Integrated Service Delivery Scrutiny Report

Programme Name:	Integrated Health and Wellbeing		
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Projects:	Integrated Health and Social Care Delivery		
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Recommendations

1. Cabinet approves the high level operating model for Adult Social Care proposed in section two of this document.
2. Cabinet approves the transfer of staff in scope of this project through the use of TUPE arrangements.
3. Cabinet approves the detailed design that is being proposed and authorise its implementation in partnership with staff and stakeholders and are in support of the actions that will take place as outlined in this document.

1. 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
1.1	24-10-2014	Crag McArdle / Anna Coles	Update following Cab Planning	All
1.2	24-10-2014	Sam Sposito	Editing / proofread	All
1.3	27-10-2014	Jenni Doudoulakis	Editing	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)
23/10/14	PCH	Plymouth community Healthcare Board approval
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
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 SERVICE DELIVERY

The 'right care, at the right time in the right place'

SECTION	SUB SECTION
1. Introduction	Background Strategic Context Programme Approach Workstreams Communication Approach Key Decisions
2. Integrated Service Design	Introduction Context for Change Co-design and High Level Proposals Staff in Scope
3. Project Plan	Next Steps Communications Timeline Benefits Risk Log
4. Recommendations	

SECTION 1 Introduction

Background

The personalisation agenda acted as a catalyst for Local Authorities to bring about significant changes to how adult social care services delivered community care assessments and support plans. Despite these improvements many people that use health and social care services still experience care that is fragmented, with services reflecting professional and institutional boundaries when they 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. Currently people who require support from health or social care in Plymouth have multiple access routes in order to gain support (some are available 5 days per week, some available 7 days per week).

The feedback from the Transforming Community Services engagement work highlighted that individuals are sometimes unsure of how to access support when they need it and organisational boundaries can get in the way of excellent care being delivered. This picture was echoed by staff working across the community through workshop feedback, who have described complex pathways and referral mechanisms to access services which are time consuming to navigate, thus removing their capacity to deliver frontline care and support.

There are a number of national and local drivers for integration including the Health and Social Care Act which contains provisions to enable NHS and Local Authorities to improve patient outcomes, the Care Act which aims to create the new principle where the wellbeing of an individual is at the forefront of their care and support, the Better Care Fund which ring fences budgets to improve out of hospital care, early intervention and admission avoidance as well as Public Health, Adult Social Care and NHS Outcomes frameworks.

The Integration of Health and Social Care service delivery is a complex activity but will be achieved by adhering to the following agreed principles:

- To ensure people who use services design and shape the way these are delivered
- To ensure staff who deliver services have an opportunity to shape the future
- To provide access to the right care and support for individuals at the right time and in the right place
- To ensure people only have to tell their story once

Strategic Context

Public sector organisations across the country are facing a combination of severe budget pressures and increasing demand for services. System wide changes will be needed in order to meet these 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 for people, reduce cost in the system and align to the 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". It provides a core programme to promote integration of Health and Social care, with an emphasis on person centred care. It aims to deliver the right care at the right time and in the right place. The three key principles 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 financial and human) to the prevention, and health and wellbeing agenda.

This will involve working across the whole of the local health, public health and social care systems and 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.

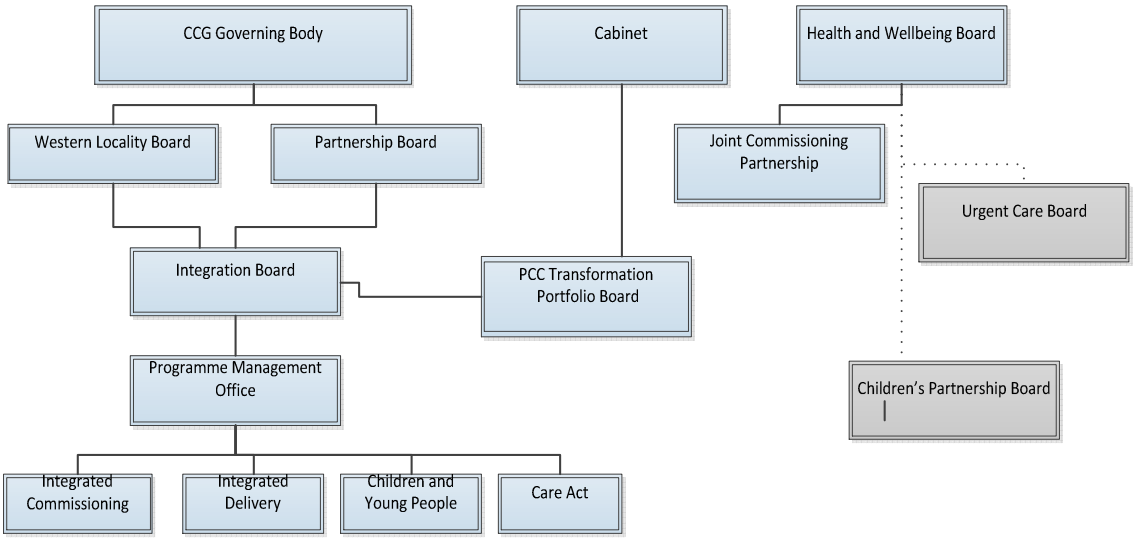
Programme Management Approach

In order to meet the challenges facing Plymouth and 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
- Care Act 2014 Implementation

The following overarching governance structure has been adopted

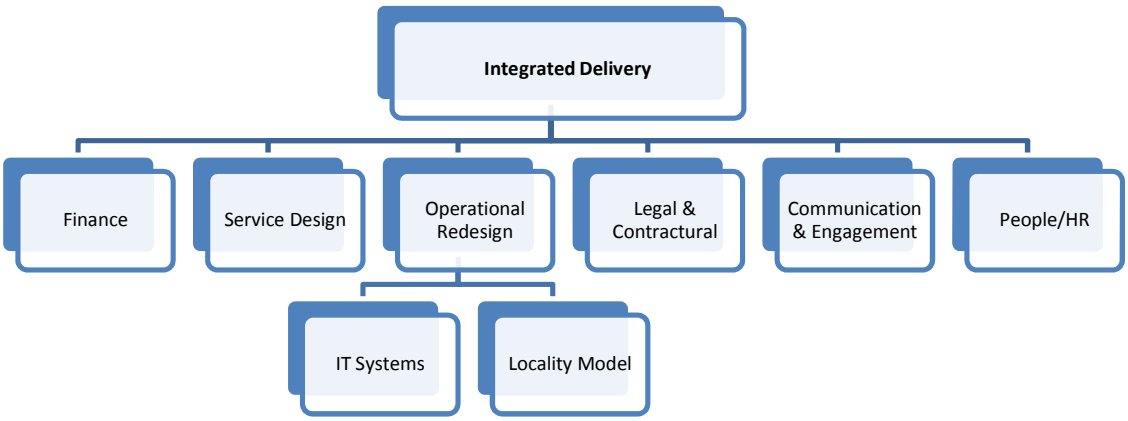


In order for more detailed work to start on the development of an integrated Health and Social Care offer; in July 2014 New Devon CCG and Plymouth City Council approved the following recommendations for the Integrated Delivery Programme:

- 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
- Plymouth City Council to work with NEW Devon CCG to develop robust governance, contractual and financial systems that provide appropriate assurance to both organisations
- 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.
- To consult with staff, unions and stakeholders in developing the new service model.

Workstreams

The development and design of an integrated health and social care system will be achieved through extensive public and staff engagement, the evaluation of existing interfaces and services along with the development of a new specification by the Integrated Commissioning project which will ensure that statutory social care functions are delivered via the new integrated provider. The service will be measured using a range of key outcomes and performance indicators. To deliver an integrated Health and Social Care offer the following workstreams have been developed, they all have nominated leads who report to the project team and will deliver a number of core products:



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 2 Integrated Service Design

Introduction:

The future integrated provider service will focus on the redesign of how people will access services, , the delivery of shared records via the use of a single assessment process, the creation of a shared IT, the establishment of integrated workforce development, delivery against key outcomes as set by the Commissioners of Health and Social care.

The specific teams that are considered to be in scope within PCC are:

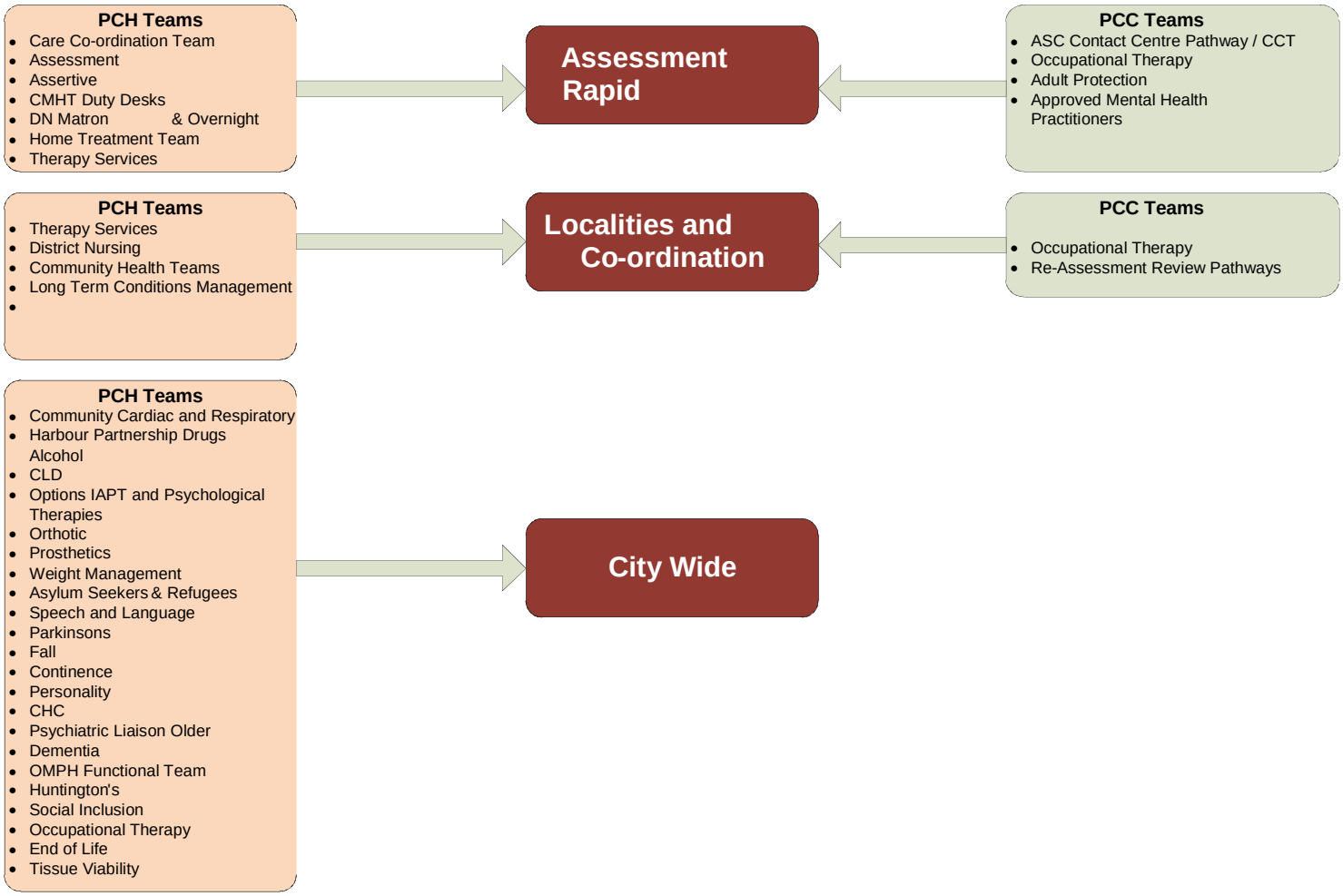
- Social Care Assessment and Support Planning Service, including Social Workers, Occupational Therapists and Community Care Workers.
- PCC back office functions including Business Support, HR, Finance

The Plymouth Community Healthcare services in scope of the project are those available in the community including:

- District Nursing
- Long Term Condition Management
- Therapy Services
- Mental Health services
- Out of Hours functions
- Intermediate Care services (CCT)
- Duty functions

The scope of the programme does 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.

The following diagram illustrates the scope of the teams across health and social care that will be affected by any changes to the way we deliver services in the future.


