COMMISSIONING STRATEGY FOR COMPLEX CARE

DRAFT

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Part: I

DOCUMENT CONTROL

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Table of Contents **Page Number**

1.0 EXECUTIVE SUMMARY

The Complex Care system will consist of quality specialist health and care services that promote choice, independence, dignity and respect.

The provision that supports people with complex needs is mainly delivered in an acute hospital, residential, nursing home or hospice setting but also includes some people with complex needs supported at home.

The aim of this strategy is to develop an integrated, streamlined system to meet the needs of people with complex health and social care needs. Through an integrated assessment process people will have equity of access and provision that promotes a good quality of life right up to the end of life.

We will achieve this by:

- Providing pro-active care co-ordinated by GPs to ensure the most vulnerable frail older people are kept safe and as well as possible
- Commission an effective dementia care and support system that aims to keep people living well with dementia
- Developing an integrated assessment, referral and placement process for care homes across health and social care
- Undertaking a market review of the care home sector to ensure consistent quality and fee rates
- Reviewing and redesigning local pathways and provision in order to prevent and reduce out of area Individual Patient Placements
- Develop a commissioning plan for end of life care that aims for people being able to die in their preferred place of care

All designed with a system aim of reducing acute provision and acute episodes of care

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 includes;

- 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: Current health and social care commissioning budgets

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 of Complex Care

These are services that support people with complex needs, who need specialised care which is mainly delivered in an acute hospital, residential, nursing home or hospice setting but also includes some people with complex needs supported at home. This includes care homes for both working age adults and those over 65s. Support at home will mostly relate to end of life care as other nursing or specialist domiciliary care at home will be covered in the Community Strategy. Individual Patient Placements are a placement or treatment commissioned on an individual basis for people with complex mental health needs, learning disabilities, acquired brain injury and other complex needs that cannot be met locally. These are often out of area, high cost but small volume.

Supporting the complex system is a Clinical Effectiveness and Medicines Optimisation Framework which has the following mission:

"Our mission is to achieve the best possible care and outcomes for patients through ensuring the safest and most effective use of medication and other treatments while delivering value for money

for the NHS. We will achieve this by working closely with doctors, nurses, pharmacists, the public we serve, and other stakeholders in the health and social care community."

2.7 Scope

2.7.1 Care Homes

The majority of people choose to move into a care home due to their own personal circumstances and preferences. Following an assessment process described further on in this strategy, health and social care services will agree to fund placements where a person's health and care needs are too complex to be met cost effectively in their own home. This may also be subject to a financial assessment to determine if the person has to contribute to their care home fees. Many people pay for their own care.

Care homes offer accommodation and personal care for people who may not be able to live independently. Some homes also offer care from qualified nurses or specialise in caring for particular groups such as younger adults with learning disabilities. A care home is a place where personal care and accommodation are provided together and are integral to the health and care system in Plymouth; providing additional choices in respect to where people live and receive care to meet their needs.

Care homes can be residential or nursing or a combination, nursing homes include nursing homes, convalescent home with nursing, respite care with nursing, mental health crisis house with nursing and care home services without nursing. Residential homes include: residential home, rest home, convalescent home, respite care, mental health crisis house and therapeutic communities

The key reasons for bed use:

- A person's home
- Intermediate Care (Reablement and other services may make temporary placements in care homes as a 'step down' from hospital or 'step up' to avoid hospital admission. Reablement is described in the Community Strategy. There are also some beds used by people who have had serious physical injuries and are recovering which may be for several months)
- Respite care
- Long term care due to frailty
- Long term care due to complex health needs

2.7.2 Individual Patient Placements (IPPs)

Individual Patient placements are generally specialist hospital placements for individuals who have been detained under the Mental Health Act (MHA). S117 aftercare is care that is commissioned to meet an individual's mental health and care needs following an admission under Section 3 MHA.

Currently ways of offering care in or as close to individuals' homes as possible are being explored. Where individuals are placed out of area, there is a need to assure the quality of these placements and that they are not 'out of sight and out of mind'.

Individual Patient Placements include the commissioning of some highly specialist assessments, individual placements, and packages of care for:

a) adults with complex mental health problems 18 to 64 years

b) older adults over 65 years - these are more often related to functional mental health problems and sometimes clients will have had a forensic history. There is also a small minority of clients with dementia whose needs cannot be met by existing older people's inpatient units that require placement elsewhere
c) adults less than 65 years with early onset dementia
d) people with a learning disability and complex needs
e) physical disability requiring rehabilitation who do not currently meet the criteria for CHC. eg people with a Brain Injury requiring neuro rehabilitation or who have challenging behaviour or people with a complex mix of physical and mental health problems.
f) health funded components of s117 aftercare packages. This is aftercare for individuals who have been detained under certain sections of the Mental Health Act
g) health component of s17 leave for 1 month. This is leave from a hospital placement when an individual has been detained under the mental health act as part of a discharge process
h) Psychiatric Intensive Care Units (PICU)

2.7.3 End of Life

This is a range of services to provide palliative care, night time and day time nursing care, personal care and beds across the community. This includes bed based care such as that at St Lukes, care in hospital settings, care homes and services that take place in individuals homes, as well as that provided by other charitable service provision. Increasingly this is orientated towards provision of end of life care that would take place in a setting of an individual's choosing. Services need to develop to reflect this changing landscape.

