ A shared folder will be provided that is visible to both PCC and CCG integrated commissioning staff to allow for collaboration
▪ Existing IT workarounds within PCC will be retained</td>
<td>HR

The following changes will be made with respect to the Human Resource Management Capability configuration:
▪ Staff involved in Integrated Commissioning will be identified and notionally segregated
▪ Staff involved in integrated commissioning activities will still be employed by their owning organizations
▪ There will be no staff transfers or secondments
▪ Staff serving the Western Locality within the NEW Devon CCG will continue to serve the Western Locality</td>
</tr>
<tr>
<td>Finance

The following changes will be made to the Finance Management capability:
▪ Funding for Integrated Commissioning Operations will be re-aligned to a single pooled budget
▪ The single pooled budget will be held by a single organisation (TBD)
▪ Accountabilities of the organization contributing to the pooled budget will be retained by the contributing organization
▪ VAT operations with respect to Integrated Commissioning operations will be re-aligned to satisfy the VAT regimes of both Plymouth City Council and the NEW Devon Clinical Commissioning Group</td>
<td>Legal

The following changes will be made to the legal management capability configuration:
▪ The Integrated Commissioning organisation will be supported by a legal agreement that adheres to Section 75 of the Health and Social Care Act 2012
▪ A new legal entity will not be created to support the April 1st 2015 release of the Integrated Commissioning function
▪ There will be no changes to existing contracts
▪ Legal services for social care will continue to be provided by the PCC in house Legal function</td>
</tr>
<tr>
<td colspan="2">Commissioning
The following changes will be made to the Commissioning function:
• Model will put people/communities in the centre
• Design will be easily recognisable to staff from both organisations, be clear and simple
• The new Integrated Commissioning function will be supported by the creation of an Integrated Leadership team
• Public Health Advice and Business Intelligence will inform and influence the ICO across the entire system
• The commissioning design will maximise the use of existing knowledge and skills whilst facilitating a culture where the workforce is developed to address future requirements.</td>
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- Initially staff will be aligned in 5 key areas:
  - *Wellness*
  - *Community-based Care*
  - *Complex*
  - *Acute*
  - *Children*

Section Six High Level Commissioning Strategies

In order to make the step change in planning and designing public services it is vital that commissioning activity is focused at a system level. To support this approach a number of system level commissioning strategies have been developed and these are outlined below. These strategies will be further developed leading to the development of integrated commissioning intentions and activity.

COMMISSIONING STRATEGY FOR ACUTE CARE SERVICES - SUMMARY

Currently NEW Devon CCG commissions a range of planned care services and interventions across a variety of settings, for which the CCG has existing strategies and associated plans which are relevant to the scope of "acute" commissioning.

There is also a variety of specialist health care needs which may be provided locally or outside of the Locality and for which the CCG does not have direct responsibility but an interest in terms of delivery of pathways of care.

PCC do not currently commission planned health care services.

As part of integrated commissioning, all service provision will be considered jointly as this aligns with the proposed whole system approach.

COMMISSIONING STRATEGY FOR CHILDREN AND YOUNG PEOPLE- SUMMARY

This strategy seeks to take a whole system review of services to meet all levels of need, including collaborative working and capacity building with partners to enable prevention and early help.

The Case for Change

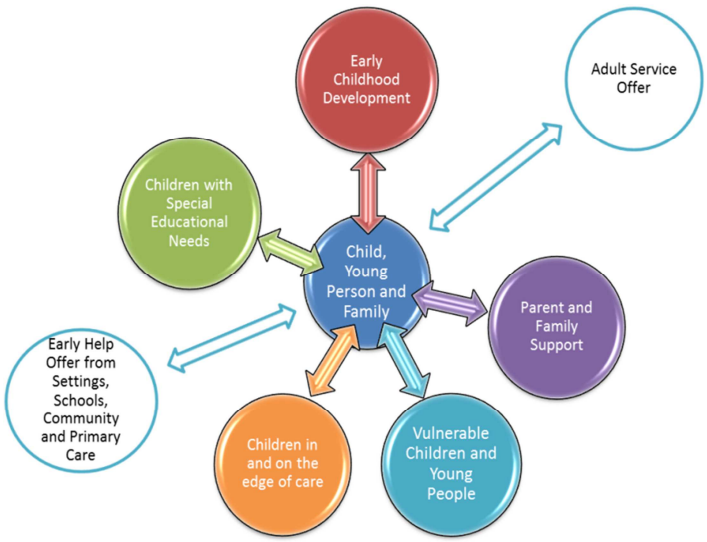
- The Children and Families Act 2014 seeks to improve services for vulnerable children and support strong families.
- Childhood represents a unique opportunity to prevent lifelong poor outcomes through targeted prevention and intervening early when difficulties arise.
- Deprivation in Plymouth is higher than average and about 22.4% (10,100) children live in poverty
- There are continued significant health and education inequalities between vulnerable children and their peers.
- Plymouth has seen a steady increase in the number of referrals to specialist services, including Children's Social Care, Child and Adolescent Mental Health Service (CAMHS) and hospital admissions.