PCH Teams
Care Co-ordination Team
Assessment
Assertive
CMHT Duty Desks
DN Matron & Overnight
Home Treatment Team
Therapy Services
Assessment Rapid
PCC Teams
ASC Contact Centre Pathway / CCT
Occupational Therapy
Adult Protection
Approved Mental Health Practitioners
PCH Teams
Therapy Services
District Nursing
Community Health Teams
Long Term Conditions Management
Localities and Co-ordination
PCC Teams
Occupational Therapy
Re-Assessment Review Pathways
PCH Teams
Community Cardiac and Respiratory
Harbour Partnership Drugs Alcohol
CLD
Options IAPT and Psychological Therapies
Orthotic
Prosthetics
Weight Management
Asylum Seekers & Refugees
Speech and Language
Parkinsons
Fall
Continence
Personality
CHC
Psychiatric Liaison Older
Dementia
OMPH Functional Team
Huntington's
Social Inclusion
Occupational Therapy
End of Life
Tissue Viability
City Wide

Context for Change

Employees from both PCC and PCH were invited to a series of workshops in July to begin co-designing the future service. Employees were given an update on the following key drivers for change;

- Integration of Health and Social care
- Frailty, Reablement and complex care delivery
- Urgent care and prevention of admission
- Care Closer to Home
- Care Act Compliance

INTEGRATION

- Improvement of patient/individual experience and outcomes,
- Better management at times of escalation of need i.e. preventing hospital admission, and immediately post hospital discharge,
- Efficiency of use of staff and staff capacity and skills. Reduction in queues for access to services.
- Minimising duplication of roles and assessments.
- Economy of workforce and value for money.

CARE CLOSER TO HOME

- To provide for patient/individual preference and choice.
- Increase the likelihood of achieving the best outcomes when assessment and care is delivered and monitored in an environment the individual knows and functions best in.
- To drive the need for joining teams together in the community as multi-professional groups focused around the person, looking to find the best way of using resources and meeting their health and social care needs.
- To allow bed/hospital related resources to be re-channelled to support care closer to home

FRAILTY OR COMPLEX CARE

- Individuals need simpler ways of accessing health or social care services
- Teams need to be more holistic in how needs are assessed and how care is then delivered in a more co-ordinated way, rather than through separate teams with little sharing of information across services.
- Skills need to be developed to meet as many needs as possible in single visits and preferably at home wherever possible, or in the most appropriate environment to meet these needs most effectively.
- Physical, mental health and social care services to come together more holistically to

jointly assess, care plan and deliver.

CARE ACT COMPLIANCE

- Drive to pool health and social care budgets under the Better Care Fund and performance metrics.
- The integration of ASC with PCH will see the integrated service provider undertaking statutory responsibilities that are enshrined within this act.
- Services must be co-ordinated for an individual, delivering an integrated level of support. Personal health and social care budgets are made available more generally for individuals with multiple and longer term needs.
- Create the appropriate support to meet choice and individual needs.

URGENT CARE AGENDA

- It is well recognised that acute hospitals continue to struggle to meet the levels of demand for urgent care provision that tends to arrive at the front doors of Emergency Departments.
- Commissioners are required by April 2015 to have started to shape their commissioning intentions with regard to alternative urgent care options.
- It seems very logical to look at all the urgent response services that exist within PCH and ASC and to explore how and where these might come together to form a joined up and multi-professional range of approaches to the provision of urgent care (not acute care) for those who need rapid response to meet escalating needs, whilst largely not being in need of the types of functions that an acute hospital setting appropriately provides. Examples are many where social breakdown starts to result in health issues emerging; a person who does not keep up with the need to take tablets or eat and drink well, or a person who may become more confused than normal has perhaps an infection which underlies what might be happening. Many of these are scenarios that could be responded to rapidly within a community setting and made easier if the range of different professional inputs could be brought together in a more co-ordinated way than currently exists across PCH and ASC.
- An expectation from the public and the Government that services, will move increasingly towards 7 day working and for 24 hours a day where this is appropriate, in order that the open all hours option of Emergency Departments , is not always the default for the public and for referrers.
- Overall, there remains little new money to aid in supporting the growth in demand and complexity of what health and social care are trying to achieve, and whilst joining up and integrating what all teams do, may bring some economy of scale, efficiency and hopefully professional satisfaction to staff, it will be necessary to look at new ways of working, more use of technology to create efficient ways of managing workload anencouragement of self-care and responsibility.

Co-Design and High Level Proposals

PCH and ASC have run 18 joint open workshops for staff over the last two months. The above context and agenda has set the scene and then two main problems have been posed to them as groups of multi-professional staff.

Community Support and Integration

Individuals in the community have the majority of their healthcare needs met by the GP practice with which they are registered. When an individual's needs increase they may come into contact with a variety of professionals in other organisations. Each of these workers will record their needs in separate systems and none of them currently have the ability to share information with each other relating to the person. As a result support is often delivered in an uncoordinated way.

An individual might be known and supported by the voluntary sector, social workers or support roles from ASC, a domiciliary care provider, sometimes a district nurse or community therapist, perhaps a community mental health worker – or a combination.

They may experience several people calling them and talking to them about their care needs, or visiting them where they live, do things for them or encourage them to do things for themselves. They may be asked to come to a variety of appointments, clinical or office environments, whilst also needing to access their own primary care services closer to home. This can be very confusing for those people with a range of complex or longer term needs.