3.0 NEEDS ASSESSMENT

3.1 Local demographics

For generic population information see Appendix 2 below. The following information gives an assessment of current need that has an impact on the complex care system.

3.2 Prevalence

3.2.1 Frailty[1]

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

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.

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. It is estimated that of the 65 and over population approximately 11% are frail whilst about 42% have one or two of these symptoms and

[1] Better Care Fund planning template, Plymouth City Council and NEW Devon CCG, September 2014

are thus 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".

Table 2: Older people frailty estimates, Plymouth. (Source: 2012 mid-year estimates of usual resident population - ONS)

Age-group (years)	Reported frailty rate (%)	Reported pre-frailty rate (%)	Population	Estimated frail population	Estimated 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	-

3.2.2 Dementia

Approximately 60 people aged 30-64 years in Plymouth are estimated to have early-onset dementia in 2014.[2]

Over 3,130 over-65s are predicted to have a dementia in 2014. The number of cases of dementia in the over-65s is projected to increase over time, reaching around 4,850 by 2030[3].

The following are also useful statistics that impact on complex care:

- 70% of people living in care homes are thought to have a dementia
- 25% of people in hospital beds are thought to have a dementia
- 72% of people with dementia have at least one other long-term condition[4]

Table 3: People aged 65 and over predicted to have dementia, by age and gender, projected to 2030 (Source: Projecting Older People's Population Information - POPPI)

Ages	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**

[2] http://www.poppi.org.uk/ Viewed October 31st 2014
[3] http://www.poppi.org.uk/ Viewed October 31st 2014

[4] Care Home Residents Health Needs Assessment, Public Health Devon, April 2014
http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/

Figure 1: Care Home Population Pyramid for Plymouth as at 31st December 2013 (Source: Care Home Needs Assessment, April 2014 Public Health Devon)

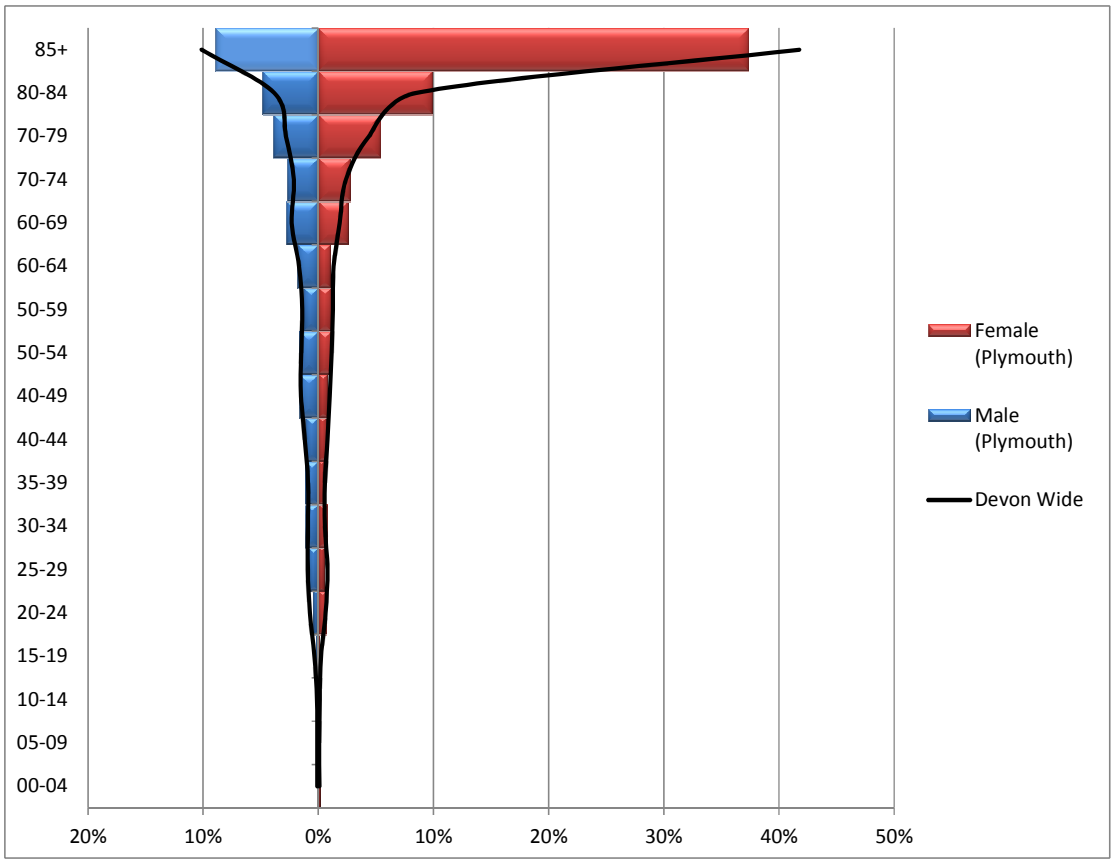
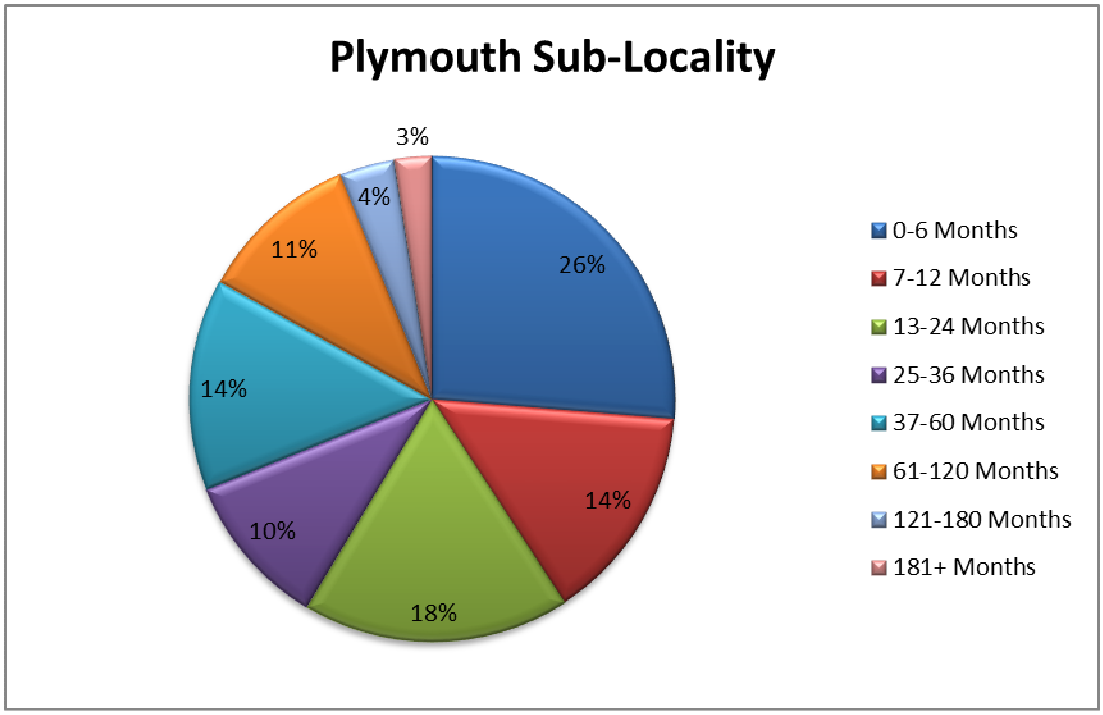