The Current System & Spend

- A large part of the existing pattern of services has been designed and developed around specific service responses to specific need, with a range of thresholds, outcomes and targets.
- The separation of budgets and processes can cause a delay in the ability to offer the right support at the right time.
- Despite some improvements in the targeting of services to those who need them most, there is still an increase in the numbers of children with complex needs, who require a high cost service response.

The Proposed Future System – What We Need To Do

This strategy sets out five core categories of services to inform future commissioning to form an offer of integrated service provision to meet presenting need.



Commissioning Priorities

- Create an Early Help Single Point of Contact
- Remodel Family Support into a single service response.
- Review how Early Years services deliver key pathways to ensure
    - the right support for vulnerable families,
    - improvement in public health outcomes
    - children are ready for school
- Build a competent, confident and collaborative workforce that can deliver early help including for
    - Behaviour, social and emotional difficulties
    - Speech language and communication issues
    - Autistic Spectrum Conditions
- Develop business case to fully integrate the health and local authority offer for those with special educational needs and disability
- Commission an alliance/collaboration of providers to support vulnerable Children and Young People
- Develop integrated "wrap-around" support for children in and on the edge of care

COMMISSIONING STRATEGY FOR WELLBEING – SUMMARY

This strategy covers services that are generally universally accessible with key aims of promoting individual, family and community health and wellbeing, and / or preventing the need for statutory services.

The Case for Change

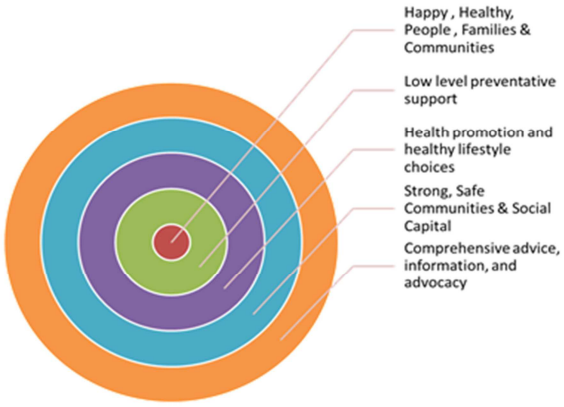
- Health inequalities – health outcomes are persistently poorer in deprived areas
- Negative health behaviours e.g. smoking are more prevalent than comparator areas and mortality rates for preventable disease are high in Plymouth: 4-4-54%
- National and local policy and legislative drivers push towards more preventative and early intervention services that build the capacity of people to make healthy life choices
- Increasing ageing population will put pressure on the health and care system
- People in Plymouth have told us they want health and care services that enable them to manage and improve health in a community setting

The Current System & Spend

- There is no defined wellbeing 'system' - multiple commissioners and limited join up
- Range of services have been commissioned in response to specific priorities and needs, that overlap / duplicate
- Limited understanding of the impact 'Wellbeing' services have on health promotion and prevention
- Majority of commissioning activity and resource through Plymouth City Council

The Proposed Future System – What We Need To Do

Commission wellbeing services that empower and enable people to live healthier lives for longer are crucial to meeting future demand for health and care services.



Commissioning Priorities

Develop a 'Advice and Information Strategy' in response to the Care Act

Strategic review of volunteering

Primary Care co-commissioning with Area Team

Physical Activity Commissioning Plan

4-4-54 Action Plan

Strategic review of low level preventative services to ensure a sustained impact on improving wellbeing and reducing pressure on the wider health and social care

Wellbeing System Element	System Outcomes	Potential delivery mechanisms
Comprehensive advice, information and advocacy offer	Well informed communities empowered to make positive health choices	Advice and information (Advice Plymouth, Livewell Team PCH, libraries), social prescription, support early diagnosis
Strong, Safe Communities & Social Capital	Improve wider determinants of health	Timebanking, volunteering, carers
Health promotion & healthy lifestyle choices	Promoting and enabling healthy lifestyle choices	Primary care, physical activity services, self-management Livewell Team PCH
Low level preventative support	Reducing or delaying the need for specialist care and support	Befriending, home from hospital, sheltered housing

COMMISSIONING STRATEGY FOR COMMUNITY - SUMMARY

This strategy covers targeted health and care services for people who need support to live in the community, or who may be at risk in the future. This includes services that provide an urgent or rapid response to an immediate health and care need, to longer term services that help maintain independence for as long as possible.

