COMMISSIONING STRATEGY FOR COMMUNITY BASED CARE
DRAFT

Northern, Eastern and Western Devon
Clinical Commissioning Group

PLYMOUTH
CITY COUNCIL

Part: I

DOCUMENT CONTROL

Version	**Date**	**Author**	**Change Ref**	**Pages Affected**

QUALITY REVIEWERS: (General QA and accuracy)

Name	Position	Signature	Date

FINANCE SIGN OFF:

Name	Position	Date

CONSULTATION PATHWAY:

NAME

Table of Contents **Page Number**

Document Control 1

1.0 Executive Summary 4

2. INTRODUCTION 4

2.1 Background – Strategic Challenge 4

2.2 An Integrated Commissioning Response 4

2.3 Purpose of the Strategy 5

2.4 Implementation and Action 5

2.5 Finance 6

2.6 Definition & Scope of Community Based Care 6

3.0 Needs Assessment 7

3.1 People who may have Multiple Needs 7

3.2 People in need of an Urgent Care response 9

3.3 People needing Long Term Support 12

3.4 Consultation feedback 18

4.0 Strategic Context 19

4.1 National 19

4.2 Local 21

4.3 Key legislation 24

4.4 Evidence based / good practice 25

5.0 Current Provision 25

5.1 Strategic overview 25

5.2 Existing service provision 25

5.4 Community asset mapping 30

6.0 The Future 'Community Based Care' System Model 30

6.1 Available Resources 32

6.2 System Performance – Current and Future 32

7.0 Commissioning Plan 2015/16 – Community Based Care 33

Appendix One 37

1.0 EXECUTIVE SUMMARY

The introduction of the Health and Social Care Act 2012 provided us with new and exciting opportunities to work together across health and social care and address the key issues that undermine the health and wellbeing of those people in the city of Plymouth.

Plymouth's Health and Wellbeing Board, established under the Health and Social Care Act 2012, provides a key partnership, where leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The Board's vision is for "Happy, Healthy, Aspiring Communities" and its core purpose is to encourage commissioners across the public sector to work in a more joined-up way.

This commissioning strategy sets out the approach for Health and Social Care Community based services commissioning intentions which includes an integrated Commissioning and Delivery approach for services putting the person at the centre with support services wrapped around them.

2. INTRODUCTION

2.1 Background – Strategic Challenge

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. 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

2.2 An Integrated Commissioning Response

In order to meet the challenges facing Plymouth New Devon CCG and Plymouth City Council have agreed to develop a single commissioning function working towards jointly approved commissioning strategies and pooled budgets.

The primary driver of this is to streamline service delivery and provision with the aim of improving outcomes for individuals and value for money. Integrated commissioning must deliver integrated wellbeing.

To support this strategic aim 4 commissioning strategies have been developed that stretch across the spectrum of early years, health, social care, and wellbeing need in Plymouth.

These co-dependent Commissioning Strategies aim to move the balance of care towards prevention in order to improve life chances, manage demand and improve health outcomes. Specific aims of this system's approach include;

- Provide and enable brilliant services that strive to exceed customer expectations
- People will receive the right care, at the right time in the right place.
- Improve pathways and transitions
- 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.
- Prioritise prevention
- Sustainable Health and Wellbeing System
- Improve System Performance

2.3 Purpose of the Strategy

Each strategy describes the current and projected need in Plymouth, as well as the local and national strategic context that the future system will need to address / respond to. They also describe current provision how the existing system is performing.

This then builds into a vision of Plymouth's future system over a 5 year period, and details of how commissioners in Plymouth will achieve this through a series of annual implementation plans setting out and signalling to the market commissioning priorities, and how the impact of these will be measured across the system.

2.4 Implementation and Action

System Design Groups against each strategy will drive the implementation of the identified commissioning priorities within each strategy.

2.5 Finance

Table 1 provides an overview of how the current commissioning budgets in scope for integration are currently spread across the system.

Full detail on the existing resources allocated within each strategy area is provided in the 'current provision' section.

Table1

Strategy Area	Approximate total spend	% of spend in each Strategy area
Children and Young People	£27,150,102	6.72%
Wellbeing	£60,752,235*	15.03%
Community Care	£119,742,637	29.62%
Complex Care	£196,616,072	48.64%
TOTAL	£404,261,046	

*Includes approximately £40 million of prescribing spend

2.6 Definition & Scope of Community Based Care

Targeted services for people who need support in the community to maintain independence or those who may be at risk in the future of losing their independence. The services may be long term for those who need on-going personalised support or may respond to a crisis, providing a timely response, reablement and recovery.

The opportunity that the Integrated Health and Wellbeing Commissioning agenda presents is to undertake a whole system review of a wide range of service provision in order to consider what changes are needed to meet the needs of people who access health and social care services and deliver outcomes.

In scope of this strategy are services currently commissioned for the people of Plymouth by NEW Devon CCG and PCC. Examples of these include social care, community nursing, domiciliary care, day opportunities, reablement, community equipment, supported living for people with a learning disability, housing and homelessness support, substance misuse treatment, mental health services and Telecare.

3.0 NEEDS ASSESSMENT

Plymouth's population has grown by over 15,000 people (an increase of 6.4%) from 2002 to 2012 (mid-year population estimates shown in Table 1). All six ONS localities have increased in population size, with the largest percentage increase in the South West (12.1%) and South East (12.0%) localities. The smallest percentage increase occurred in Plymstock (1.9%).

Table 2: Mid-year population estimates (all ages) for Plymouth localities and Plymouth, 2002-2012

Year	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
2002	49,727	51,805	29,301	24,234	35,118	52,365	242,550
2004	49,699	51,841	29,438	24,235	35,850	52,974	244,037
2006	50,316	52,180	29,345	24,545	37,554	55,238	249,178
2008	50,864	52,307	29,656	24,698	38,426	56,537	252,488
2010	50,855	52,261	29,747	24,680	39,063	57,621	254,227
2012	51,488	53,779	30,029	24,687	39,342	58,701	258,026
% change	3.5%	3.8%	2.5%	1.9%	12.0%	12.1%	6.4%

Source: Office for National Statistics

It is estimated that Plymouth's population will increase by over 16,000 by 2030 (Table 2). The largest increase will be seen in 75+ year olds (54.6%), whilst it is estimated there will be a 5.2% reduction in the 30-64 year old population.

Table 3: Sub-national population projections by age group, 2012-2030

Age group	2012	2015	2020	2025	2030	% change
Under 18	50,912	51,482	53,645	55,241	55,102	8.2%
18-29	52,613	53,779	53,169	52,133	54,820	4.2%
30-64	111,026	109,880	109,002	107,814	105,247	-5.2%
65-74	23,367	24,964	25,584	25,569	28,205	20.7%
75+	20,108	21,210	23,904	28,511	31,091	54.6%
90+	2,119	2,296	2,700	3,475	4,432	109.2%
All ages	258,026	261,315	265,304	269,268	274,466	6.4%

Source: Office for National Statistics

Such a demographic profile is likely to put increasing pressure on a range of public services and especially those who may access community based services

3.1 People who may have Multiple Needs

This section relates to a cohort of people that have multiple needs and use services relating to homelessness, substance misuse, offending and mental health. Whilst neither issue on its own may trigger a statutory or secondary care service the combination of support needs create a complexity that requires a more specialist intervention in the community. For the purposes of this strategy we are using the Making Every Adult Matter (MEAM) definition which describes adults who experience

several problems at the same time that; impact on families and communities, have ineffective contact with services, and live chaotic lives (http://meam.org.uk/)

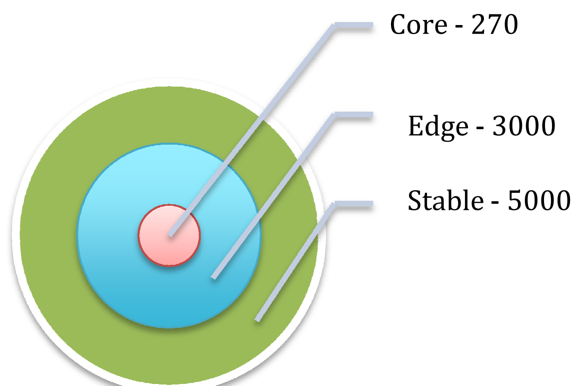
Comprehensive 'Needs Assessments' have been completed separately for alcohol, mental health, and substance misuse in Plymouth. Information from each of these has been extracted and brought together to try and understand the overlap and synergy across these different categories.

What we know - Prevalence

Client Group	Source	Number of people in Plymouth with need
Alcohol – Hazardous drinking	Alcohol Needs Assessment, 2011	25,300
Alcohol – Harmful drinking	Alcohol Needs Assessment, 2011	6,360
Homelessness – Statutory Applications	PIE Statistics 2013/14	523
Homelessness – Local Authority Prevention and Relief	PIE Statistics 2013/14	898
Drugs	Substance Misuse Atlas	5,600
Drugs – OCU	Public Health England	2372
Mental Health – common mental disorder (18-64)	PANSI	26,300
Offender		

Overlap of Need

Local information, combined with national modelling indicates that adults experience complex needs at different levels with a core group of approximately 270 requiring intense support for a number issues at the same time, approximately 3000 people that are not in immediate crisis but could trip into core without intervention, and approximately 5000 people who have complex needs but are stable and engaging with support.



There is significant overlap across the different categories of need within the MEAM definition that until now have been assessed, developed and commissioned for separately, high level summary information as follows:

Commissioned service area	% of current service users also have support needs around homelessness	% of current service users also have support needs around mental health	% of current service users also have support needs around substance misuse	% of current service users also have support needs around offending
Homeless	N/A	44%	46%	21%
Mental Health	tbc	tbc	tbc	tbc
Substance Misuse	24%	18%	N/A	tbc
Offending	27%	40%	46%	N/A

Prevalence of need across all categories is focussed within the same neighbourhoods indicating communities with multiple needs. These communities are generally high levels of deprivation.