Figure 2: Care Home Length of Stay for Plymouth, February 2014 Source: Care Home Residents Health Needs Assessment, Care Quality Commission 2013



This demonstrates that 42% are in a care home for over 2 years, with 26% in a care home for less than 6 months. This is a very similar pattern to the rest of Devon.

Some of the people who will be in a care home for 0 – 6 months could be there because they are in respite or recovery as a 'step down' from hospital. Further work with providers will be needed to find out if they needed to be admitted to a care home at all or could have been discharged to their home.

3.2.3 Care Home to Hospital Admissions

The Care Quality Commission 'State of Care Report' (2013) looked at avoidable care home admissions and categorised them as bone fractures, dehydration, pneumonia and respiratory infections. In Devon (including Plymouth) there has been considerable interest in avoiding admissions from care homes due to the volume and cost of admissions. More older people are being admitted to hospital in an emergency with conditions that are generally avoidable**.** This is increasing faster than the growth in the older population. Among people living in care homes, hospital admissions for avoidable conditions were 30% higher for those who had dementia compared to those without dementia.

Avoidable admissions to hospital

Residents of care and nursing homes account for about 30% of all patients with hip fractures admitted to hospital. About one-fifth of people with a hip fracture die within one month and one-third within 12 months mostly due to associated conditions. Falls prevention is an essential intervention to improve the health and wellbeing of care homes residents. In Devon (including Plymouth) fractures and predominantly fractured neck of femur account for a large number of care homes admissions to hospital and the highest cost of any single cause. It is important to prevent falls but the principle of responding to the first fracture and preventing the second is also important[5].