The Case for Change

Projected demographic changes indicate an increase in the older population, and an increase in complexity of health and care needs

There is significant overlap in the support needs of people currently accessing homelessness, substance misuse and mental health services

National and local policy requires a focus on:

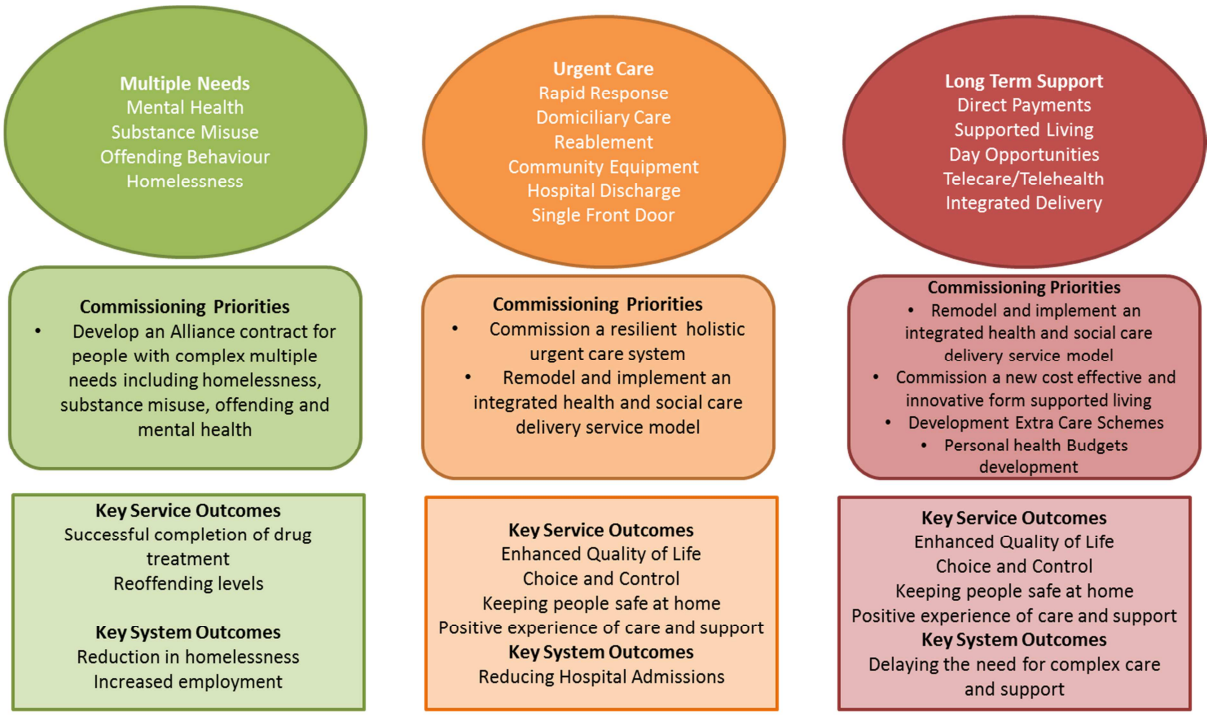
- Preventing avoidable hospital admissions / readmissions
- Improving hospital discharge - reducing delayed transfers of care from hospital to the community, and proportion of people still at home 91 days after discharge
- Preventing permanent admissions to residential and nursing homes
- Individualised care – Self Directed Support and Personal Health Budgets
- Integrated health and social care delivery

People in Plymouth have told us they want health and care services that enable then to manage and improve health in a community setting, and they only want to 'tell their story' once

The Current System & Spend

- No consistent approach to delivery of health and social care
- Multiple commissioners across the system - a more joined up approach would create streamlined services
- Significant budget pressure across the system

The Proposed Future System – What We Need To Do



COMMISSIONING STRATEGY FOR COMPLEX - SUMMARY

This strategy covers services that support people with complex health and care needs, who require specialised care mainly delivered in hospital, residential or nursing home settings and some support at home.

The Case for Change

Projected demographic changes indicate an increase in the older population, and an increase in complexity of health and care needs – putting pressure on the current health and care system

A high proportion of Plymouth's mental health spend is on out of area Individual Patient Placements (IPP's)

National and local policy requires a focus on:

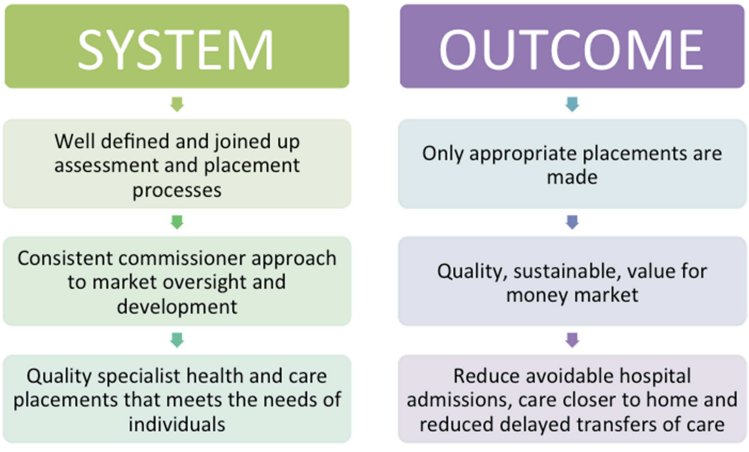
- Preventing avoidable hospital admissions – we have a statistically significant higher proportion of admissions to hospital from care homes
- Reducing delayed transfers of care from hospital to the community – local studies / information indicates that older people in hospital could be cared for in an alternative community setting
- Ensuring the quality and governance of CHC and IPP assessment processes
- Providing care closer to home where possible
- Increasing the proportion of all deaths that occur at home
- Having clear market oversight as a result of the Care Act 2014

People in Plymouth have told us they want health and care services that enable then to manage and improve health in a community setting

The Current System & Spend

- The system for assessing, sourcing and placing people in care homes or IPP's is inconsistent across both providers and commissioners
- There are budget pressures on Continuing Health Care and Individual Patient Placements (out of area beds)
- There is limited oversight across commissioners of the care home market creating a range of rates and quality for PCC, CCG, and self-funders.