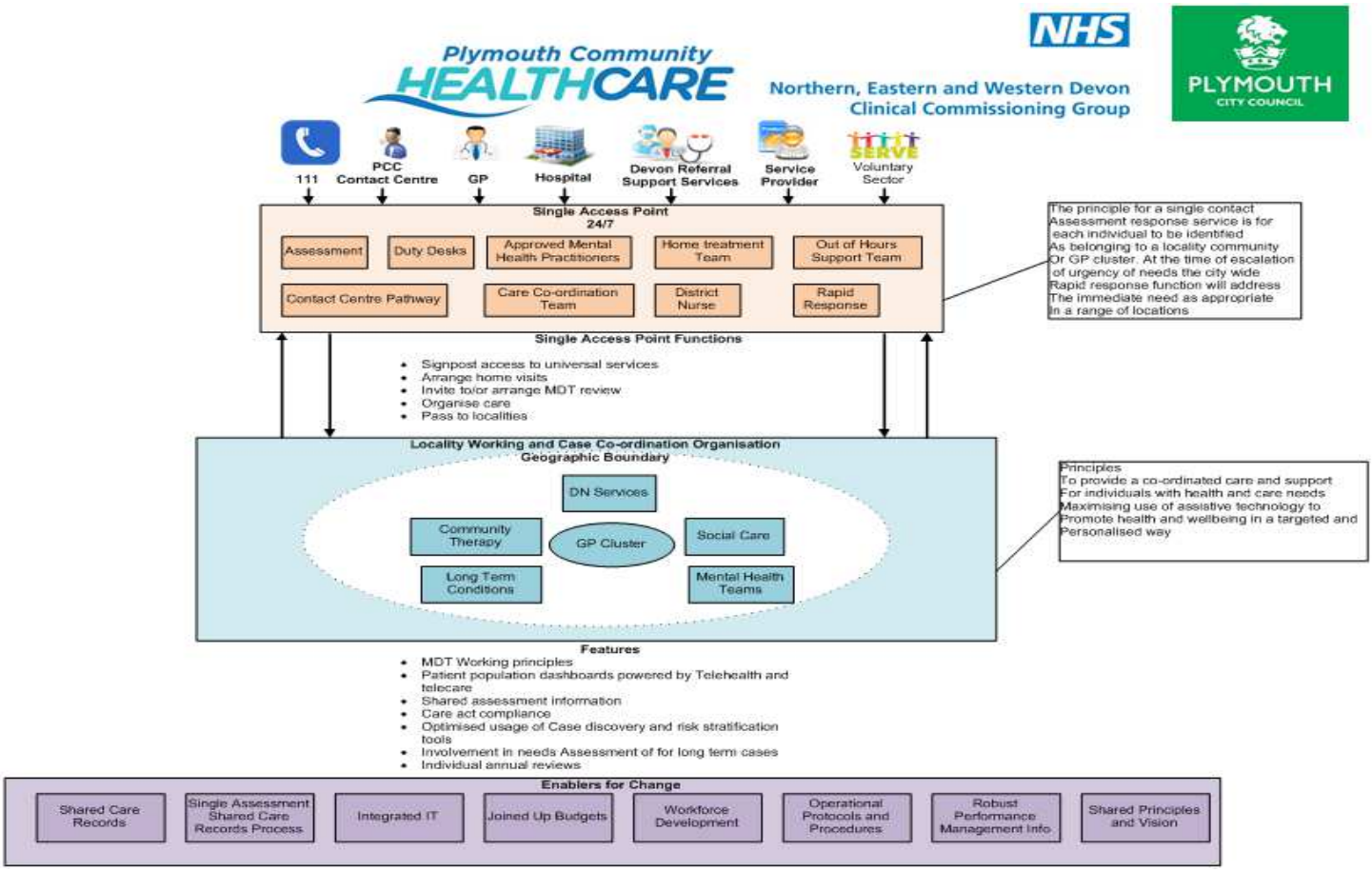
The challenge is to look at how to bring these teams together in a way that allows a more co-ordinated approach to deliver a quicker and less complicated service.

1. Single access point

This is well recognised as a better way of co-ordinating care:

- A single telephone number.
- Available 24/7
- People referring someone for a service will be able to get straight through to discuss the individual/patient with the professional they wish to speak to.
- The team will be multi-professional and co-located.
- The team will run the assessment unit and the rapid response services to the place where someone lives. This will allow for the team to pool skills and expertise, be flexible depending where demand is greatest and be very open to deciding jointly the best environment in which to see an individual or patient.
- Staff will rotate between functions.

The proposed model is illustrated below:



2. Urgent and Rapid response services

The view from the public, commissioners and from these organisations is that this citywide offer would need to be directly available from the single contact point and would provide an urgent response for individuals in times of escalating needs.

For an individual facing the need for some urgent support and/or help, the current service can feel be confusing. From a primary care perspective it is also confusing, when facing the need to get some additional support for someone, especially if this happens out of hours.

Teams within the joint organisation staff workshops were able to identify the range of points of urgent response currently on offer between ASC and PCH. It is anticipated that by joining the functions together which are currently delivered by duty desks across the city individuals' access to the right support can be achieved in a more timely way.

3. Multi-professional localities/case management/longer term care

It generally makes sense for as much care as possible to be provided, organised and delivered in these locality settings. This enables continuity for the patient/individual, links to wider community services and primary care, specific needs/high incidence of specific areas of need in particular areas of the city. There is an import that the teams are resourced to cope with urgent and more planned and preventative care support to enable continuity, rather than handing off the patient/individual to other teams; with all the associated difficulties: lack of continuity of information, the need for reassessment by other teams, confusion over who is doing what and then the question of when does the patient/individual get handed back.

Assessments need to take account of physical, mental and social needs and as such, drives the requirement for the organisations to organise themselves in a way that brings such groups of staff together, to jointly assess, plan, organise and deliver so the persons needs are met. . We need to progress from teams being organised in single professional groups and organising their work in this way, to a multi-disciplinary approach.

There will be a need to accommodate these teams in buildings that allow these multi-professional teams to meet (MDT rooms) and work together on a daily basis, whilst easily accessing the areas of the city in which they need to be available to visit patients and individuals. Staff believed that it would be sensible eventually to design team staffing rotas around peaks and troughs of when workload is referred or is discharged to better meet people needs. With a move to a multi-professional way of working on a day to day basis, it was also felt important to ensure there remain opportunities for single professional supervision, training and governance i.e. a networked organisational model.

These teams would be responsible for the phase of care that also includes assessing long term needs, eligibility for financial support and review in line with statutory requirements to ensure, the continuity of knowledge about the individual is maintained. Locality teams can then build their links and relationships over time, as the GP practices begin to federate and work alongside care homes where many of the most vulnerable individuals reside.

If a patient/individual needs urgent care, the locality will retain responsibility for co-ordinating what is happening and take the patient/individual back after immediate delivery of additional support. This will remove existing team/organisational barriers. Each locality will have a single access point to co-ordinate activity and address enquiries in a timely way.

Whilst initially it is anticipated that teams will incorporate health and social care staff, representatives at the workshops were keen to explore the potential of joining up with the voluntary sector to ensure good access to advice and information on community support available.