Table 4: Number and Types of Admissions from Plymouth Care Homes (1stApril to 31 December 2013) (Data includes emergency and non-elective admission case types only) Source: Care Home Needs Assessment, April 2014, Public Health Devon

Fall	Pressure Sore	Diabetic Complication	Flu / Pneumonia	COPD	Constipation	Dehydration
423	162	49	183	266	130	248

Table 5: Types of Admissions per 100,000 Bed Days in Plymouth (Over the previous 24 months as at 31 December 2013) (Data includes emergency and non-elective admission case types only) Source: Care Home Needs Assessment, April 2014, Public Health Devon

No. Falls per 100,000 Care Home Bed days	No. Pressure Sores per 100,000 Care Home Bed days	No. Diabetic Complications per 100,000 Care Home Bed days	No. Flu / Pheumonia per 100,000 Care Home Bed days	No. COPD per 100,000 Care Home Bed days	No. Constipation per 100,000 Care Home Bed days	No. Dehydration per 100,000 Care Home Bed days
24.8	9.5	2.9	10.7	15.6	7.6	14.5

[5] Care Home Residents Health Needs Assessment, Public Health Devon, April 2014 http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/

Table 6: Cost of Admissions to Hospital from Plymouth Care Homes (Data includes day case elective, emergency, inpatient elective, inpatient non-elective and day attender admissions) Source: Care Home Needs Assessment, April 2014, Public Health Devon

Period	Total No. of Admissions	Total Cost (£s)	Total Admissions per 100,000 Care Home Bed Days
Last 12 months	1380	£3,420,261	168.41
12 – 24 months	1491	£3,312,868	
24 – 36 months	1594	£3,750,626	

Ambulatory Care Sensitive (ACS) conditions are a group of conditions including angina, Coronary Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), asthma and diabetes where admissions to hospital can be avoided through effective case management in primary and community care.

The Care Quality Commission 'State of Care Report' (2013) recommends three ways that providers and commissioners can respond to reduce rates of Ambulatory Care Sensitive admissions:

- Develop a local understanding of the rate and trend of admissions for each Ambulatory Care Sensitive condition in their area as markers of local performance. Where admission rates for a particular condition in their area appear atypical (that is, usually higher than expected) when compared with similar areas, undertake further local analysis to explore why this is the case.
- Where proven interventions or quality standards exist for a condition, ensure that these are in place across their own area.
- Consider the extent to which broader strategies for reducing the need for emergency admission are being successful. In particular, focus on changes in key patient groups, especially care for frail older patients. The need is not only to prevent hospital admission, but also to prevent the distress and deterioration of the patient that leads to hospital admission

3.2.4 Limiting Long Term Illness[6]

Between 2014 and 2030 it is expected that the number of people in Plymouth aged over 65 with a limiting long term illness will rise from 23,739 to 31,950. By 2030 16,538 people will be severely limited in their day to day activities. This may have an impact on the demand for complex care services including care homes and IPPs.

Table 7: Illnesses, conditions or disabilities which may impact on the complex care system in Plymouth (Source: Care Home Residents Health Needs Assessment, April 2014, Public Health Devon)

Illness/ Condition/disability (total population 65 and over)	2014	2015	2016	2017	2018	2020	2025	2030
Limiting long term illness severely limiting day-to-day activities	12,041	12,269	12,434	12,643	12,875	13,368	14,980	16,538
Longstanding health condition caused by a heart attack	2,222	2,256	2,290	2,321	2,362	2,416	2,672	2,931
Longstanding health condition caused by a stroke	1,045	1,064	1,079	1,097	1,119	1,149	1,284	1,407

[6] http://www.poppi.org.uk/ Viewed February 17th 2015

Longstanding health condition caused by bronchitis and emphysema	766	778	790	801	815	831	914	1,004
Number admitted to hospital as a result of falls	935	953	965	985	1,010	1,065	1,228	1,343
Those with severe / profound sensory impairment – visual and hearing	1,876	1,909	1,942	1,969	1,987	2,001	2,076	2,316
Mobility – unable to manage at least one activity on their own	8,235	8,392	8,567	8,735	8,947	9,305	10,429	11,749
Obesity (BMI of 30 or more)	11,925	12,079	12,240	12,376	12,536	12,695	13,693	14,854
Diabetes (Type 1 or Type 2)	5,656	5,733	5,820	5,918	6,025	6,125	6,690	7,342
Moderate / Severe Learning Disability	128	130	132	134	135	137	147	160

3.2.5 Learning disability and challenging behaviour in Plymouth[7]

The number of people aged between 18 and 64 with a severe learning disability or with a learning disability who are likely to display challenging behaviour is likely to remain stable up to 2030. So this will not in itself create pressure on care homes or IPPs.

Table 8: People aged 18-64 predicted to have a severe learning disability, and hence likely to be in receipt of services, by age, projected to 2030

People aged 18-64 predicted to have a severe learning disability	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have a severe learning disability	73	74	71	70	78
People aged 25-34 predicted to have a severe learning disability	52	52	53	53	51
People aged 35-44 predicted to have a severe learning disability	50	49	49	51	52
People aged 45-54 predicted to have a severe learning disability	40	40	37	33	33
People aged 55-64 predicted to have a severe learning disability	33	33	36	37	36
Total population aged 18-64 predicted to have a severe learning disability	**249**	**249**	**246**	**245**	**250**

[7] http://www.pansi.org.uk/ Viewed February 17th 2015

Table 9: People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030

People aged 18-64 with a learning disability predicted to display challenging behaviour	2014	2015	2020	2025	2030
People aged 18-24 with a learning disability, predicted to display challenging behaviour	16	16	15	15	17
People aged 25-34 with a learning disability, predicted to display challenging behaviour	16	16	16	16	15
People aged 35-44 with a learning disability, predicted to display challenging behaviour	14	13	13	14	14
People aged 45-54 with a learning disability, predicted to display challenging behaviour	15	15	14	12	12
People aged 55-64 with a learning disability, predicted to display challenging behaviour	13	13	14	15	13
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	**74**	**74**	**73**	**72**	**72**

3.4 Predicting future demand

3.4.1 Care Homes

Demand for care home placements derives from 3 main sources: Plymouth City Council commissioned activity, NHS Continuing Health Care activity and people who pay privately (self-funders). There are a small number of other factors that influence demand for care home beds, such as other local authorities and charitable funding.