The Proposed Future System – What We Need To Do



Commissioning Priorities

Develop an integrated assessment, referral and placement process for care homes and IPP's across health and social care

Market review of the care home sector to ensure consistent quality and rates irrespective of who is the commissioner

Review and redesign local pathways and provision in order to prevent and reduce out of area IPP's

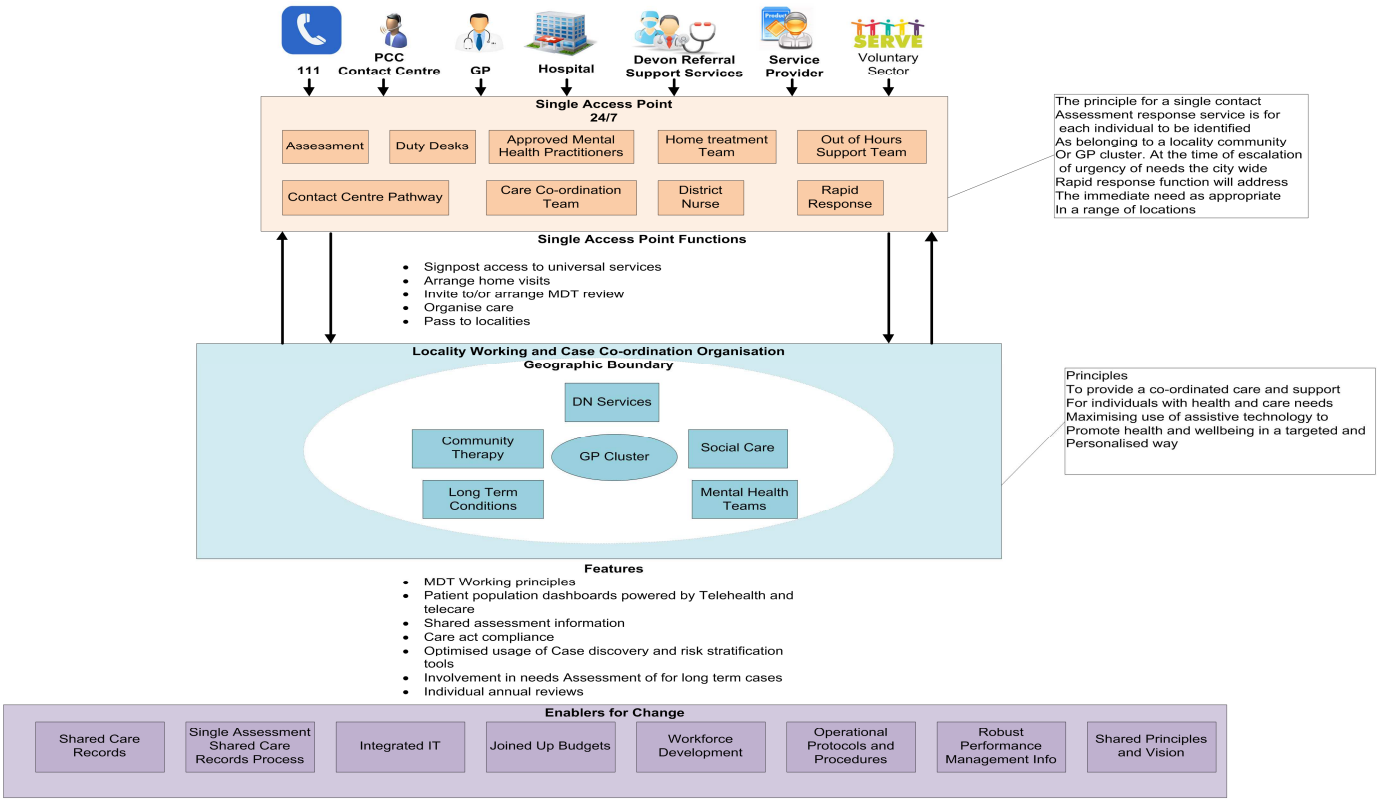
Develop a commissioning plan for end of life care

Commission an effective dementia care pathway

Section Seven Commissioning the new Integrated Health and Social Care Provider

Integrated Provider Design

A key aim of the Integrated Commissioning project is to commission an integrated health and social care community provider. Commissioners and providers have collaborated to develop the following high level design model -