General feedback from the sector reports:

- Younger and more complex cases which is changing the intensity and capacity of effective interventions.
- Poly drug use very common – alcohol, illegal drugs, New Psychoactive Substances (NPS) and prescribed drugs
- That moderate/common mental health problems are increasing
- Austerity is both increasing demand and making 'recovery' more difficult
- Increasing demand and pressure on the homelessness system

3.2 People in need of an Urgent Care response

This section covers the needs of people who are in crisis and need care and support to avoid admission to hospital or a care home and support to recover to regain maximum independence. They may need services such as rapid response home care, standard home care, mental health support services, reablement and/or community equipment.

Census data indicates the percentage of the Plymouth population identify health as bad or very bad, of have limited day to day activities. These figures are an indicator of potential need for domiciliary care or are at risk of needing urgent care if not supported to remain stable in their own homes.

- 6.5% identified their health as bad or very bad[1]
- 10% of people find their day-to-day activities are limited a lot[2]

We know that one of the most significant factors which are going to impact on further demand for community services is the growing numbers of older people.

[1] Summary 2011 Census Profile. Produced as part of the JSNA. Public Health, PCC. December 2013.

[2] Summary 2011 Census Profile. Produced as part of the JSNA. Public Health, PCC. December 2013.

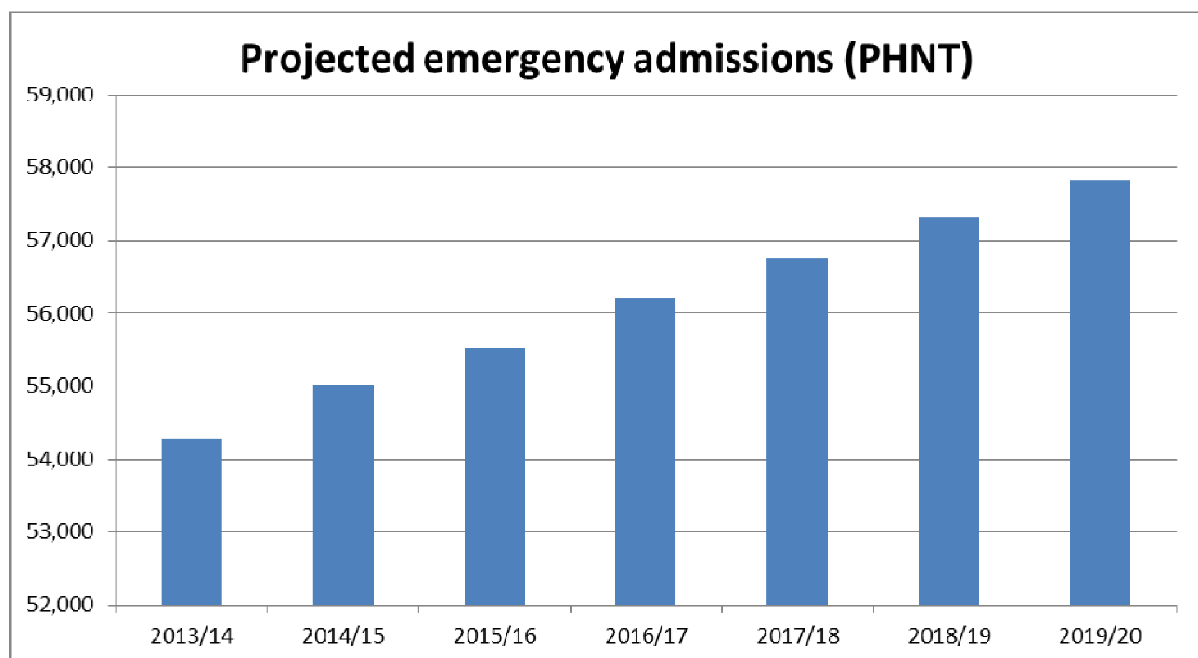
Age Group	2014	2015	2020	2025	2030
65-69	14,200	14,200	12,500	14,000	15,200
70-74	10,400	10,800	13,100	11,600	13,000
75-79	8,500	8,600	9,600	11,800	10,500
80-84	6,400	6,500	7,100	8,100	10,100
85-89	3,700	3,800	4,500	5,100	6,000
90 and over	2,200	2,300	2,700	3,500	4,400
Total	**45,400**	**46,200**	**49,500**	**54,100**	**59,200**
% Change		**1.73%**	**6.67%**	**8.50%**	**8.61%**

Source: Projecting Older People Population Information

What we know - Inappropriate and lengthy stays in hospital – & delayed transfers of care[3]

Demographic projections are showing that the number of emergency admissions to hospital is expected to rise by around 1.1% per year (see graph below). However, due to the aging population it is expected that this will increase the total number of emergency bed days by around 1.6% per year. It is also known that the prevalence of long-term conditions are rising which will place an additional demand pressure on the urgent care system.

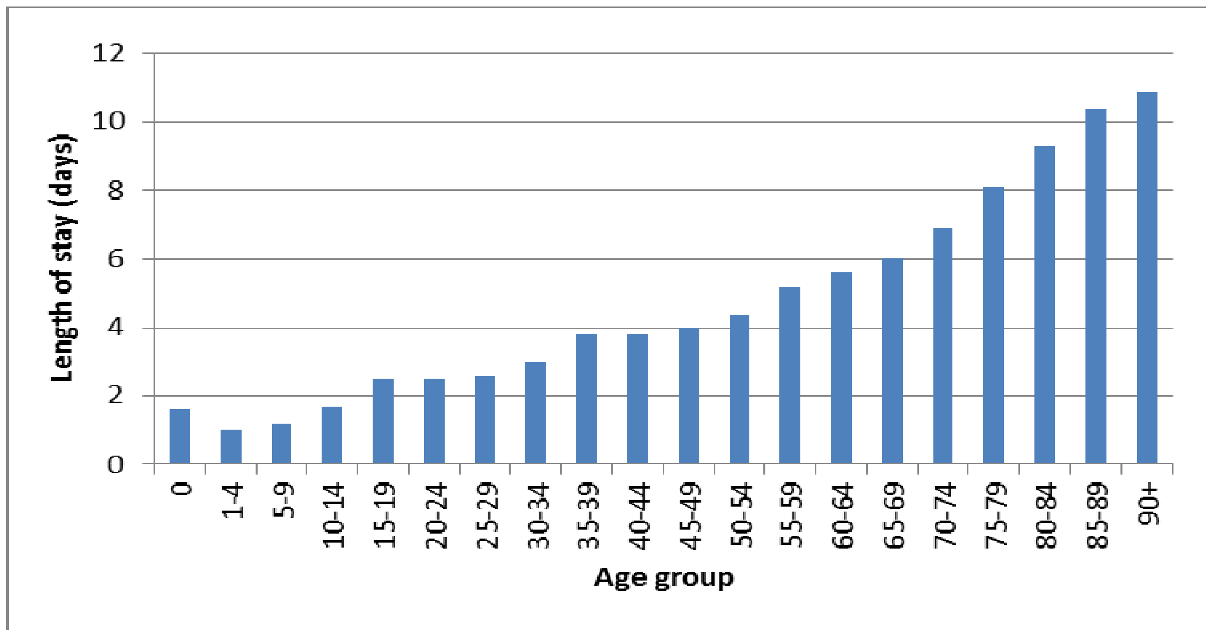
Chart 1: Projected increase in emergency admissions (PHNT)



The average length of stay in hospital varies significantly by age with an older person having, on average, a significantly longer length of stay (see graph below). This is a key reason why the aging population has such a dramatic effect on hospital capacity.

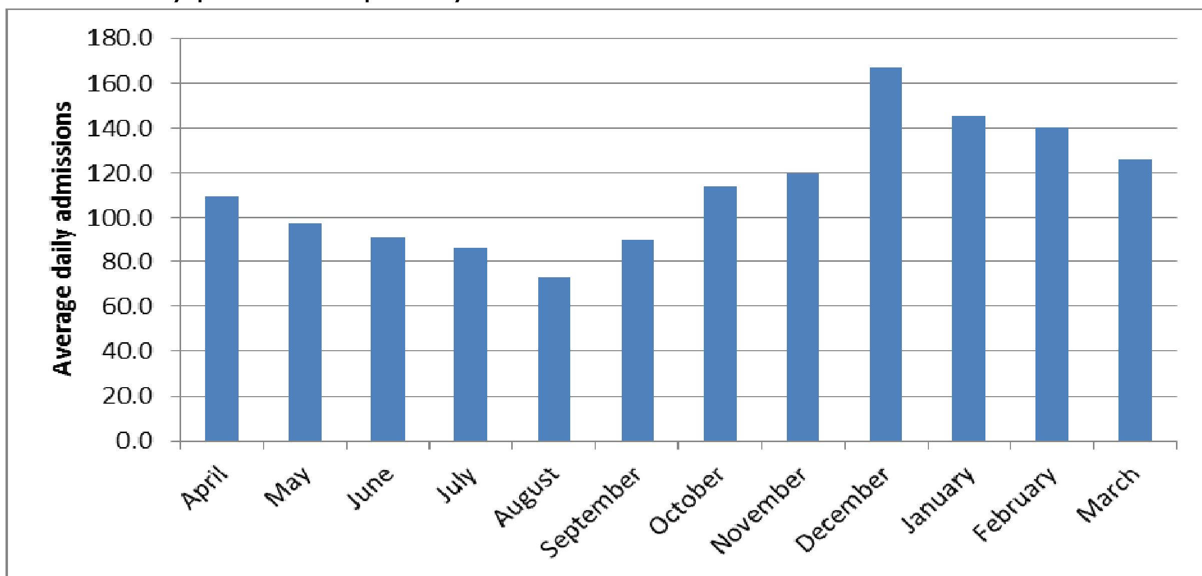
[3] Western Locality CCG, IPAM Reporting from PHNT April 2014

Chart 2. Average length of stay by age group for emergency admissions



Demand on the urgent care system is known to be seasonal. Older people are much more susceptible to the effects of the cold weather and as a consequence have higher rates of emergency admissions in the winter months. This combined with their longer length of stay creates a significant bed pressure on acute hospitals in the winter. Respiratory conditions are known to be the most seasonal of all conditions as shown in the graph below. Plymouth Hospitals NHS Trust will increase its bed base by around 60 extra beds in the winter months to accommodate this extra demand.