Projecting Older Peoples Population Information (POPPI) projects an increase in demand in over 65s care home places in Plymouth. The total population aged 65 and over living in care homes with or without nursing is predicted to rise from 1,524 in 2014 to 2,408 in 2030. This increase in provision will need to be met through an increase in bed capacity unless alternative models of care are developed.

An ageing profile of older people will mean increased prevalence of dementia and other long-term conditions with individuals often having multiple long-term conditions. Indeed the complexity of need of people living in care homes appears to be increasing

The number of physically frail elderly in nursing and residential care has fallen since 2005 whereas there has been an increase in NHS funded placements in care homes with nursing. There has also been a significant increase in the proportion of older people with mental health difficulties in care homes. These trends are expected to continue and reflect the desire and ability of physically frail older people to remain independent at home for longer, as well as the growth in the number of older people with dementia

Projecting Adult Needs and Service Information (PANSI) predicts that the number of people with a severe learning disability and those with LD who also have challenging behaviour is predicted to remain stable over the next 15 years. The number of care home places for people under 65 is predicted to fall as people with learning disabilities are better supported to remain in the community.

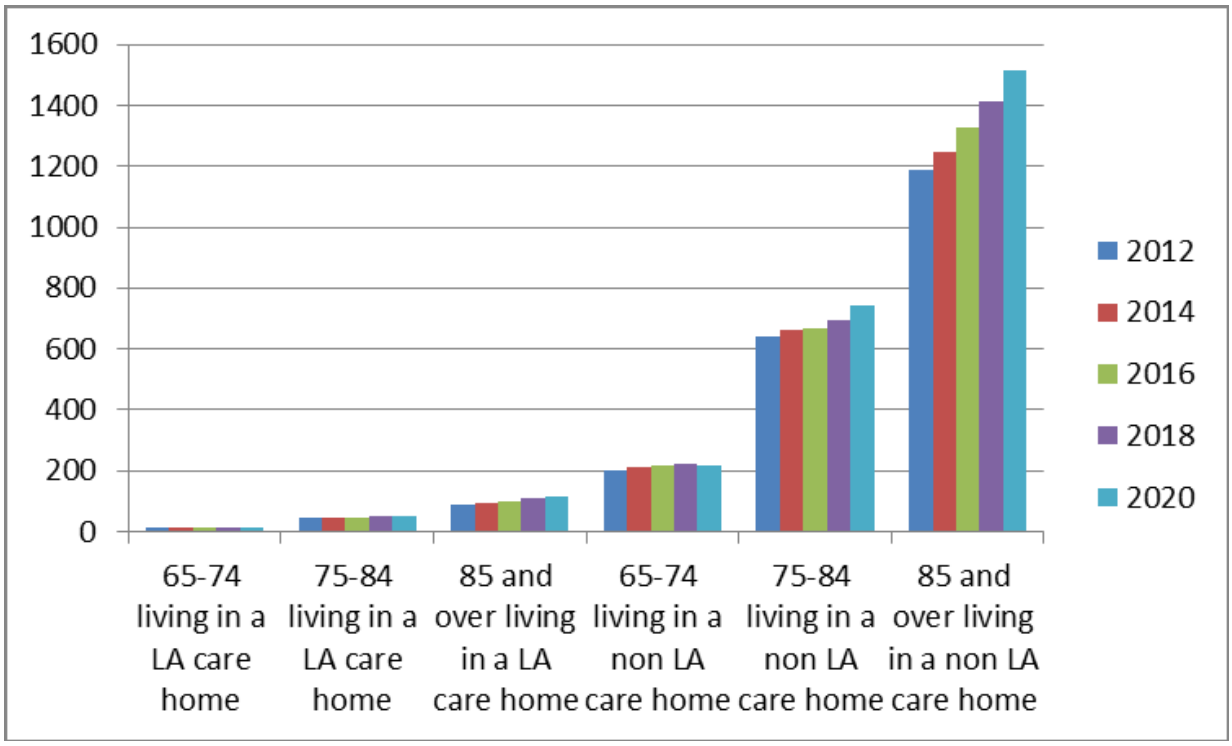
3.4.1.1 Ageing population and increasing complexity of need impact on residential and nursing care

Plymouth is expecting to see a rise in the number of older people in the City over the next 20 years. This, together with the predicted rise in those living with dementia and the projected increase in other illnesses leading to a longstanding health condition is likely to have an impact on the residential care services required in Plymouth. This can be addressed by commissioning priorities within the Community Strategy which aim to reduce length of stay, develop extra care, delay need for care and support whilst also ensuring a sufficient capacity in terms of care home placements where required.