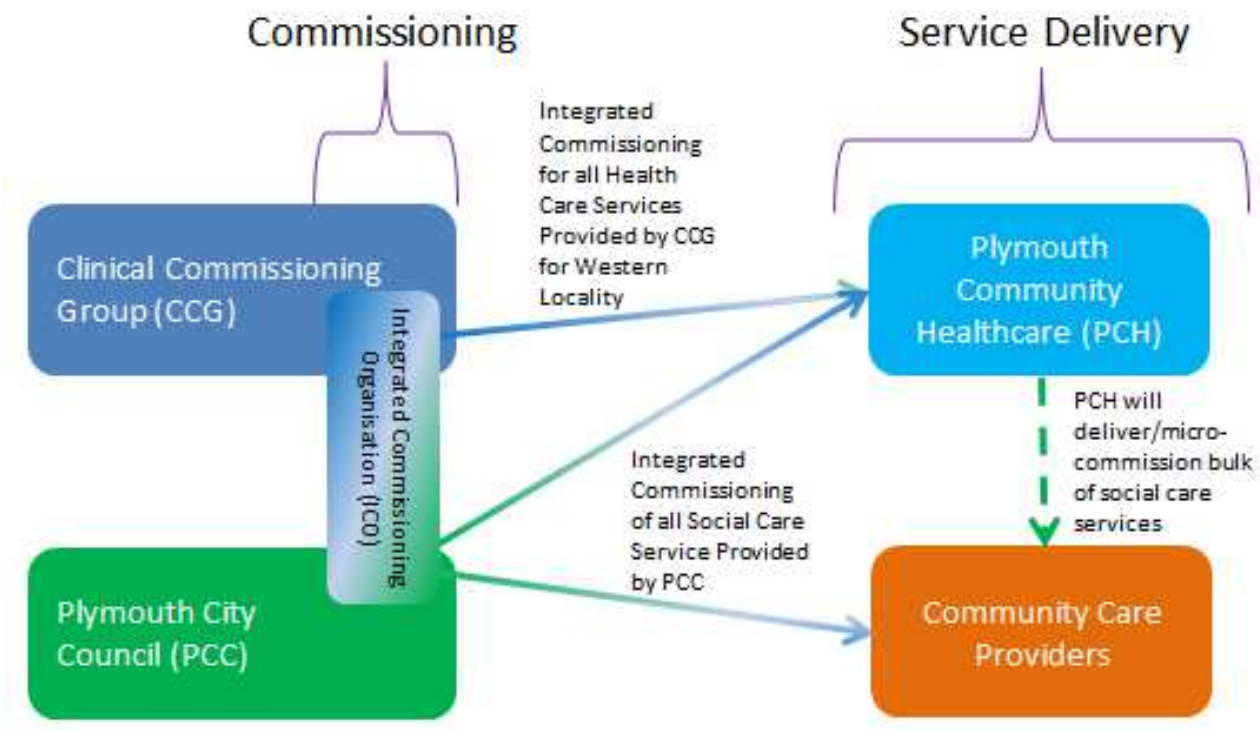
Going forward it is recommended that the Integrated Delivery project focuses on the detailed operational design and transfer of staff whilst the Integrated Commissioning process focuses on the commissioning and contracting of the new provider.

Target Operating Model

The diagram below shows the relationship Integrated Commissioning and Integrated Service Delivery Model that will come into effect 1st April 2015.
Key features of this model are:

1. The "shadow" ICO will create the Service Delivery specification, develop the performance frameworks and contract monitoring arrangements that the new integrated provider of Health and Social Care will be required to deliver against.

2. The provider will be responsible for assessment and planning of support for users of services, the micro-commissioning social care services will remain where the budget sits and this is likely to be within the shadow ICO.



Protecting Social Care

In order to ensure that Plymouth City Council delivers its statutory duties and ensures a continued focus on promoting social care it is recommended that three interconnected approaches be taken forward.

Contractual	Provider	Retained Client
•Due Diligence Process •Specifications •ASC Delegated Statutory •Front Door •Rapid Response •Localities •Service Improvements	•Senior Social Care Staff within PCH •Principle Social Worker •Work Force Development Posts •Specified minimum number of SW, OT's, CCWs	•DASS Role •Oversight of Statutory Functions & Returns •Safeguarding •Brokerage/Verification

Key elements of these arrangements are set out below:

Contracting Process

At the start of the formal commissioning process Plymouth City Council will undertake a thorough due diligence process on Plymouth Community Healthcare to determine its suitability to deliver Adult Social Care services. The process will focus on the following core areas;

- Professional and Business Standing
- Organisational Finance & Insurance
- Health & Safety Policy & associated documentation
- Data Protection
- Equalities and Diversity Policy & associated documentation
- Safeguarding Vulnerable People Policy &associated documentation
- Quality Management
- Recent Contracts/References
- Business Capability – focus on skills knowledge and previous experience and Business continuity plans

The process will be undertaking by an evaluation team with representatives from Commissioning, Procurement, Finance, Human Resources, Legal Services and Adult Safeguarding with sign off being provided by the Strategic Director for People.

Service specification development and Contract Negotiations will be undertaken jointly by NEW Devon CCG and Plymouth City Council and will form part of the wider CCG contracting round with final Contract Award being brought back to Plymouth City Council's Cabinet in early 2015.