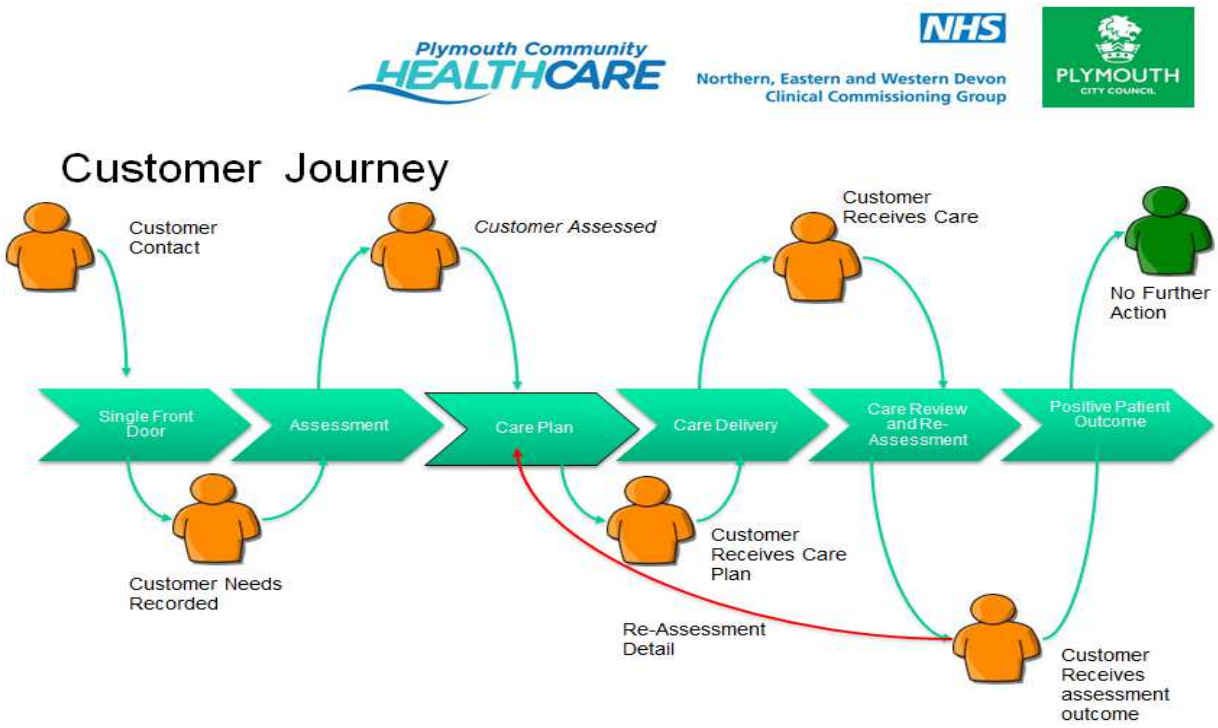
The Locality function will pick up discharges from hospital, undertake regular reviews and reassessments of need. The services may also access the rapid response front door function if needs escalate and a rapid response is required.

The areas identified above are consistent with the feedback received from service users and carers through the Transforming Community Service consultation process and are in line with the Better Care Fund requirements and are summarised in the table below:

Options Considered	Activity	Outcome
Operation Design	Engagement with staff through 'Shaping Our Future' workshops across partner organisations to develop operational design. This combined group has also shaped the design of urgent care, frailty, reablement and complex care delivery.	Emergence of option for a single point of contact, with which firmly places focus on person-centred care. This will be Care Act compliant.
Single Point of Contact	Options considered with staff and subject matter experts to design how the single point of contact could become a reality; how this would look and work. Business architecture has contributed towards building a framework for the design piece.	High level plans have been developed which merges existing contact points to form a multi-professional single access point, open 24hrs, 7 days a week. This will provide a rapid response and assessment function and feed into localities for longer-term care.
Therapy Services	Review to decide how and where services are placed together.	Aim to establish a single referral route, using single assessment principals.
Locality Working	Review of locality working to consider options on how they would operate with a single point of contact.	Each locality/hub will have a single contact point, with teams operating with multi-disciplinary principals, to include for example; Social Care, Community Therapy, Long term Conditions, Mental Health.

IT	There are a number of options regarding an IT solution for April 2015, options appraisals are on-going to investigate the most appropriate solution which will build towards full integration of IT across health and social care.	There is requirement for the social care system (CareFirst) to continue to be available post April 2015, however current options intend to make available a single assessment process for all health and social care staff which will involve the health IT system (SystmOne).

The diagram below provides an overview of the customer's journey through a new Integrated Health and Social Care system.



4. Care Records/IT development

The future operational design of a single point of access will require IT systems that can facilitate a joined up approach to health and social care. This workstream will look to enable delivery of seamless health and care support by removing system and institutional barriers. This will enable benefits of health and social care integration to be realised in terms of either release of capacity, or cashable savings.

This project has ambitious plans to integrate IT systems across both Plymouth City Council and Plymouth Community Healthcare (PCH) by using a shared system which will support a single assessment.

There are two main phases to this workstream;

- providing an interim IT solution in time for integration on April 2015; and
- developing longer-term options for full IT integration between organisations post April 2015.

A series of options have been considered for implementation by April 2015 and emerging from those workshops is the requirement for an achievable and realistic solution within this challenging timeframe. Current progress aims to achieve:

- The development of a single assessment (through SystmOne) which will be available to both Health and Social Care employees.
- Providing a shared view for frontline Health and Social Care employees to access both IT systems (SystmOne and CareFirst).
- Utilising NHS numbers as a primary identifier for records and information.
- Maintaining CareFirst for finance function and database, ensuring it is updated to be compliant with the Care Act for April 2015.

The IT work stream continues to work closely with the operational design team to ensure co-ordinated development which will be fit-for-purpose. The interim solution will also contribute towards a phased approach to a full IT integration post April 2015.

There are a number of dependencies to be considered:

- Software licenses require review to establish the number of additional users permitted.
- Resource across IT teams needs to be established as commitment is required to implement solution, update systems and train staff.
- System/IT access needs to be resolved so that employees across partner organisations are able to view required systems on existing equipment or a method made available to allow this access.
- There may be additional cost as a result of the design work, for example location, method or working, hardware requirements etc.
- Reporting requirements need to be resolved through operational design work in conjunction with IT work stream.