Chart 3: Monthly profile of respiratory admissions



Winter pressures are not restricted to acute hospitals and most health and adult social care service areas experience this increase in demand. Ensuring efficient patient flow through the whole urgent care system is a key element in ensuring high quality patient care.

What we know – Domiciliary Care

The Community Domiciliary Care market has continued to grow in terms of demand of people growing older and wanting to remain living independently for as long as possible in their own home. The table below demonstrates the Domiciliary Care service growth of hours per week that are commissioned by PCC and NEW Devon CCG.

	2012/13	2013/14	2014/15
PCC	12,928	12,552	13,391
CCG	4,354	5,383	6,710
Total	**17,282**	**17,935**	**20,101**
% change		**3.8%**	**12.1%**

This demonstrates a slight decrease in the number of hours commissioned for adult social care but an increase in health commissioned domiciliary care.

What we know - Reablement and Hospital Discharge

Reablement services provide intensive support to people for a time limited period to either prevent an escalation of need, or to promote speedy recovery.

- The capacity of the commissioned Reablement service - in January 2015 there were 165 people in the reablement service with 47 people awaiting review for discharge.
- Between 250-400 referrals are received per quarter.

The Home from Hospital and Community Support service provides a smooth transition from hospital to home for people which assists in the prevention of delayed discharge from hospital. Once home they support the person to regain confidence and live independently in the community and prevent any breakdowns in care and unnecessary hospital admissions. They also support carers and provide practical and emotional support.

- In 2013/14 the service received 563 referrals. 84% of referrals were for clients over the age of 65, with 40% of referrals for people aged between 80 and 89
- So far in 2014/15 (up to December 2014) the service has received 418 referrals. 86% of referrals were for clients over the age of 65, with 43% of referrals for people aged between 80 and 89.

3.3 People needing Long Term Support

This section covers the needs of people who have the need for on-going personalised support or those who may be at risk in the future of developing more complex needs. The aim is to support people to live as independently as possible within the community, for as long as possible. The type of services currently commissioned to respond to this need include Day Opportunities, Supported Living, Home Care, Housing Adaptations, and Telecare. In line with personalisation agenda an increasing number of people will direct their own care through Direct Payments and Personal Budgets. This group includes both older and younger people with disabilities.

What we know - Long term limiting illness

- In 2014 a total of 12,041 people over the age of 65 were predicted to have a long term limiting illness where their day to day activities are limited a lot
- Between 2014 and 2030 it is expected that the number of people aged over 65 with a limiting long term illness will rise from 12,042 to 16,538

People with a long term limiting illness whose day to day activities are limited a lot by age group	**2014**	**2015**	**2020**	**2025**	**2030**
65 - 74	4,801	4,880	4,997	4,997	5,504
75 - 84	4,657	4,719	5,219	6,219	6,438
85 +	2,583	2,670	3,152	3,764	4,596
Total	**12,041**	**12,269**	**13,368**	**14,980**	**16,538**
% change		**1.86%**	**8.22%**	**10.76%**	**9.42%**

Source: Projecting Older People Population Information

- In 2014 550 people were predicted to have a profound hearing impairment

People predicted to have a profound hearing impairment by age group	**2014**	**2015**	**2020**	**2025**	**2030**
18 - 24	0	0	0	0	0
25 - 34	0	0	0	0	0
35 - 44	0	0	0	0	0
45 - 54	16	16	15	13	13
55 - 64	36	36	39	40	37
65 – 74	151	153	157	156	172
75 – 84	94	95	104	123	128
85 +	253	262	306	363	437
Total	**550**	**561**	**621**	**696**	**787**
% change		**0.18%**	**9.66%**	**10.78%**	**11.56%**

Source: Projecting Older People Population Information

- The National Census indicates 27,247 informal carers living in Plymouth with 28% of them providing more than 50 hours of support a week.

Older people are the largest group in this population. Not all older people need support and the fitter and healthier we help them stay the less likely they are to need help from us. However some older people do need long term support. Older people falling into the following groups are more

likely to need long term support - frail older people, older people with dementia and hearing and/or sight loss.

What we know - Older people with dementia

- In 2014 3,134 people over the age of 65 were predicted to be living with dementia
- By 2030 it is expected that the number of people over 65 with dementia will be 4855.

People predicted to have dementia aged 65 and over by age group	2014	2015	2016	2017	2018	2020	2025	2030
65 – 69	177	177	174	166	160	154	174	188
70 – 74	288	296	312	340	355	358	316	359
75 – 79	499	504	504	504	526	561	690	615
80 – 84	768	778	791	801	815	848	963	1,201
85 – 89	744	744	783	822	861	900	1,017	1,189
90 and over	659	687	687	714	745	804	1,038	1,303
Totals	**3,134**	**3,185**	**3,251**	**3,348**	**3,462**	**3,624**	**4,197**	**4,855**
% change		**1.60%**	**2.03%**	**2.90%**	**3.29%**	**4.47%**	**13.65%**	**13.55%**

Source: Projecting Older People's Population Information

What we know - Frail older people

Frailty is defined as having three or more symptoms from weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, and weak grip strength.

Frailty in older people negatively impacts on their quality of life and causes ill-health and premature mortality. Older people who are frail have an increased risk of falls, disability, long-term care and death.

There is also a significant cost associated with the frail older population. Over half of gross local authority spending on adult social care and two thirds of the primary care prescribing budget is spent on people over 65 years of age.

It is estimated that approximately 11% of over 65 year olds are frail. About 42% of over 65 year olds have one or two of these symptoms and are categorised as pre-frail.

This equates to 1.9% (4,782 people) of the Plymouth population who are frail and 7.0% (18,086 people) who are "pre-frail".

An increased risk of adverse health outcomes can be predicted by early identification of frailty, and adverse outcomes prevented by appropriate multidisciplinary interventions.

Older people frailty estimates, Plymouth

Age-group	Reported frailty rate (%)	Reported pre-frailty rate (%)	Population	Est. frail population	Est. pre-frail population
65 and over	11.0	41.6	43,475	4,782	18,086
65 to 69	4.0	-	13,540	542	-
70 to 74	7.0	-	9,827	688	-
75 to 79	9.0	-	8,219	740	-
80 to 84	15.7	-	6,190	972	-
85 and over	26.1	-	5,699	1,487	-

Source: 2012 mid-year estimates of usual resident population (ONS) using rates stated in the Devon Better Care Fund application, 2013

What we know – Continuing Health Care

There are currently approximately 545 Continuing Health Care (CHC) eligible people within the Plymouth footprint, with 239 people living at home within the community or residential home. There are 307 living within care homes with nursing. In addition there are 182 people in receipt of Funded Nursing Care Contributions.

What we know – Mental Health

- In 2014 it was predicted that there were 26,295 people with a common mental health disorder
- Between 2014 and 2030 it is expected that this number will rise to 25,670.

People aged 18 – 64 predicted to have a/an:	2014	2015	2020	2025	2030
Common mental disorder	26,295	26,282	25,988	25,647	25,670
Borderline personality disorder	734	734	725	716	716
Antisocial personality disorder	577	577	574	566	569
Psychotic disorder	653	653	645	637	637
Two or more psychiatric disorders	11,781	11,774	11,656	11,505	11,524

Source: Projecting Adult Needs Service Information

What we know – Learning Disabilities

- GPs identified 1240 people (5.7 in 1000) as having a learning disability in Plymouth compared to the national average of 4.54 in every thousand. [4]
- Hate Crime - the number of reported hate crimes to the Council are rising every year from Year 2011/12 - 34 (17 related to learning disabilities), Year 2012/13 - 47 (27 related to learning disabilities, Year 2013/14 - 59 (41 related to learning disabilities).

[4] Learning Disabilities Profile for Plymouth 2013. Public Health England.

It is suggested the data reflected above only represents a small percentage of the actual incidents that take place in Plymouth across all groups of disabled people. The increase in hate crimes, year on year, specifically related to people with learning disabilities in Plymouth reflects the national picture around the difficulties that people with learning disabilities face on a daily basis living in their local communities

- Accommodation - 665 (68.21%) people with learning disabilities were living in settled accommodation in Plymouth (2011/12), 21.54% were living in non-settled accommodation and 10.26% had an unknown accommodation status to LA[5]. Devon Home Choice collects information about the number of people with specific disabilities who wish to be considered for social housing.
- 815.38 in 10000 population adults with learning disabilities (age 18-64) are receiving community services, above the national 749.71[6]
- 282.05 in 10000 population adults with learning disabilities (age 18-64) are using day services, below the national figure of 347.20.[7]

People predicted to have a learning disability by age group	2014	2015	2020	2025	2030
18 - 24	964	971	924	906	1,003
25 - 34	869	869	879	886	852
35 - 44	741	729	729	756	771
45 - 54	802	801	740	654	654
55 - 64	647	654	716	734	680
65 - 74	529	538	558	553	610
75 - 84	298	302	336	404	418
85 +	112	116	139	167	206
Total	**4,962**	**4,982**	**5,021**	**5,060**	**5,194**
% change		**0.40%**	**0.78%**	**0.77%**	**2.58%**

Source: Projecting Older People Population Information

[5] Learning Disabilities Profile for Plymouth 2013. Public Health England.