Provider Function

The new service specifications set down by Commissioners will clearly state the expectations in relation to Adult Social Care staff, practice, professional development and continuous improvement. This includes ensuring Social Care staff have senior roles in the integrated provider, the appointment of a Principle Social worker to provide quality assurance to practice, develop workforce plans and ensure competency of the workforce is maintained to achieve statutory requirements. The specification will also set down a minimum number of Full Time Equivalents in relation to Social Workers, Community Care Workers and Occupational Therapists.

Retained Client Function and Statutory Functions

Within the new arrangements model it is recognised that Plymouth City Council will delegate some of their statutory functions whilst retaining others. These are set out below-

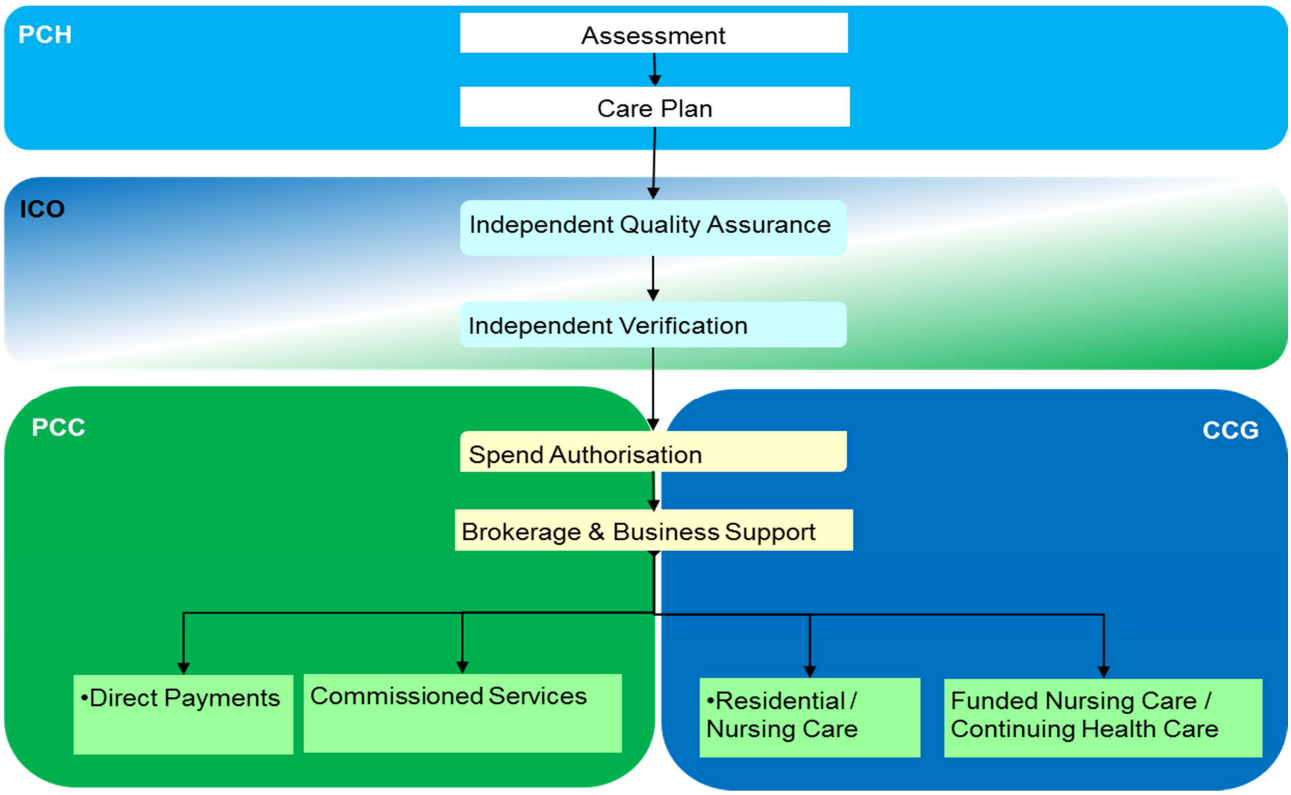
Care and Support Assessments	Can be delegated to alternative provider
Development of Support Plans	Can be delegated to alternative provider.
Provision of personal budget	Can be delegated to alternative provider
Safeguarding	Can delegate alert capture, information gathering and investigation. Outcomes must

	be subject to scrutiny from Independent Chair/Safeguarding Manager within LA
Carers assessments and provision for carers	Can be delegated to alternative provider
Fairer Charging Policy	Provider to apply the policy but LA to hold.
Development of policies	Policy changes overall need to remain in LA.
Powers to enter a property Section 47 of National Assistance Act, now section 47 of Care Act	Specification will need to ensure Social Workers are available to undertake joint visit with environmental Services if access to a property required
Emergency Planning	Responsibility to establish rest centre can be delegated to another Category 1 responder such as PCH.
Communication and disclosures	Liaison with press and members liaison will need to be managed by Commissioners in partnership with new provider
FOI/Complaints/Representations	Initial complaints can be managed by integrated provider. Ombudsman requests and FOI will remain with LA
Necessary and Appropriate confirmation for Disabled Facilities Grants under Housing and Regeneration Act	Can be delegated to alternative provider, but needs to be undertaken by suitably qualified Allied Health Professional
Mental health Act/ Mental Capacity Act	AMHPs need to be approved by LA, cannot be delegated. Guardianship Orders need to be signed off by LA, cannot be delegated.
DASS function/role	Needs to be retained by Local Authority
Statutory Returns (See below)	Cannot be delegated. PCH to collect data and LA to make return.