Working towards a single central health and care record post April 2015 will realise significant benefits for partner organisations. TPP SystmOne (the digital health records system currently being implemented by PCH) has potential to provide the core platform. In support of this are as follows:

- IT savings from the decommissioning of Plymouth City Council's social care case management and finance system, CareFirst;
- Anticipated benefits from organisational consolidation coupled with pathway redesign and simplification;
- A single assessment process which will drive rationalisation and simplification of business processes and improve patient/individual service experience
- Elimination of duplicate effort and multiple assessment processes
- A significant proportion of GPs within the local CCG area use SystmOne,
- Potential to extend to Children and Young People's data.

The IT workstream will develop options and complete further work to establish if SystmOne is the most appropriate platform given the system needs for social care.

5. Staff in Scope

The PCC staff affected are primarily those within the Adult Social Care part of the People Directorate. The specific teams that are to be considered as part of the integration process and therefore subject to Transfer of Undertakings Protection of Employees (TUPE) transfer are:

- Social Care Assessment and Support Planning Service, including Social Workers, Occupational Therapists, Community Care Workers and their management teams.

The indicative number of frontline delivery staff subject to transfer is 172. This is split across a range of professional, semi-professional, and management staff.

There are a range of back office functions which support this service, however the undertaking relating to "back office" functions will not be considered as part of the transfer until an impact assessment is completed by the Integrated Health and Wellbeing and Co-operative Centre of Operations programmes. This analysis will be presented to PCC Cabinet prior to transfer and as part of the contract award process.

The current staffing budget is £7.9m.

Staff Engagement:

In addition to the 18 workshops already completed; frontline staff have access to fortnightly briefing sessions delivered by the Assistant Director for ASC. There have been regular communications issued and a questions and answers page has been established to gather

feedback. Over the coming weeks, the detail to support the new operating model will be co-designed with current and future users of services along with frontline staff who are affected by these changes. Once the new operating model design has been completed and has been through the due diligence process the intention is to transfer staff from the Adult Social Care provision team from Plymouth City Council to the new provider in accordance with Transfer of Undertakings (Protection of Employment) Regulations 2006 (usually referred to as TUPE), this will be completed by April 2015.

Existing terms and conditions of employment of transferring staff are protected and will transfer with them. The protected terms include such areas as salary, pension, annual leave and sick pay. A further period of 'due diligence' work will be undertaken in order to ensure that the TUPE process is completed in a fair and consistent way.

Workforce Development

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

There are 2400 staff across both organisations with a range of professions and disciplines that will be impacted by the project, there is a widespread acknowledgement that significant investment in workforce development will be required to achieve a truly integrated approach to health and social care support. Over the coming months workforce skills profiles will be developed to support the creation of a system wide development plan and workforce profile to allow for adequate modelling to take place.

The following are some of areas that would benefit from a workforce development targeted approach:

- Breaking down cultural differences across organisations by jointly developing staff
- Understanding of practices across disciplines, professional accountabilities and statutory duties to support co-ordinated working
- Further developing skills and knowledge at all levels that improves current care and support by keeping individuals at the centre

The project recognises the risks associated with change and the impact this has to both staff and service delivery. Fundamental to the new service provision will be a workforce development programme that will support and equip staff through the change process and ensure that the workforce is appropriately skilled to work within the new integrated models that intelligently commission and deliver care tailored to the needs of the individual.

Staff will be supported through this process by:

- Developing the required culture and behaviours of a confident and capable workforce with the appropriate skills and knowledge to deliver the organisations priorities and outcomes.

- Being equipped to be agile and adaptable to requirement changes and allowing the organisations to able to use their asset base to meet the needs of its customers and the services that it supports by being able to deploy capable staff in the right place at the right time.
- A well-developed system leadership approach.
- The implementation of a toolkit for learning and development which will support staff transition. This will include the development and implementation of processes, governance, policies and tools to meet the needs of staff.

Through the operational design process an analysis of existing practices and functions will be undertaken and a program will be developed that focuses on how best to support staff through the transition. Ultimately the success of a well-integrated workforce will be evident in the community through the impact it has on the wellbeing of the individuals receiving support, however success will also be measured by:

- Improved staff retention
- Increased staff satisfaction and feedback
- Customer surveys
- On-going progression and development of existing workforce (where opportunities present themselves)
- Impact on baseline measurements of performance (to be set once integration is live) through departmental metrics such as numbers of individuals assessed within a set timeframe
- Staff engagement and participation in developing services further.

PROJECT

Next Steps:

- Completion of demand analysis across existing pathways
- Detailed design workshops with frontline staff from PCC/PCH
- Stakeholder/Provider re-engagement events
- Development of the new operating model, protocols and procedures
- Development of cross organisational staff briefings
- Arrangement of shadow opportunities for staff/managers
- Commencement of TUPE consultation
- Development of single assessment framework
- IT Option implementation plan

Communications

The project principles aligned to the integration transformation are;

- **Sharing information** – to plan and deliver intelligently
- **Sharing financial resources** – to maximise the effective use of financial resources
- **Sharing staff** – to enable best us of skill and resources
- **Sharing risk** – to maximise shared gain and mitigate shared losses

Meeting need through the operational re-design of adult health and social care	
"I want services that support me to manage my situation in life not just my condition"	• Information sharing protocol to be put in place to allow sharing of information across wider range of organisations. • Workforce development to increase awareness of voluntary sector and universal services available to support individuals in the community. • Workforce development to enable staff to support plan with individuals holistically.
"I want the information I need to make healthy choices and stay healthy, and to have systems in place	• Workforce development to work together with a person to design their health and care needs support plan to best suit their needs • Workforce development to ensure staff are up to date and able to promote telecare / telehealth as well as support them in accesssing universal and

that can help me at an early stage to avoid a crisis"	information services. • Care Co-ordination function in place to support individuals in manageing their care • Structured care and support plans that focus on meeting need and plan for any breakdowns • Sustem that provides support for carers • Service accessible 24/7 capable of addressing crisis and able to put in place immediate short term support
"I want the ability to talk to a health or social care professional when I need to and to tell my story once-share my information with colleagues"	• Single Front Door into community based health and social care • Staff working from a joined up IT system approach • Information sharing protocol to be developed to allow sharing of information across wider range of partners • Single Assessment form that is owned by a localiy and that allows contibutors to update / add • Access into service 24/7 at first instance
"I want to be able to have services provided in lots of different places, at a time that suits, me having choice and control over the care I need"	• Locality model to be created around population need • Access into service to be delivered through face to face visits, telephone assessments and in a clinical environment working in the best environment for the person
"I want access to a range of services that support me and the people who care for me to lead a full and healthy life"	• Commitment to increase number of carer assessments and support • Workforce training to identify and support carers earlier