[6] Learning Disabilities Profile for Plymouth 2013. Public Health England.

[7] Learning Disabilities Profile for Plymouth 2013. Public Health England.

What we know – Autism

- In 2014 2,070 people were predicted to have an autism disorder
- Between 2014 and 2030 it is expected the number of people with an autism disorder will rise from 2,070 to 2,186.

People predicted to have autistic spectrum disorders by age group	2014	2015	2020	2025	2030
18 - 24	374	377	361	354	393
25 - 34	355	356	368	377	363
35 - 44	300	295	294	306	315
45 - 54	339	334	304	270	270
55 - 64	283	287	313	314	289
65 - 74	241	244	245	248	276
75 +	178	183	213	259	281
Total	**2,070**	**2,076**	**2,099**	**2,128**	**2,186**
% change		**0.29%**	**1.10%**	**1.36%**	**2.65%**

Source: Projecting Older People Population Information & Projecting Adult Needs Service Information

What we know – Physical Disabilities in young people

- In 2014 there were 3,520 people predicted to have a serious physical disability aged between 18 and 64
- Between 2014 and 2030 it is expected that this figure will rise to 3,443.

People predicted to have a serious physical disability by age group	2014	2015	2020	2025	2030
18 - 24	285	287	274	269	298
25 - 34	140	140	141	142	137
35 - 44	513	505	503	520	529
45 - 54	929	926	851	748	745
55 - 64	1,653	1,670	1,827	1,873	1,734
Total	**3,520**	**3,528**	**3,596**	**3,553**	**3,443**
% change		**0.23%**	**1.89%**	**-1.21%**	**-3.19%**

Source: Projecting Adult Needs Service Information

3.4 Consultation feedback

The ***Plymouth Fairness Commission Report*** March 2014, 'Creating the Conditions for Fairness', makes a series of recommendations for improving fairness and addressing inequalities within the city following a "*Summer of Listening*". The report identified areas that would have the highest impact on fairness in Plymouth. These are:

- Strengthening Communities
- Improving individual and Family Wellbeing
- Improving services for young People and young Adults
- Reducing discrimination and social exclusion
- Assisting people to cope with the escalating cost of living
- Strengthening the Local Economy
- Improving housing
- Addressing the implications of an ageing population

The ***Strategic Vision for Transforming Community Services*** document has been developed by CCG. The document provides context around the issues surrounding community based services and provides a vision for the future of service delivery within the Community to address these issues.

The CCG developed a large stakeholder reference group at the start of the programme. The reference group provided feedback that enabled 10 commissioning principles to be developed. These principles form the basis of the case for change:

1. Integrated and seamless delivery
2. Clear pathways and access
3. Consistent outcomes
4. Evidence based foundations
5. Individuals and carers at the centre
6. Personalised and localised models
7. Honest and open relationships
8. Care that reflects health needs
9. Sustainable, agile and flexible responses
10. Shifts of resources and innovation

These principles were then turned into 'I statements' which will be used to guide planning and decision making on the strategy and delivery arrangements.

- "I want the services I value now to be strengthened"
- "I want no barriers to care caused by geographic, regulatory or any other kind of boundary."
- "I want services that support me to manage my situation in life not just my condition"
- "I want the information I need to make healthy choices and stay healthy"
- "I want what my carer does to be recognised and for them to have the support they need to have a full, healthy life of their own"
- "I want to be able to get to my community services at times that are convenient for me"

- “I want to be able to have services provided in lots of different places not just health centres”
- “I want to be able to talk to healthcare providers when I need to.”
- “I want to tell my story once - share my information with colleagues”
- “I want to be able to use new technology to help me manage my own health”
- “I want to continue to get the services I value that are provided by the voluntary sector”
- “I want to be able to get to the services in my community”.

4.0 STRATEGIC CONTEXT

4.1 National

Transforming the Delivery of Health and Social Care, The case for fundamental Change 2012

This policy sets out the major progress which has been made in improving the performance of the NHS in the past decade. Notwithstanding this progress, the current health and social care delivery system has failed to keep pace with the needs of an ageing population, the changing burden of disease, and rising patient and public expectations. Fundamental change to the delivery system is needed, with greater emphasis on:

- Preventing illness and tackling risk factors, such as obesity, to help people remain in good health
- Supporting people to live in their own homes and offering a wider range of housing options in the community
- Providing high standards of primary care in all practices to enable more services to be delivered in primary care, where appropriate
- Making more effective use of community health services and related social care, and ensuring these services are available 24/7 when needed
- Using acute hospitals and care homes only for those people who cannot be treated or cared for more appropriately in other settings
- Integrating care around the needs of people and populations.

Some of the key findings:

1. Services have struggled to keep pace with demographic pressures, the changing burden of disease, and rising patient and public expectations. Too much care is still provided in hospitals and care homes, and treatment services continue to receive higher priority than prevention
2. The traditional dividing lines between GPs and hospital-based specialists, hospital and community-based services, and mental and physical health services mean that care is often fragmented and integrated care is the exception rather than the rule
3. Current models of care appear to be out-dated at a time when society and technologies are evolving rapidly and are changing the way patients interact with service providers
4. Care still relies too heavily on individual expertise and expensive professional input although patients and users want to play a much more active role in their care and treatment
5. National and local leaders need to take a strategic view rather than focusing on short-term fixes designed to preserve existing services

6. Implementation of new models of care will involve: decommissioning out-dated models of care; supporting NHS organisations to innovate and adopt established best practices; recognising the potential of new providers as an important source of innovation; developing a culture that values peer support for learning and innovation; encouraging players at the local level to test new models of care.

NHS Five Year Forward View 2014

This sets out an agenda to further modernise NHS Services, ensuring there is a focus on tackling the causes of ill health, such as obesity, smoking and alcohol use, alongside creating more diverse and locally shaped service models, designed to meet local need.

Within this is a clear agenda to work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government

The Better Care Fund

The £3.8bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single integrated budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

It creates a substantial ring-fenced budget for investment in a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge.

Integrated Personalised Commissioning and Personal Health Budgets

Integrated Personal Commissioning is a new voluntary approach recently launched by NHS England to help to join up health and social care for people with complex needs. This proposal makes a triple offer to service users, local commissioners and the voluntary sector to bring health and social care spend together at the level of the individual. People will be offered power and improved support to shape care that is meaningful to them. Local authorities and NHS commissioners, and providers will be offered dedicated technical support, coupled with regulatory and financial flexibilities to enable integration. The voluntary sector will be a key partner in designing effective approaches, supporting individuals and driving cultural change. Plymouth City Council and NEW Devon CCG are jointly participating in this work and will be collaborating with NHS England and partners across the South West. This is an opportunity to bring together resource and expertise, share good practice and collectively overcome barriers to implementation.

Personal health budgets are a key strand of the government's drive to personalise public services. The Personal Health Budget Programme was launched in 2009 after the publication of the Next Stage Review. An independent evaluation was commissioned alongside the programme which revealed that personal health budgets led to a better quality experience for service users and helped them to become less reliant on conventional health services.

From October 2014 people receiving NHS Continuing Health Care (CHC) were given the 'right to have' a personal health budget. It is now a priority for Plymouth City Council and the NEW Devon CCG to integrate health and social care services to ensure that people who choose to have a personal health budget are properly supported and can maximise the opportunities that this can bring, to take more control over their care and support and achieve a greater level of independence.

Our ambition for personal health budgets locally is to use the concept as a spring board to foster person-centred care and deliver services in a more integrated fashion. Implementation will help

commissioners to support people with health and social care needs, particularly those in receipt of Continuing Healthcare (CHC) funding, to live more independently, remaining in their own communities and staying in their own homes for longer.

4.2 Local

Our Plan: The Brilliant Cooperative Council

The Strategy will support the achievement of the following Council objectives and outcomes:

- Pioneering Plymouth: A Council that uses its resources wisely
- Growing Plymouth: More decent homes to support the population
- Caring Plymouth: People are treated with dignity and respect
- Confident Plymouth: Government and other agencies have confidence in the Council and partners: Plymouth's voice matters.

The Plymouth Plan – How Plymouth Will be a Healthy City (in development)

The Plymouth Plan is a single holistic plan setting out the direction for the City up to 2031. It brings together all the key strategies and plans for the city into one coherent document. It does so because the interdependencies of these strategies and plans are key to transforming the City. The section on health recognises that over the course of the Plymouth Plan period demographic changes and increasing complexity of need will continue to put pressure on all vital front-line services. The challenge for the public sector is to meet the volume and complexity of demand with decreasing resource. A focus on prevention is evidenced to reduce the burden of disease and consequently reduce demand on front-line services. The Plymouth Plan will show how partners and services from across the city can achieve this aspiration.

Health and Wellbeing Strategy (2014) Plymouth Health and Wellbeing Board

The Joint Health and Wellbeing Strategy is intended to inform commissioning decisions across local services, such that they are focused on the needs of people and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. Underpinned by the Marmot review the Strategy recognises that health and wellbeing must be addressed across the whole life course.

Transforming Care in Devon and Plymouth: Five Year Strategic Plan, (2014) CF01 NEW Devon CCG

This Strategic Plan states that, 'By 2019, healthy people will be living healthy lives in healthy communities. Services will be joined up and delivered in a flexible way. Resources will follow need. More care will be provided in the community'. Healthy living and wellbeing is cited as one of the key elements to the model of care recognising that interventions 'focus on preventing ill health and social factors such as isolation in the first place, focused on those most at risk – where the returns are greatest in terms of quality benefits for patients and service users and the reduction in demand (and cost) along the care pathway'.