Adult Social Care Finance Return	Mental Capacity Act – Deprivation of Liberty Safeguards Mental Capacity Act – Deprivation of Liberty Safeguards – Quarterly Return
Mental Health Guardianship	National Minimum Data set for Social Care
Short and Long Term (SALT) Return for the year ending 31 March 2015	Safeguarding Adults Return
Registers of people who are blind or partially sighted	Adult Social Care Survey, 2014/15
Survey of Adult Carers in England, 2014-15 (biennial)	ASC Outcomes Framework

Verification Model

Maintaining oversight and management of Adult Social Care funding will be a key element of the new arrangements with an outline verification process set out below:



The new integrated provider of Health and Social Care Services will provide a single access point for all incoming enquiries across the system. This will be available for members of the public, their carers', service providers, professionals and GP's. This service will offer excellent advice and information using the existing Online Directory, provide access to immediate support or arrange for clinic appointments as necessary. Following the assessment of needs the provider will develop a plan with the individual detailing the support that they require to meet their current needs this may take the form of support from the voluntary sector, friends and family as well as targeted support from commissioned services. Following an internal quality assurance process the provider will pass this proposal to the Local Authority's verification team who will review the plan, ensure statutory needs have been addressed and agree funding for the proposal. Plymouth City Council Brokerage team will then source the package of care to ensure that value for money is obtained from the market.

Section: Eight Project

Project Plan

Workstream	Activity	Timeframe
Commissioning Design	Develop commissioning model for integrated commissioning function	October- November 2014
	Agree areas in scope	November/December 2014
	Confirm staff in scope across organisations	January 2015
	Scope High Level Business Requirements to Support Integrated Function	November-December 2014
	Agree Commissioning Design	February 2015
	New Integrated Commissioning Function in Place	March 2015
Legal and Governance	Develop New Integrated Commissioning Governance Architecture proposals	November 2014 – January 2015
	Develop and Agree Interim Management Structure	November 2014 – January 2015
	Move to Shadow Governance Arrangements	January 2015
	Develop Schemes of Delegation	January 2015
	Finalise Pool and Sign off Section 75	February 2015
Finance	Identify Spend in Scope and Develop Spend Profiles, Funding Framework and Risk Sharing Principles	September – November 2014
	Agree Size of Pooled Budget and Host Organisation	November/December 2014
	Appoint Pooled Budget Manager	February – March 2015
	Agree financial framework and risk sharing	February 2015 (in Section 75)

Workstream	Activity	Timeframe
Strategy Development	Commence Engagement with Providers and Stakeholders on Strategies and Service Specification	November 2014
	Development of Commissioning Strategies (Wellness, Community, Complex, Children, Acute)	November 2014 – February 2015
	Consultation on Strategies	February - March 2015
	Finalise Commissioning Strategies	April 2015
	Establish System Design Group	April 2015
Commissioning the New Integrated Provider	Develop New Integrated Provider Specification	September – November 2014
	Develop Performance/Contractual Management Framework for New Integrated Service Delivery Provider	October – November 2014
	Complete Due Diligence on Preferred Community Provider	November 2014
	Commence Procurement/Contract Negotiation Process for New Integrated Service Provider	November 2014 – January 2015
	Contract Award	March 2015

Communication Plan

A communications plan has been produced by Plymouth City Council and Northern, Eastern and Western (NEW) Devon CCG to support the integrated health and wellbeing (IHWB) transformation programme. The plan covers the communications requirements for the commissioning and delivery of health and social care services. Focused communications and engagement events have taken place as illustrated in the table below in order to support the engagement plan and co-design process with staff from across all organisations. In addition Integration has been added as an agenda item to team meetings with appropriate presentations and other materials shared with the teams. A film is in the process of being edited that includes various people talking about integration and what this actually means and includes interviews with the public, someone who has used and been through health and social care services (as a case study), Commissioners, frontline staff from Plymouth City Council Adult Social Care and those from Derriford and Plymouth Community Healthcare who work in the Care Co-

ordination Team as well as the Cabinet member for Health and Adult Social Care and Dr Steve Harris, clinical GP lead in the CCG for integration.