A Communications Plan has been developed jointly by PCC, PCH and the CCG. Key activities in relation to the Integrated Delivery of Health and Social Care include:

- Clear timelines: For stakeholder engagement, both internal and external.
- Identification of all stakeholder groups: Both Plymouth City Council and NEW Devon CCG have existing relationships with stakeholders and agreed approaches and involvement will be decided according to these legacy relationships.
- Clear shared messages: To agree a set of clearly defined messages that both organisations can sign up to and uphold throughout the integration phases.
- Staff as key champions and endorsers: Staff will be taken through the transformation process in an informed way using the evidence base that has been clearly prescribed through these processes.
- Consistent leadership: Leaders within the integration and transformation programme should maintain consistency at all levels.
- A set of agreed principles: Agreed principles that both organisations sign up to throughout the integration programme, as an internal code of conduct.
- Frequently asked questions: A living FAQ document will be maintained throughout the integration programme by the project team.
- Ensuring use of the existing evidence base: Using the TCS process and other engagement and consultation activities that have taken place across the city over the last few years.
- Meet the differing needs for internal and external communications: Communication plan outlines how the needs and requirements of key groups will be met.
- Media use: Digital communications, Social Media, Direct Communications, Face to face, Board to Board and Public Relations.

Focused communications and engagement events have taken place as illustrated in the table below in order to support the co-design process with staff and ensure that the staff groups received information tailored to them. A number of events and communications have been shared between the commissioning and delivery project as these are closely linked and the PCC staff are currently part of the same department.

Integration has also been added as an agenda item to team meetings with appropriate presentations and other materials shared with the teams, and staff have been encouraged to raise any questions with their managers and senior managers.

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 / Delivery	Case Studies	Cases studies to demonstrate positive outcomes of joint working and commitment to projects	C	Staff across CCG & PCC	Staff intranet
TBC	Delivery	Video	Video to explain and promote integration to the city		Public	Integration
TBC	Commissioning / Delivery	Newspaper Article	Launch of integration agenda in the Herald			

Timeline:

Activity	Timeframe
Staff consultation	Throughout September/October 2014
Consultation and Engagement with staff and partners to support remodelling work	September through to November 2014
Due diligence process	Throughout October and November 2014
PCH / CCG contract update	Beginning of November 2014
CCG Governing Body	5th November 2014 and 3rd December 2014
Plymouth City Council Cabinet	11th November 2014
Finalise High Level Operating Design	November 2014
Scope accommodation requirements	November 2014
Commence detailed operational design	November 2014
Develop workforce development plan	November 2014
Finalise integrated/pooled budget accountabilities and monitoring arrangements across organisations	End of November 2014
Provide feedback to Integrated Delivery Specification	End November 2014
Develop Integrated delivery governance architecture	End of December 2014
Commence staff development and training programmes	December 2014
Commence liability arrangements for TUPE of staff	January 2015
Develop and agree workforce structure	January 2015
IT solution in place	End of March 2015
New Integrated delivery structure in place	End of March 2015
Investigate options to integrate IT (SystmOne)	August 2015
Full Integration of IT systems	April 2016

Benefits Map/Profiles

Delivery of health and social care integration will realise recurrent cashable benefits to the Commissioners whilst delivering improved customer outcomes. This supports the requirements for the Better Care Fund to place significant focus on services based in the community, such as:

- Investment in out-of-hospital care,
- Early intervention,
- Admission avoidance,
- Early hospital discharge.

There is effective cross-working in place, with key, trusted relationships to enable and support meaningful collaborative working and realise the full benefit potential that integration can deliver. There is collaborative leadership in place between partner organisations, with the mandate to make the necessary decisions and commit resources to deliver the vision.

Partner organisations have a shared vision and priorities for health and social care integration and there is a firm commitment to achieve this. An integrated programme management approach will coordinate delivery and oversee benefits realisation.

Improved System performance benefits currently scoped are:

- Reduction in non-elective admissions via the provision of timely access to support 24/7 by 3%
- Reduction in admissions to long term care homes by 6% achieved via the provision of good quality preventative services
- Reduction in number of readmissions 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
- Increase in number of carers assessments and services

Service delivery benefits for patients/individuals currently scoped are:

- Improved service satisfaction
- Improved wellbeing scores
- Improved carer satisfaction
- Improved access to Universal and Preventative Services for all
- Widespread engagement in how services are designed
- More care delivered in the community
- Better access to condition management information
- People only needing to tell their story once
- Improved sharing of information to enable people to make their own choices
- Support from a 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
- A single contact place to call when needs arise
- Assistance available 24/7 for when a crisis occurs

Staffing benefits currently scoped are:

- Greater more flexible career opportunities achieved through generic/multi-disciplinary approach
- Improved recruitment and retention performance
- Reduced levels of sickness
- Improved staff morale

The following table illustrates how benefits realisation leads to the Council's core objectives:

Dependency	Capability Delivered	Project Benefits	Programme Benefits	Council Values
Development of universal services	Integrated IT	Reduction in number of professionals involved in individuals care	Organisational Benefits	**We are Democratic**
	Single assessment framework	Improved ability to manage the whole system, reduce duplication and wastage and manage variations in demand		
Shared information governance arrangement	Single Management Structure	Increased Wellbeing scores	Financial Benefits	
	Support 24/7	Outcome measures to be determined through contracts		**We are Responsible**
CCO project - DELT	Intensive co-ordinated multi agency intervention	Increase in carer assessments and support plans	Improvement for Staff	
	Rapid assessment/treatment services	Increased positive response to Individual journey survey (TBD) of those still at home 91 days after		
CCO Project – Support services	Shared commitment to common vision and goals	Reduction in hospitals admissions	Improvement for the Environment	**We are Fair**
	Single Community provider delivering improved local health and	Reduction in number of delayed transfer of care (days) per 100,000		

	wellbeing	Reduction in non-elective admissions	Improvement for Partners	
P&OD – Accommodation Strategy	Simplified collaborative arrangements with opportunities for integration with a greater number of partners	Improved patient experience – more seamless care		**We are Partners**
		Greater and more flexible career opportunities	Improved Customer Experience	

Details of cashable benefits are captured in the Integrated Commissioning paper as it is commissioning where these benefits will be realised.