In this framework NEW Devon CCG state they 'will work with its partners to commission services that contribute to the delivery of the Joint Health and Wellbeing Strategy'. The framework sets out the key CCG intentions.

Transforming Community Services: Proposed Commissioning Intentions for the Western Locality

The Transforming Community Services programme with our local strapline of 'Your Health, Your Future, Your Say' has given an opportunity to review the community services NEW Devon CCG currently commission, engage with the community and look at what is wanted and needed for our future to ensure resources are used in the way that best meets the needs of the Western locality population.

The aim of this document is to share the commissioning intentions for services in the community in the future. The document has been informed by public health information to incorporate knowledge about local needs, how the population may change over forthcoming years, listened to individual and community views and taken into account evidence and national policy to inform how we plan for tomorrow, not just today.

In doing so a model has been described where community services work clearly and healthcare is closely integrated with social care in some areas. There must be a greater focus on health promotion and ill health prevention, where resources are moved for the benefit of individuals, the population and sustainability of the system from traditional acute services to modern, efficient community services.

Integrated Health & Wellbeing – Integrated Commissioning

Public sector organisations across the country are facing a combination of severe budget pressures and increasing demand for services and are only able to meet these combined challenges through system wide change.

In response Plymouth Health and Wellbeing Board has adopted a system's leadership approach that has set down a vision of system integration based around Integrated Commissioning, Integrated Health and Care Services and an integrated system of health and wellbeing.

PCC and NEW Devon CCG have already developed strong relationships which can act as a solid foundation to support system wide integration. Co-location has brought commissioning teams into the same building at Windsor House, and this has assisted the development of lead commissioning arrangements, some pooling of budgets, and joint commissioning strategies.

Therefore by 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, through a section 75 agreement.

The single commissioning function will therefore focus on developing joined up population based, public health, preventative and early intervention strategies and adopt an asset based approach to providing an integrated system of health and wellbeing, focusing on increasing the capacity and assets of people and place.

Integrated Health & Wellbeing – Integrated Delivery

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

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

With the customer requirements combined with key drivers such as the Better Care Fund, Care Closer to Home, NEW Devon CCG strategy and initiatives such as Admission Avoidance the

emphasis in setting up the integrated function requires a significant focus on services based in the Community.

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

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

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

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

Better Care Fund Submission 2014 (NEW Devon CCG and Plymouth City Council)

To use the Better Care Fund to support our wider strategic aims for integration across our population. These aims are to:

- Strategically join the key actions we know will make a difference.
- Consistently commission great services that deliver to defined outcomes.
- Positively shift resources to parts of the system where there is most benefit.
- Adopt an asset based approach to help communities to help themselves.
- Target our attention to impacting on inequalities and services for the most vulnerable.
- Bring a new model of out of hospital care.
- To put in place schemes and arrangements to progress towards the national conditions of the BCF and achieve our desired outcomes. The national conditions include protecting social care services, seven day working, data sharing, and ensuring joint assessment and accountability for individuals at high risk of hospital admission.
- To improve performance outcomes. This will include the national outcomes set by the BCF, but also the additional local outcomes that will enable us to achieve our aims. The national outcomes for performance improvement include: delayed transfers of care, avoidable admissions and effectiveness of reablement and patient / user experience.
- To fully embrace the opportunity presented by the BCF to change the nature of commissioning and the speed and scale of integration. To work closely with our local authority partners and providers to make this happen.
- To integrate our commissioning, services delivery and health and wellbeing.
- To fully embrace the opportunity presented by the BCF to change the nature of commissioning and the speed and scale of integration.

Examples of current Plymouth Strategies, Commissioning Plans and other key documents supporting the scope of this Commissioning Strategy:

- How do we make Plymouth a healthier city? (2014) Plymouth Plan Topic Paper Health and Wellbeing
- Community Domiciliary Care Business Case 2015-19
- Dementia Strategy 2014-15,
- Carers Strategy 2014-18,
- Strategic Alcohol Plan for Plymouth 2013-2018
- A Mental Health Commissioning Strategy for Devon, Plymouth and Torbay 2014-2017,
- Housing Plan 2012-2017 Plymouth City Council

4.3 Key legislation

Health & Social Care Act 2012

The Health and Social Care Bill 2012 contains a number of provisions to enable the NHS, local government and other sectors, to improve patient outcomes through more effective and coordinated working within the context of economic austerity. The Act provides the basis for better collaboration, partnership working and integration across local government and the NHS at all levels.

The Bill identifies Clinical Commissioning Groups (CCGs) as being best placed to promote integration given their knowledge of patient needs, and the commissioning power to design new services around these needs. This is endorsed by early findings from the Department of Health's 16 Integrated Care Pilots (evaluated independently in the RAND report, 2012) which suggest that GPs in particular are taking on responsibility not only for the individual patient but also for that person's journey through the system

Care Act 2014

The Care Act 2014 creates a single modern piece of law for adult care and support in England. The reforms introduce significant new duties on Local Authorities and consequently will involve significant change to finances, processes and people.

The Care Act ensures that people will have clearer information and advice to help them navigate the care system and a more diverse, high quality range of support to choose from to meet their needs.

The Act places more emphasis than ever before on prevention – shifting from a system which manages crises to one which focuses on people's strengths and capabilities and supports them to live independently for as long as possible. Duties also include additional responsibility for assessment. This includes:

- Carers – the Act also included the need to supply services if the carer is eligible
- All adult regardless of need/support or regardless of financial resources.

Funding reforms will introduce a national minimum eligibility threshold, a cap on care costs, the introduction of Independent Personal Budgets, the maintenance of Care Accounts and a universal Deferred Payment Scheme.

The Social Value Act (2012)

Requires all public bodies to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the community. 'Social value' involves looking

beyond the price of the individual contract and considering the social impact on the community when the contract is awarded.

4.4 Evidence based / good practice

This strategy will incorporate good practice and build on an evidence base to improve the health and social care outcomes of people in Plymouth. The following good practice resources, research and data can be accessed by health and social care professionals and commissioners:

- Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/
- National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/
- The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/
- NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/
- Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/
- Care Quality Commission (CQC) - http://www.cqc.org.uk/
- Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/
- Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm

More detailed descriptions of the resources listed above can be found in appendix 1.

5.0 CURRENT PROVISION

5.1 Strategic overview

This section will describe the current 'Community Based Care' system in three parts:

- Multiple Needs Services
- Urgent Care Services
- Long Term Support Services

5.2 Existing service provision

Multiple needs

This area covers adults who experience several problems at the same time (e.g. mental health, substance misuse, homelessness, offending), that have significant impact on families and communities. Often people are living chaotic lives, and have ineffective contact with services

In Plymouth services to support adults with multiple needs are commissioned by different commissioners through service specific contracts that cover only on the issue they are commissioned to provide. Correspondingly the provider market has developed into specialist areas, although there are some good examples of joint working there is limited meaningful partnerships that respond to the range of needs an individual often presents with.

This can lead to duplication with the same clients often accessing a number of different services in an unpredictable manner and potentially, more worryingly, clients with complex health and social care needs, not being able to access any services due to lack of clarity as to "who does what".

The diagram below demonstrates the silo approach to commissioned services, albeit a range of services are delivered in a more integrated manner. The diagram raises the following questions:

- Where does a client go with a combination of problems?

- What happens if the client is homeless and has a mental health problem and some form of addiction?
- Does the information about the client who presents to one commissioned service go with them or get shared with another service with whom the client engages?
- Does the system chaos adversely impact on people whose lives, by the very nature of their health and social care issues, are often chaotic?

Commissioner - ODPH	Commissioner - CCG	Commissioner – CC & ASC	Commissioner - MOJ
Substance Misuse Treatment Services £4,219,900	Mental Health Services £32,565,524 (Pledge 90)	Homelessness Services £2,361,266 Adult Social Care £3,862,000 (Pledge 90)	Community Rehabilitation Company / National Probation Service £?
Prescribing, substance misuse workers, drug intervention program, day services	Services for people with mild / moderate needs and people with severe or enduring needs	Hostels, supported accommodation, community based support, advice and information	Probation, lifestyle and treatment interventions
Person with substance misuse issues	Person with MH issues	Homeless person	Ex Offender

Services are also performance monitored separately. There is a general sense of the following performance across each individual element of the system