An engagement plan has also been developed and sets out who we will engage with, how, when and why. For both the Western Locality of NEW Devon CCG and Plymouth City Council it is important that the people affected by decisions are part of the decision-making process, both organisations place a high value on the input of stakeholders into the decision-making process and both work to a set of engagement principles which are that we will:

- Involve and engage all those people who experience healthcare and who wish to be involved
- Involve people in the whole decision making process
- Recognise that interest in being involved will vary and that decisions not to be involved must be respected too
- Provide information that is clear, appropriate, timely, accurate and up-to-date
- Make sure that there are appropriate opportunities for people experiencing care to be involved
- Make sure that any support people need to be involved effectively is provided for
- Treat everyone with respect and respect their dignity
- Value every voice
- Make no decision about you without you

It is proposed that the public engagement fall into three stages. Stage one is predominantly about giving people the information they need to be constructively involved, stage 2 is about providing people with opportunities to contribute to the discussions relating to specific services and stage 3 is about providing feedback so that the public is able to see how their contribution has impacted on the outcomes of the work.

Date	**Project**	**Event/ Actions**	**Key outcomes/ messages**	**Comms or Engagement (C/E)**	**Stakeholder**	**Channel**
Future plans						
TBC	Commissioning / Delivery	Whole staff engagement sessions	AD staff engagement sessions on Integration and BAU	C/E	ASC C & D Staff	F2F
TBC	Commissioning / Delivery	Engagement Events	1) HealthWatch, the Octopus project 2) Facebook page 3) Online via web	C/E	ALL	F2F, Social Media, Internet
TBC	Commissioning / Delivery	Sofa/foyer event at WH	Opportunity for staff to discuss with each other and management and ask questions in an informal setting	C/E	Commissioning Staff PCC/CCG, Delivery staff, Staff at Windsor House	F2F

TBC	Commissioning	Post event comms	To be issued to PCC and NHS staff who attended the design events on 4 &5 Sep a post event communique.	C	Commissioning Staff PCC/CCG	ASCHQ Email
TBC	Commissioning / Delivery	Case Studies	Cases studies to demonstrate positive outcomes of joint working and commitment to projects	C	Staff across CCG & PCC	Staff intranet
TBC	Commissioning	Visual engagement piece	visual engagement piece i.e. posters, banners etc – these will show 'I' statements, key messages from comms plan, quotes, case studies to remind staff of the evidence that supports integration and promote involvement	E	Commissioning Staff PCC/CCG, Delivery staff, Staff at Windsor House	Visuals
TBC	Commissioning / Delivery	Newspaper Article	Launch of integration agenda in the Herald			

Risk Register and Risk Management

Risk Description (A short summary of the event)	Current Risk Rating	Actions to reduce risk to target
Savings delivered from Integration are not sufficient to meet the financial challenge	H	1. Scrutiny and validation of anticipated projected benefits in further phases. 2. Account for optimism bias in financial model when developed
Staff/union resistance to the proposed changes and service redesign	M	1 Early consultation with Unions 2 Union representation at key workshops. 3 Staff co-design process
Difficulty in securing agreement across the partners to structure and ownership of Commissioning Hub causes delay in delivery leading to savings targets being leaked, and delaying benefits realisation	M	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 4. Confirming VAT impact will support options appraisal. 5. Options appraisal to confirm support. Partners to arrive at decision.
New legislation/policy initiatives introduced which impacts on plans	M	1 Remain well-informed of policy and legislative developments and build in necessary changes early and challenge solution development
Changes to funding environment impacts disproportionately on one agency	M	1 Annual Reviews to be built into Section 75 2 Risk Sharing Principles to be agreed
Legal challenge regarding competition, contracting and procurement	M	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	M	1. Plan and get cross party sign up to this 2.Cross- party investment planning meeting to agree resource commitment
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 implementation	M	1. Potential areas of conflict identified early and formal protocols or agreements put in place
Failing to reach agreed terms that are compliant with Teckal criteria, due to differing legal opinions	M	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. Review with legal teams in PCC and CCG. 3. 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	M	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.	M	1. Potential internal support requirements identified and raised at Joint Management Meeting
System leadership is not sufficiently embedded and does not drive or leaver system change	M	1. Development of Joint Management team. 2. Workforce development activities directed towards building system leadership 3. Transformation capacity directed towards system change
Providers are resistance is change	M	1. Early engagement with provider base 2. Roll out of commissioning principles 3. Establishment of system design groups

Pro-active risk management is applied throughout the process through a series of measures

- Each risk is allocated a risk owner
- Risks are reviewed at Project and Programme Board Meetings
- Risk Workshops are held with members of the project team

Section Nine: Recommendations

Supported by the above information it is recommended that:

8. The new high level governance arrangements set out in Section two are approved
9. The scope of the integrated commissioning pooled budget is agreed and the indicative contributions are noted
10. The Risk Sharing principles are used as a basis to develop the Section 75 Agreement
11. The high level Integrated Commissioning Design is approved and is allowed to proceed to the design and build phase
12. The High Level Commissioning Strategies for Children's, Wellbeing, Community and Complex are approved for consultation and development.
13. The commissioning and contracting approach for the Integrated Health and Social Care Provider is approved.
14. The next steps are noted and the Contract Award report for the Integrated Health and Social Care Provider and the finalised Section 75 agreement is brought back to Cabinet before March 2015