Table 10: People aged 65 and over living in a care home with or without nursing, by age, projected to 2030 (POPPI)

	2014	2015	2016	2017	2018	2020	2025	2030
People aged 65 - 74	202	206	209	212	212	211	211	233
People aged 75 – 84	445	450	450	457	469	498	594	615
People aged 85 and over	877	907	937	966	996	1,071	1,278	1,560
Total population 65 and over living in a care home with or without nursing	**1,524**	**1,563**	**1,596**	**1,635**	**1,677**	**1,780**	**2,083**	**2,408**

Figure 3: Projected Increase in Residents in Plymouth Living in Care Homes With or Without Nursing (POPPI 2013)



3.4.1.2 Care Act 2014 impact on residential and nursing care

The Care Act will result in increased pressure on public funding and will potentially have an impact on the care home market.

The implementation of the Care Act could significantly extend the number of individuals receiving Local Authority contribution toward their residential care costs - in effect, a new class of 'self-funder top-ups'. Given individuals who become entitled to a Local Authority contribution to their residential care costs cannot be expected to move, these self-funder top-ups are therefore likely to be subject to existing rules on top-ups, which seek to protect local authorities, providers and families.

3.4.2. Individual Patient Placements

More information is needed about possible increasing numbers of young people with autism/mental health and very challenging behaviour. A rising number of older people with dementia are likely to mean that s117 packages for people with dementia and complex needs are likely to rise. The number of people with severe learning disability with challenging behaviour is predicted to remain stable. However, planned commissioner response to this should mean that demand for out of area placements are not in the main expected to rise.

3.4.3. End of Life

Medical advances allow us to keep people alive for longer and there will be a continuing increase in the number of people who are living with increasingly complex conditions. Whilst the number of people dying at home is gradually increasing, the public expectation to die at home will mean increasing resources in terms of the cost of nursing complex conditions. Indications are that when people are asked about "Preferred Place of Care" at the end of their lives, the majority of people would chose home. If their usual place of care is a care home, this should be supported although it has implications in terms of service provision to safely support complex packages of care

End of Life providers are able to fund a majority of the care they provide through their own fundraising and are thus able to influence how the market provides this care. However, statutory services provide a significant amount of input to the care provided in the community

3.5 Consultation feedback

NHS England through national consultation has developed the following 'I' statements in relation to the outcomes for patients from Continuing Health Care and Dementia Care:

The CHC 'I' statements are:

- I receive care and support that helps me live the best life I can and promotes my independence
- My care workers know me, understand me and do everything they can to help me
- My care workers have the right knowledge and skills to meet my needs
- I am supported to have choice and control wherever possible over my care and support
- The care and support I need is designed around my needs
- I know who to contact about my care arrangements

The Dementia Strategy 'I' Statements are:

- I have personal choice and control or influence over the decisions about me
- I know that services are designed around me and my needs
- I have support that helps me live my life
- I have the knowledge and know-how to get what I need
- I live in an enabling and supportive environment where I feel valued and understood
- I have a sense of belonging and of being a valued part of family, community and civic life
- I know there is research going on which delivers a better life for me now and hope for the future

The Devon, Plymouth and Torbay Care Home Quality Collaborative has developed the following 'I' statements in relation to what good medical care in care homes looks like:

- I will be able to register with a GP of my choice, and stay with my existing GP if this is possible
- I will be able to see or speak to my GP when I have a medical need; my needs and feelings will be the most important part of decisions about my medical care and treatment, whether I am able to discuss this or not. I may also want my family or other significant person to be included in these decisions
- I will be cared for by a team of people who are equally valued and able to meet my needs, and who treat me with dignity and respect
- I will have the same access to specialist care when I need it, provided in the most appropriate setting to my needs
- I (care home staff) will feel valued and respected as part of the team looking after our residents

3.6 Summary of Needs, Performance and Future Demand

- A significant proportion of the adult social care and primary and secondary health care budgets are associated with the elderly frail population
- Early identification of frailty and appropriate interventions can reduce adverse outcomes and save money
- Residents of care homes account for a significant proportion of avoidable admissions to hospital, falls being a major cause, and admission to hospital is more likely for people with dementia
- Lifestyle related diseases and multi-morbidities in future years are predicted to increase resulting in a larger number of residents who could be more dependent.
- An ageing profile of older people will mean increased prevalence of dementia and other long-term conditions; with individuals often having multiple long-term conditions. The complexity of need of people living in care homes is increasing. This will mean care home provision will need to be better at supporting people with complex needs particularly dementia and mental ill-health
- The changing demographics described above will result in increasing demand for care home placements and nursing care
- There is not likely to be an increase over time in the number of people with a severe learning disability or challenging behaviour so this is not an area that will put pressure on the need for more care home beds or IPPs
- Individual patient placements are often out of area and expensive
- There is pressure from national policy and the public to ensure that people can die in their preferred place of care
- The 'I' statements will be used to benchmark future performance

4.0 STRATEGIC CONTEXT

4.1 National

4.1.1 Winterbourne View and Frances Reports[8]

A number of serious cases have been identified nationally including reports of abuse and neglect exposed in the Winterbourne View review. The Frances report published on 24th February 2010 reviewed the failings of the Mid Staffordshire NHS Foundation Trust between the periods of 2005–09. The Francis report highlights 'a systematic failure of the provisions of good care'. To support all organisations to learn from and respond to the recommendations of the report, three further reports have been published to help embed effective governance and detect and prevent such serious failures occurring again. The themes of these are identifying early warning signs, assuring quality and providing governance to present such failings occurring.