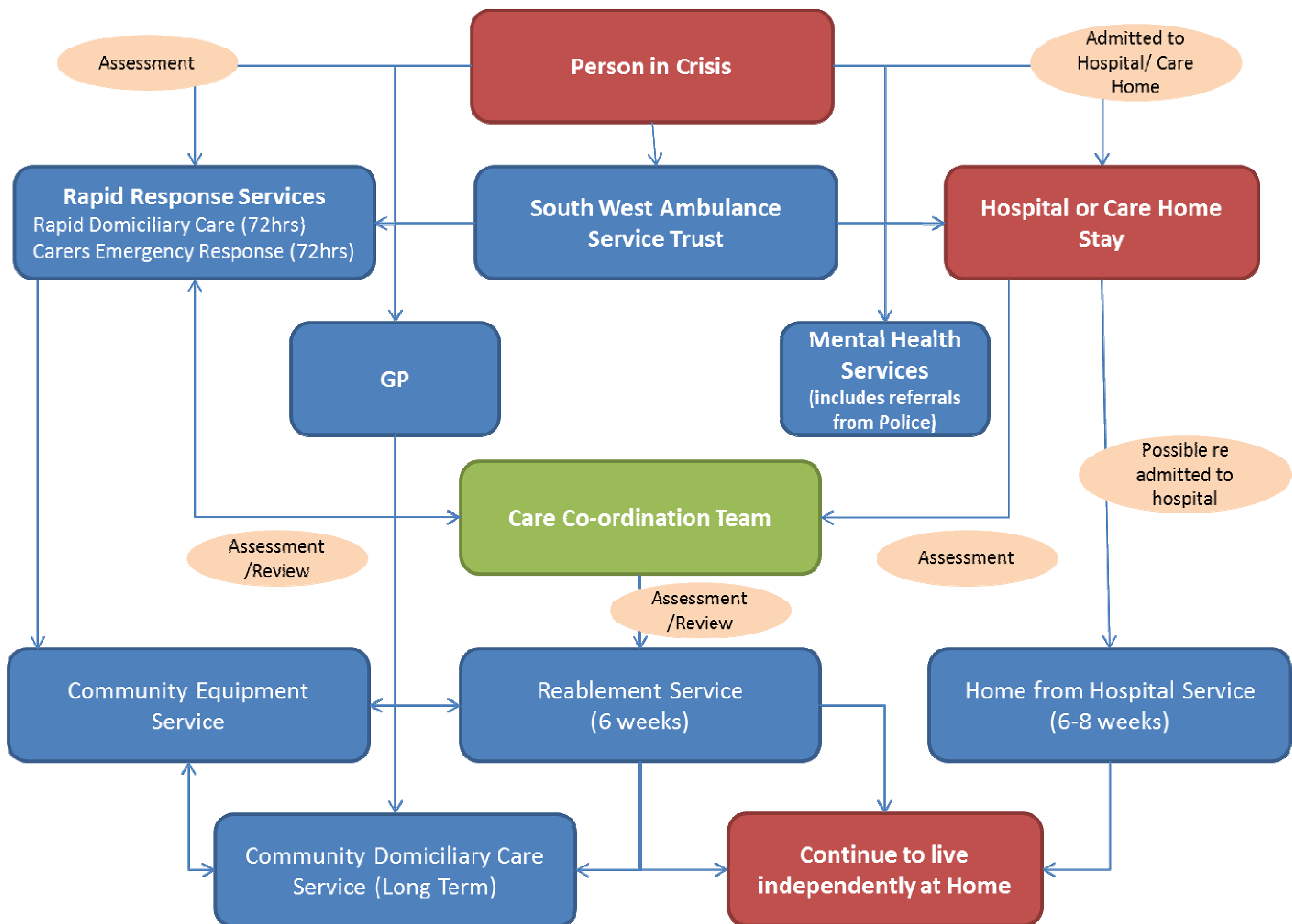
- Homelessness – well utilised services with high planned move on to independent tenancies
- Substance misuse – trajectory of improving levels of successful completions
- Mental health – some specific concerns around referral to treatment, service capacities, and outcomes (e.g. Plymouth Options).

It remains difficult to gauge a comprehensive picture across the whole system. The national outcomes frameworks provide an indication of how Plymouth is performing overall compared to other areas

Public Health Outcome Framework (PHOF) Indicator	England	Plymouth
1.06ii Secondary MH in stable & appropriate accommodation	58.5	53
1.08ii Gap in employment rate between MH and overall	62.3	63
1.13ii Reoffending levels	26.9	27.5
1.15i Statutory Homelessness	2.3	2.5
2.15i Successful completions (opiate)	7.8	7.2
2.18 Alcohol related hospital admissions	637	708
2.23iv Self reported wellbeing (high anxiety)	21	24.1

Urgent Care

The purpose of the existing provision of Urgent Care Services is to support people and their carers in crisis, to avoid admission to hospital or care and to promote recovery and reablement as quickly and effectively as possible. There is a variety of services within this area however the system is difficult to navigate with the increasing pressures due to demand and complexity.



There are a significant number of pressure points within this system.

The system does not currently prevent people from going into a crisis and too many people are admitted to hospital in an emergency. At any point in time, in the region of 30% of people are admitted to hospital when, in fact, their needs could be met elsewhere. Once people, particularly the frail elderly are admitted, there is the very real risk that they will recover slowly, potentially become more unwell, be isolated from their usual support networks and more dependent. This results in long lengths of stay (delayed transfers of care) and admissions to care homes (nursing and residential), and not providing a seamless and speedy recovery journey.

This winter (2014/15) has been one of the most difficult for the health and social care system, with Plymouth Hospitals NHS Trust having spent over 6 weeks at "black escalation" as a consequence of this.

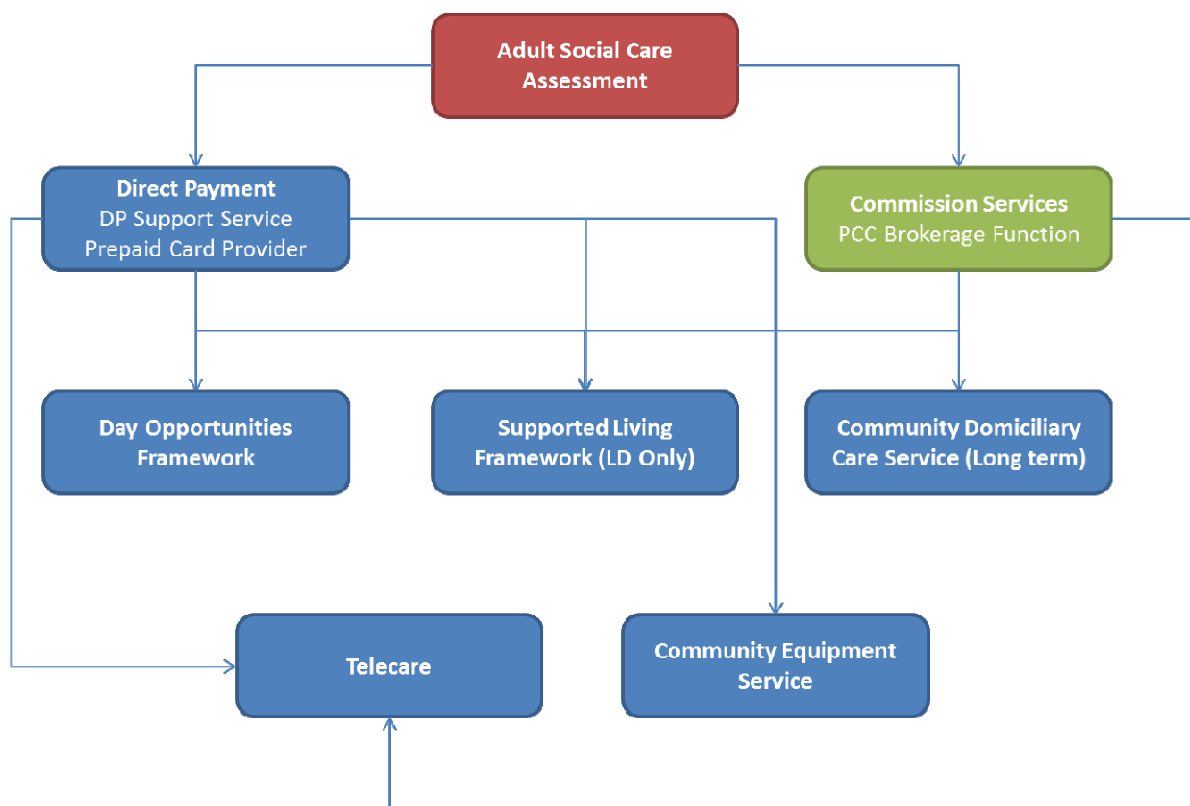
There are significant pressures within the capacity of our Domiciliary Care Providers in the City at the moment and with people needing to be discharged from hospital quickly the demand is only likely to increase as describe within the needs assessment.

Other performance indicators that can be used to indicate how well the urgent care system are described below.

Performance Indicator	National	Plymouth
Local Proxy - Avoidable hospital admissions (2013/14)	1898.3	2187
Local BCF - Delayed transfers of care (days delayed) from hospital per 100,000 population (aged 18+)	887.9 (Q2 13/14)	1514.7 (Q3 14/15)
ASCOF 2A Permanent admissions to residential and nursing care homes (aged 65+)	650.6	649.7
ASCOF 3A Percentage of adults using services who are satisfied with the care and support they receive	64.8% (2013/14)	67.8% (2013/14)
ASCOF 2B Proportion of older people still at home 91 days after discharge	82.5% (2013/14)	80.8 (2013/14)