Risk Log

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	*Amber / Red*	1. Development of Budget Recovery plan for ASC to be incorporated into Transformation Plans 2. Incorporate elements of CCG plan arising from PWC Review into project plans 3.Review in July to assess impact on programme 4. Development of robust financial model that incorporates volume/demand data
Disruption to service delivery with an impact on service quality and reputation	*Amber / Green*	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 / Green*	1. Early consultation with Unions 2. Union representation at key workshops. 3. Joint lead rep meeting with PCH 4. Consultation to be undertaken with staff 5.Involvement of staff with Shaping Futures work
Assumptions made will be wrong due to baseline data not being robust and so the business case is undermined	*Amber / Red*	1. Validation of the baseline data finance, the savings opportunities by service professionals 2. Validation and ownership of the financial model by finance and service areas
New legislation introduced which impacts on plans (e.g. Care Bill and Dilnot)	*Amber / Green*	1. Remain well-informed of policy and legislative developments and build in necessary changes early and challenge solution development 2. Impact analysis of care act to identify changes and identify solutions
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	*Amber / 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)

Multiple parties involved resulting in difficulty securing agreement with aspects of service redesign leading to delay in delivering savings and benefits realisation	*Amber / Green*	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 3. Areas of potential disagreement highlighted and discussed early in the process 4. Identification of key decision makers and a dispute resolution process 5. Formal agreements and protocols in place to enable teams to work together
Key Governing bodies, CCG and PCC Cabinet do not support recommendations at November Cabinet and project cannot proceed to Delivery phase	*Amber/ Green*	Brief Portfolio Holders, attendance at Cabinet Planning, share key decisions required with key members at early stage
TCS across the whole of CCG is delayed which impacts on local integration of services	*Amber / Green*	1. Engage with legal representation at an early stage 2.seek comprehensive legal advice at stage. 3. Understand current contractual arrangements and notice periods 4. Confirm desired options 5. Ensure notice periods are adhered to. 6. Ensure robust documentation is maintained
Lack of resources across project result in key milestones not being met.	*Amber / Green*	1. Develop programme delivery plan and get cross party sign up to this 2.Cross- party investment planning meeting to agree resource commitment 3. 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 costs should be fairly split between CCG and PCC
Inability to agree single assessment process across organisations resulting in duplication and poor customer journey	*Amber / Green*	1. Understand key requirements for all workers 2. Arrange engagement sessions 3. Obtain legal specification 4. Share draft for consultation
Failure to understand the cultural difference between health and social care resulting in poor adherence to eligibility criteria and escalated spend	*Amber / Red*	1. Arrange shadowing arrangements for managers 2. Develop key learning and development package to support staff through transition
Delay in delivering the single Information Technology (IT) system could impact on co-ordinated working	*Amber / Red*	1. Identify options to create single customer view across systems to minimise duplication. 2. Develop implementation plan for full integration including cost/benefit analysis and expedite delivery to achieve required outcomes.

Insufficient management capacity to provide leadership through significant change whilst maintaining business as usual demands across the system	*Red*	1. Minimise impact by ensuring frontline staff are well engaged through communication plans and workshop sessions. 2. Identify potential blockages with Senior Managers/Project Execs
Lack of frontline staff capacity to ensure co-design of new operating system is fully inclusive.	*Red*	1. Identify issues to Project Execs. 2. provide clarity for frontline staff to assist engagement to be prioritised
Uncertainty for staff regarding TUPE transfer, changes to work base or management arrangements may lead to resistance.	*Amber / Green*	1. Undertake early mapping of services/teams in scope. 2. Ensure regular staff communication. 3. Engage with Lead Reps, offer appropriate support. 4. Ensure staff inform design processes. 5. Develop accommodation requirements to ensure staff are informed in timely way post November Cabinet decisions
Lack of professional support for adult social workers within health's structure.	*Amber / Green*	1. Ensure specification for new provider details Professional Support requirements including recruitment to Principle Social Worker and maintenance of Practice Teacher functions
Disparities in Terms and Conditions between Health and Social Care staff.	*Amber / Red*	1. Undertake mapping of existing T & C's. 2. Staff to transfer with existing arrangements. 3. Identify areas of potential challenge and engage with Unions, HR departments and teams accordingly.
Pension transfers has associated complexities.	*Amber / Green*	1. Early engagement. 2. Pensions discussions to form part of Due Diligence arrangements.
Current capacity and demand challenges across the system result in difficulty embedding new operating system on time	*Amber / Red*	1. Identify current waiting lists/blockages across the system. 2. Develop operational action plan. 3. Consider alternative models to improve flow and thus reduce areas of concern. 4. Re-profile elements of workforce to minimise backlog prior to transfer
Ability to release staff to undertake induction and training prior to transfer due to current workload demands	*Amber / Green*	1. Develop detailed plan of training requirements and dates for delivery to ensure staff can be released at required time
Current accommodation does not allow for full co-location of staff initially	*Amber / Green*	1. Undertake early mapping of accommodation requirements. 2. Identify those teams who would benefit the most from co-location and prioritise needs accordingly
To consider a shared view of IT, the current license for CareFirst may restrict access to users which will threaten this as an option.	*Amber / Green*	1. Examine license and consider options available. 2. Possible further negotiations with OLM (CareFirst provider)

ICT resource will be required to support IT options and therefore is dependent on the availability of these teams	*Amber / Red*	1. Link into DELT and establish availability of teams to assist in IT project. 2. Plan for most appropriate time to initiate key phases in IT plan.
View access across IT systems (both CareFirst and SystmOne) provides both children's and adults' records.	*Amber / Green*	Contact relevant IT teams to establish options around sensitivity of data/data sharing and user access. Develop robust policy and procedures to protect sensitive information.
Joint IT systems will need to provide the necessary reports for statutory performance as well as other indicators, this need to be in place for any IT solution.	*Amber / Green*	1. Establish current reporting needs and availability of systems to provide reports. 2. Consider design of new reporting procedures through new systems.

Recommendations

Supported by the above information it is recommended that:

4. Cabinet approves the high level operating model for Adult Social Care proposed in section two of this document.
5. Cabinet approves the transfer of staff in scope of this project through the use of TUPE arrangements.
6. Cabinet approves the detailed design that is being proposed and authorise its implementation in partnership with staff and stakeholders and are in support of the actions that will take place as outlined in this document.