4.1.2 NHS ENGLAND standards for Continuing Health Care

The right people are being identified and being assessed for NHS CHC using the national tools, and that the assessments accurately reflect individuals' care needs

The quality of the 'patient experience' fits with the aspirations in the 'I statements' (as described in paragraph 3.5 above)

The NHS CHC assessment process is adequately resourced to ensure that statutory responsibilities are met in a timely way

All levels of staff who are involved in the NHS CHC assessment process are appropriately trained – with an emphasis on partnership working across organisations and also workforce planning

Systems are in place to support and empower staff in working confidently with individuals, their families and their representatives, and also in raising any concerns around the level and quality of care provided

Accurate written and verbal information is given to individuals throughout the NHS CHC process, and the views of the individuals (and/or their representatives) are recorded and considered

4.1.3 National End of Life Strategy (Department of Health)

The key measure of progress against the End of Life Care Strategy is the preferred place of care this is usually the 'home' setting. If this figure continues to rise it suggests that more people are able to receive care and to die in the place of their choice. "At home" has always been a proxy for choice in end of life care. For many people in care homes, that itself becomes their home and they would no more wish to leave there at the end of their life than they would their own home.

The end of life care pathway continues to provide the framework for a wide range of activity from identifying the right people who need end of life care through to supporting bereaved families and carers. It is essential that service redesign continues – in particular, to make sure that the right services are in place to support people at home and in care homes. The End of Life Care Strategy emphasizes the importance of providing care where people would prefer to be. Very often this means providing care away from the acute hospital setting. However, there will always be people who choose to die in hospital, and others for whom hospital is the only realistic option so it is important that care there improves too.

While the end of life care pathway itself is generic, different types of condition need more tailored approaches. Cancers, for example, while themselves a heterogeneous group, are a different proposition from dementia. It will not be possible or necessary to devise specific pathways for every single disease but it will be helpful to have a range applicable to the broad groupings

[8] (Transforming care: A national response to Winterbourne View Hospital *Department of Health Review: Final Report 2012)* and http://www.midstaffspublicinquiry.com/

4.1.4 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

4.2.1 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.

4.2.2 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.

4.2.3 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.

4.2.4 Joint Dementia Strategy (2014 – 16) (Plymouth City Council and NEW Devon CCG)

The Strategy sets out our commitment to improving outcomes for people with dementia and their carers, recognising the imperative of working together to achieve this. Dementia is a condition that needs to be understood not only by health and social care organisations but by the whole of society as well, making dementia 'everybody's business'.

The strategy gives the following commitments by the CCG and Plymouth City Council:

- To continue to promote the benefits of healthy lifestyles and health checks
- To recognise that the stigma still felt by some people with dementia discourages them from seeking the help and support they need and exacerbates feelings of loneliness and isolation.
- To ensure that people experience care and support that is personalised and coordinated, delivered in the right place at the right time and to continue to work in partnership to achieve this.
- To measure and report progress on delivering better outcomes and to oversee our planning and activity through a clear governance structure.
- To respond to the new duties for Local Authorities laid out in The Care Act, recognising its importance in reforming care and support and prioritising wellbeing.

Key specific aims in the strategy that relate to complex care include supporting continuous quality improvements in hospital and care home settings and ensuring carers are supported and involved in decision making. The levers for achieving this are the Dementia Quality Mark for care homes, the Hospital CQUIN targets that relate to dementia and carers and the Joint Carers Strategy.

4.2.5 NEW Devon CCG 5-Year Strategic Plan Summary 2014-2019 and 5 pillars

This plan provides the basis for moving forward with a whole-system strategy for health and social care, setting out how we will work together as a system to tackle the challenges we face and move forward to deliver changes in the way we meet the needs of people who use our services. The vision has 5 key aims to improve a patient's experience of local health services.