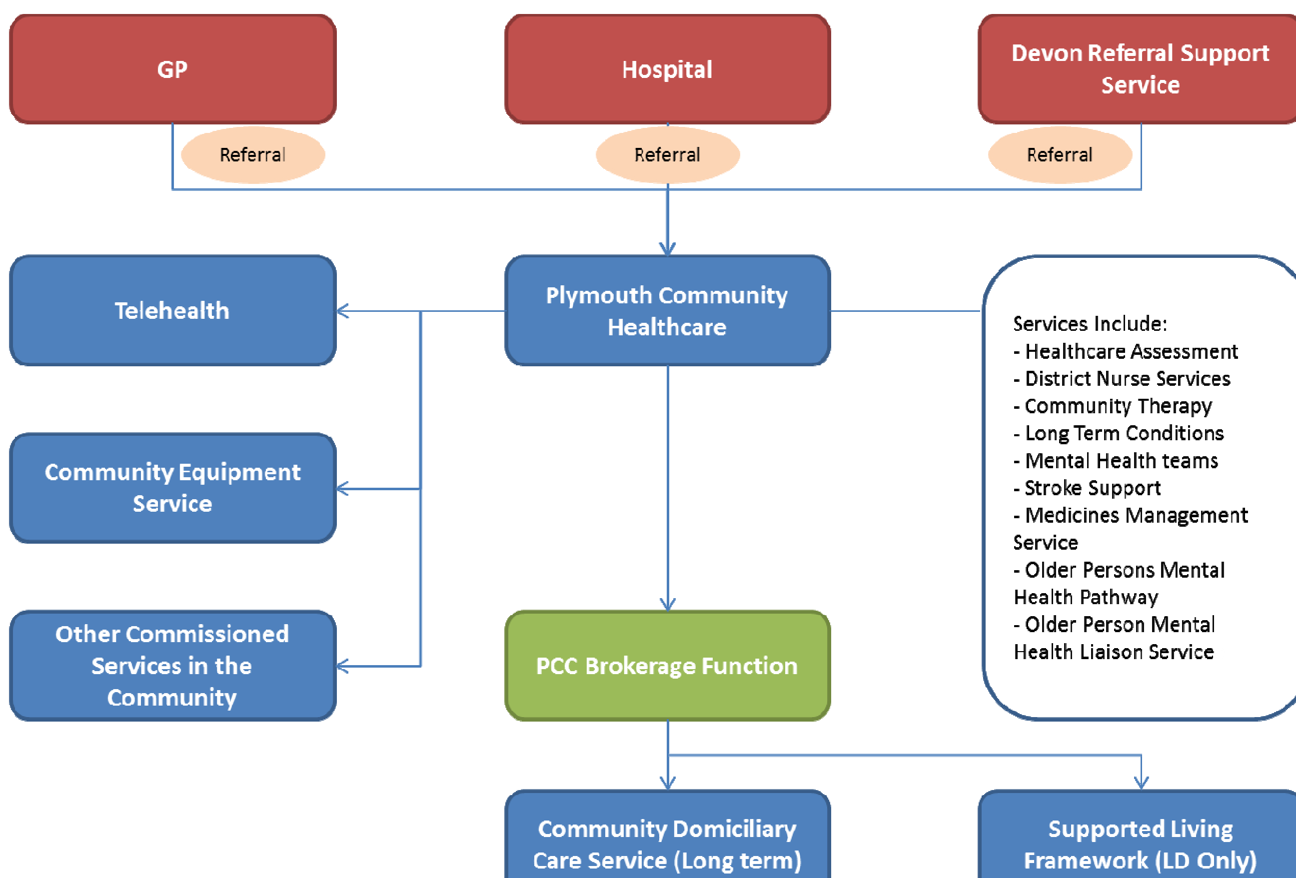
Long Term Support

The purpose of the existing provision is maintain people with on-going needs to live as independently as possible for as long as possible and to target support at those who may be at risk in the future of developing more complex needs. There is a variety of services within this area including day opportunities and most are currently commissioned through Plymouth City Council. However the system for adult social care and health are not interlinked. The below diagram below shows existing provision of long term support for people following an adult social care assessment.



This demonstrates that all of these services are delivered by the provider market and accessed via a direct payment or commissioned service.

The next diagram shows the services available for long term support following a Healthcare assessment. The majority of services for patients with a health need, are commissioned by CCG and provided by Plymouth Community Health Care Community Interest Company or brokered via the PCC function.



The opportunity for joining up the two systems is clear and responds to the feedback from service users about the need for a integrated health and social care system.

Personalisation gives people the freedom to decide how they wish their social care and health needs to be met. Currently, Adult Social Care allocates personal budgets following an assessment, and these can be deployed as a direct payment. Personalised health budgets are available to those people with long term conditions and those receiving Continuing Healthcare funded services e.g. personal care at home, physiotherapy, speech therapy, counselling. During 2014/15 the CCG has worked with people receiving these services to set up personal health budgets. The CCG currently has approaching 50 personal health budgets in place. Those people managing personal health budgets are reporting significant benefits enabling them to plan and manage their individual care requirements.

Other performance indicators that can be used to indicate how well long term support are described below.

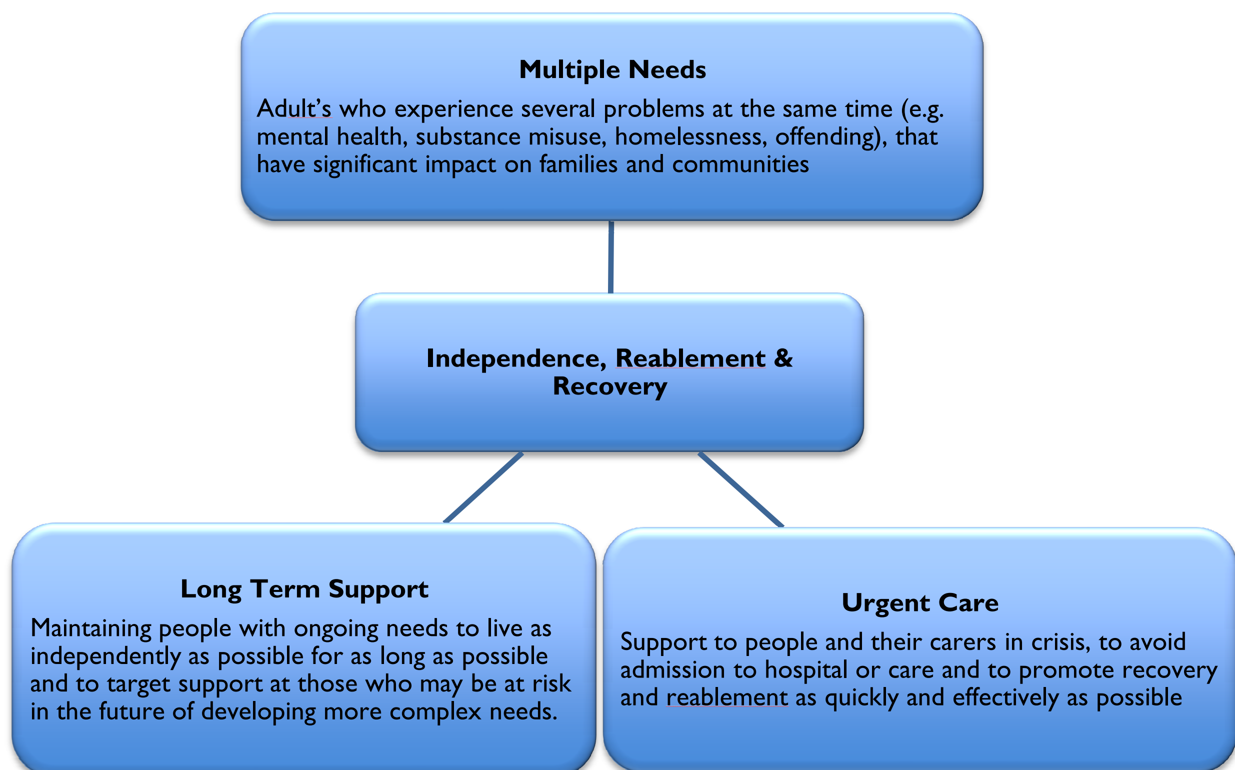
Performance Indicator	National	Local
ASCOF 1C Proportion of people using social care who receive self-directed support	62.1% (2013/14)	67.8% (2013/14)
Proportion of people using social care who receive self-directed support	19.1% (2013/14)	26.1% (2013/14)
Social care related quality of life	19.0	19.3
Satisfaction rates amongst social care clients	64.9%	67.8%

5.4 Community asset mapping

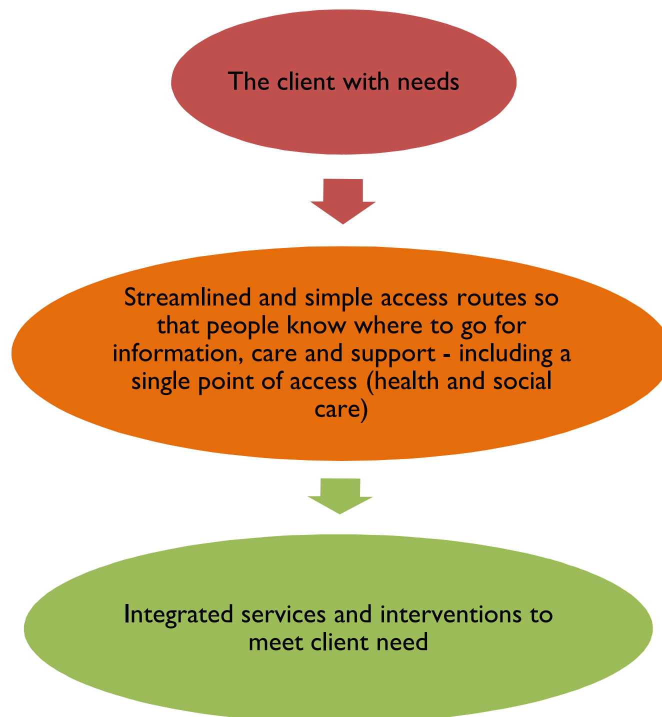
Asset mapping will be utilised to determine existing informal provision, assets and resources that people have access to in the community. A co-production approach will improve the understanding of local needs and assets and will be part of the wider needs assessment work carried out across the four strategies. The asset maps would then support the formally procured services as part of the long-term commissioning strategies (Adapted from Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014).

6.0 THE FUTURE 'COMMUNITY BASED CARE' SYSTEM MODEL

This section will pull together a summary of the above information around need and current provision, and describe what the future 'Community Based Care' System will look like in the future.



The needs assessment, strategic context and analysis of the current provision require a future system that responds to individual need through a streamlined and integrated provision. Whether a person needs support for multiple needs, around urgent care, or long term care what this means for clients is clear, simple, joined up solutions:



Multiple Needs

Commissioners responsible for existing different service elements will work together to commission a joined up 'whole system' to support people multiple needs. This will ensure services are integrated around the needs of the person, improve individual outcomes whilst also ensuring best use of resources.

Urgent Care

Commissioners are required to develop an integrated and seamless system that focuses on reducing acute episodes of care, responding quickly to a crisis, and focusing on timely discharge, recovery and reablement.

Key design principles include;

This work will be underpinned by the following design principles:

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

Long Term Support

The Long Term Support system will target resources at those who need on-going support in the community, or at those who are identified at risk of needing support with the aim of:

- Promoting Independence and reducing dependency
- Maximising peoples potential to live full and rewarding lives
- Promoting self-care

- Promotion of choice and control

Increasingly this will mean a more personalised market tailored to individual needs

Long terms support should be focussed on those who would most benefit from NEW Devon CCG and PCC are currently working towards an integrated delivery approach for Health and Social Care for a single point of contact for people. For the effective use of resources and delivery of services, requires the alignment of health and social care. The Better Care Fund and the integration of health and social care will help provide a vehicle to enable this to happen.

6.1 Available Resources

The current approximate commissioning budget against each service element is described in the table below.

System element	Approximate current budget
Multiple needs	£7,091,797
Urgent care	£79,889,251
Long term support	£32,761,589
Total	£119,742,637

6.2 System Performance – Current and Future

The following outcome performance indicators have been identified as key to measuring how this strategy contributes to improvements across the whole health, wellbeing and social care system in Plymouth. These will form part of a comprehensive performance dashboard that will be used to monitor an overview of the system.

Indicator	National	Plymouth	Impact on system – why is this a measure?	Trajectory
PHOF 2.18 Alcohol related admission to hospital	637	708	Improving these indicators demonstrate impact on the	
PHOF 7.15 Successful completion of drug treatment	7.8	7.2		
Local BCF - Delayed transfers of care (days delayed) from hospital per 100,000 population (aged 18+)	887.9 (Q2 13/14)	1514.7 (Q3 14/15)	Improving these indicate a strong community based system that supports people at home for longer reducing the impact on services in the 'complex' strategy	843.3 (Q4 15/16)
ASCOF 2A Permanent admissions to residential and nursing care homes (aged 65+)	650.6	649.7		604.2 (15/16)
ASCOF 3A Percentage of adults using services who are satisfied with the care and support they receive	64.8% (2013/14)	67.8% (2013/14)		70.0 (2015/16)
ASCOF 2B Proportion of older people still at home 91 days after discharge	82.5% (2013/14)	80.8 (2013/14)		89.9 (2015/16)

7.0 COMMISSIONING PLAN 2015/16 – COMMUNITY BASED CARE

This section describes the key commissioning activity that needs to take place to develop the 'Future Systems' described above:

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
Multiple Needs	Commission a joined up 'whole system' to support people multiple needs	Reduced homelessness Recovery from substance misuse Reduced offending	**PCC**	April 2016
Urgent Care	Establish and develop an effective multiagency Urgent Care Control Centre	Deliver a minimum of 3.5% reduction in non-elective admissions to acute Trusts. Ensure the achievement of the 95% A&E 4 hour performance target. Ensure the achievement of SWASFT performance targets.	**CCG**	2016
	Develop the Urgent Care Model through a strategic review of urgent and unplanned care services	A clear map of the current network of urgent and unplanned care services	**CCG**	2016
	Implement two Progress Enablers: 1) Completion of data analysis on impact to length of stay / identify alternative diagnostic offerings and pathways 2) Successful sharing of patient data and information	Release pressure on the urgent care system	**CCG**	2016

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
	Further analysis of emergency admissions, repeat emergency admissions and potentially avoidable admissions	Concepts tested with reference groups for agreement	**CCG**	2016
Urgent Care Long Term Support	Jointly commission an integrated health and social care service that delivers all statutory functions and maximises opportunities for integration across all disciplines	Improved service user experience of health and care Improved health and social care outcomes Care Act 2014 compliance Improved ASC Performance	**PCC/CCG**	2016
	Complete Phase 1 Community Domiciliary Care procurement	To have block contracts arrangements in place with 8 providers Seamless transfer of approx. 225 clients from all spot contracts to a block contract provider Provider to implement the following key principles for care staff: - Paid at least the living wage - Paid for travel time - Offer guaranteed hour contracts	**PCC**	April 2015
	Undertake a needs data analysis to inform the procurement and complete Phase 2 of Community Domiciliary Care including market Development	To secure further block contract arrangements for domiciliary care market Provider to implement the	**PCC**	April 2016

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
		following key principles for care staff: - Paid at least the living wage - Paid for travel time Offer guaranteed hour contracts		
Long Term Support	Explore the opportunities to create "Community Health and Wellbeing Hubs" alongside other organisations	Streamlining information and support, based in local communities and making better use of resources and facilities	**CCG**	**2016**
	The next phase of implementation of personal health budgets will be aimed at those people with multiple long term conditions, frail elderly and mental health service users.	Improved health outcomes	**CCG**	**2016**
	Reconfigure supported living services taking a whole system approach. To include commissioning services jointly with the CCG, increasing the focus on reablement to improve outcomes and independence.	Remodelled in-house reablement service with increased focus on developing people's independent living skill so enabling a reduced reliance on care services Establish supported living services across client groups for people with eligible health and social care needs	**PCC**	March 2016
	Develop and procure further Extra Care Housing Schemes	Provision of additional extra care housing units as an alternative to residential care	**PCC**	By 2019

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
	Review the impact of other provision on the rate of admission to care homes including Extra Care Housing, Domiciliary Care, Telecare and Reablement	Reduced admission to Care Homes		March 2015
	Re-procurement of the wheelchair service	New service established which has an increased service user focus driving service improvements; delivering an improved offer alongside efficiencies through more effective practice.	**CCG**	November 2015
	Reprocurement of the Community Equipment Service	New service established which has an increased service user focus driving service improvements; delivering an improved offer alongside efficiencies through more effective practice.	**PCC**	April 2015
	Revise the Section 117 After Care agreement between PCC and CCG in line with the 2015 mental health Act Code of Practice and the Care Act 2014	Establishment of clear working parameters in line with best practice regarding the provision of 117 aftercare services	**PCC**	April 2015
	Refresh the day opportunities framework by opening up for new providers and revised offers	Increase the choice of daytime activities through the day opportunities framework	**PCC**	November 2015

APPENDIX ONE

Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/The SCIE aims to improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy

National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. There are also the following NICE Standards and Indicators areas:

1. *NICE Quality Standards* are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health or care and are derived from the latest evidence and best practice. The NICE Quality Standards are divided into 3 categories:
    a. *Quality standards for health* focus on the treatment and prevention of different diseases and conditions. Topics are referred to NICE by NHS England. They are reflected in the new Clinical Commissioning Group Outcome Indicator Set (CCGOIS) and will inform payment mechanisms and incentive schemes such as the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) Payment Framework.
    b. *Quality standards for social care* focus on the services and interventions to support the social care needs of service users. Topics include supporting people to live well with dementia, looked-after children and young people, autism and the mental wellbeing of older people in care homes. Topics are referred by the Department of Health and Department for Education.
    c. Quality standards for public health will support Public Health England, local authorities and the wider public health community. Topics include reducing tobacco use in the community, preventing harmful alcohol use, and strategies to prevent obesity in adults and children. Topics are referred by the Department of Health.
2. *Quality and Outcomes Framework (QOF)* is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. NICE's role focuses on the clinical and public health domains in the QOF, which include a number of areas such as coronary heart disease and hypertension.
3. *CCG OIS* is to support and enable Clinical Commissioning Groups (CCGs) and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of services commissioned by CCGs. It is also intended to provide clear, comparative information for patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes. All indicators are evidence based and draw on NICE quality standards, NICE guidance or NICE accredited guidance.

The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/

HSCIC is the national provider of information, data and IT systems for health and social care. The Health and Social Care Act 2012 sets out HSCIC responsibilities, which include:

- Collecting, analysing and presenting national health and social care data
- Setting up and managing national IT systems for transferring, collecting and analysing information.
- Publishing a Code of Practice to set out how the personal confidential information of patients should be handled and managed by health and care staff and organisations
- Building a library of 'indicators' that can be used to measure the quality of health and care services provided to the public
- Acting to reduce how much paperwork doctors, nurses and care workers have to complete by ensuring that only essential data is collected, and avoid collecting the same information twice
- Helping health and care organisations improve the quality of the data they collect and send to us by setting standards and guidelines to help them assess how well they are doing
- Creating a register of all the information that we collect and produce, and publishing that information in a range of different formats so that it will be useful to as many people as possible while safeguarding the personal confidential data of individuals.

NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/

NHS IQ is working to improve health outcomes for people by providing improvement and change expertise across the NHS in England. NHS IQ utilises good practice and builds improvement capacity and capability and to help develop knowledge and skills across the whole health and care system. They work to the five domains of the NHS Outcomes Framework:

1. Living longer lives
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/

Ofsted independently inspect and regulate services which care for children and young people, and those providing education and skills for learners of all ages. Ofsted will work with providers which are not yet good to promote their improvement, monitoring their progress and sharing with best practice.

Care Quality Commission (CQC) - http://www.cqc.org.uk/

CQC is the independent health and adult social care regulator. CQC monitor, inspect and regulate services to make sure they meet fundamental standards of whether the service is safe, effective, caring, responsive to people's needs and well-led. CQC will publish findings, including performance ratings to help people choose care. Regulated services include:

- Hospitals
- Dentists
- Care Homes
- Community Based Services

- GPs and Doctors
- Clinics
- Home Care Services
- Mental Health Services

Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/

HCPC are a regulator who keep a Register of health and care professionals who meet our standards for their training, professional skills, behaviour and health.

Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm

The HSE's work covers a varied range of activities; from shaping and reviewing regulations, producing research and statistics and enforcing the law.

There are also a wide range of regulators for health staff, such as the General Medical Council (GMC) for registered doctors in the UK, their good practice guidance will be considered wherever applicable.