1. Partnerships to deliver improved health outcomes
    - Informed users of healthcare through improved lifestyle advice, support and preventative services, to be healthy and reduce the need for treatment
    - Services designed & delivered in a targeted way to reduce health outcome inequalities
    - Organisations and businesses across local communities supporting schemes to improve health and wellbeing with greater local co-ordination
2. Personalisation and integration
    - Greater access to personal health and social care budgets supporting and empowering those in most need
    - Personalise community health and social care services
    - More services for individuals will be coordinated by a single agency
    - Improved services will see people stay safe, well and at home for longer
    -

3. At scale general practice registered populations as the organising units of care
    - Improved access to wider primary care teams for longer hours over 7 days with a range of different locations to visit for urgent care
    - Registered GP lists ensure regular contact with the same professional for long-term care
    - Enhanced range of services delivered around a GP practice with more care organised by the wider practice team; more flexible access for minor conditions

4. A regulated system of elective care that delivers efficient and effective care for patients
    - More one-stop treatment will be the norm for elective services personalised for patients, some provided in bigger centres, but with less visits
    - More support to self-manage conditions and reduce the need for surgery or specialist care in the first instance
    - More care provided in the GP practice with support to find the right place when specialist input is required

5. A safe and efficient urgent care system
    - Supported to self-manage and stay safe, well and at home for longer
    - A single organisation to organise all care needs and respond to personal requests
    - A single number making it easy to seek advice, navigate urgent and emergency care and access the right local services the same day
    - Most specialist care available in the CCG with some further afield.

4.2.6 Integrated, personal and sustainable community services for the 21st century: A Strategic Vision for Transforming Community Services, NEW Devon CCG, Aug 2014

Five year local outcome ambitions relating to Complex Care include:

- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the proportion of older people living independently at home following discharge from hospital

4.2.7 Transforming Community Services: Western Locality Commissions Intentions, proposal document, Sept 2014

This document has been published as a consultation document by the CCG. The general proposition is that there must be a greater focus on health promotion and ill health prevention, where resources are moved from traditional acute services to modern, efficient community services.

The vision of the Clinical Commissioning Group is 'Healthy People, Living Healthy Lives in Healthy Communities'. This is reflected in the six strategic priorities for delivery of Community Services.

The following strategic priorities impact on Complex Care:

- Co-ordinate pathways

  We are reviewing pathways of care for individuals from prevention of illness, planned care, urgent care, response to crises and rehabilitation to ensure they are effective, bringing about good outcomes for individuals and populations and they represent good value for money.

- Think carer, think family

  Many people rely on carers to help them with day to day living; many people are carers who have their own needs to support their own health and wellbeing. We will actively consider carers and families when designing services such that they are offered in a way that is

conducive to people having excellent experience of their care and their care bringing about good health and wellbeing outcomes

- Home as the first choice

  We are exploring ways of offering care in or as close to individuals' homes as possible, ensuring quality, safety and cost effectiveness. There will always be a need for in-patient beds in the community. Effective and strategic use of beds will particularly help to avoid admission when care could safely and effectively be delivered elsewhere. Greater use of modern technologies, advance planning and ensuring that services are provided with individuals taking informed choices is key.

One aim of Transforming Community Services is to review pathways for people with complex needs.

It is estimated that 20 – 30% of emergency admissions to hospital could have been avoided if appropriate alternative forms of care had been available or if care had been managed better in the period leading up to admission. It is proposed to commission joined up care that follows patient flows within a natural geography – that is the path patients take through local services – in order to maximise shifts in care from acute to community settings and design the system for out of hospital care. The influence of this pathway approach is that specialist elderly care physicians and primary care expertise would be at the heart of the community services

The commissioning intentions for people with complex needs are to create pathways which will:

- support natural patient flows and geography (e.g. primary to community to acute)
- support improving patient pathways to enable more care at home or closer to home
- support the achievement of ambition through collaboration and transformation as the norm between commissioner and provider

Service providers will provide a health and social care system that:

a) Chooses to admit only those frail older people who have evidence of underlying life-threatening illness or need for surgery

b) Provides early access to an old age acute care specialist, ideally within the first 24 hours, to set up the right management plan

c) Discharges to assess as soon as the acute episode is complete, in order to plan post-acute care in the person's own home

d) Provides comprehensive assessment and reablement following acute care, to determine and reduce long term care needs.

These principles can also be applied to other people such as those with respiratory conditions.

Wherever possible the 'home as the centre' of care, built firmly around the GP as a care co-ordinator, enabling individuals to take greater responsibility for their health and wellbeing, with the support of carers and families.

4.2.8 Commissioning Framework - The Top 6 Commissioner Priorities 2014 – 16 (NEW Devon CCG)

The following priorities apply to Complex Care:

-The general thrust of commissioning for non-elective care is to move from a bed based model of reactive care to a model of care that is closer to home and places prevention and well-being at its heart. It is the intention to use funding released from bed based care to increase the capacity of community teams and the total volume of care that is available for people living in Plymouth and ensure that all people living with a dementia and/or cognitive impairment are identified.

- Individual Patient Placements. As part of their experience of learning disability, mental health and social care support and treatment services, considerable numbers of people, both adults and children, are placed in facilities in the public, independent and third sectors for support. In many but not all cases, services are local to families, friends and services. For some, services may be at a considerable distance from their usual support networks. The Winterbourne View action plan contained clear expectations regarding the reduction in out of area placement for people with a learning disability. This plan focused on overcoming the negative consequences of out of area placement and the learning from individuals' experiences of Winterbourne View can be applied to all patient groups

- The focus will be on the prevention of out of area placements through the provision of alternatives to hospital admission and the redesign of pathways for individuals requiring step down from higher levels of secure care. Consideration will be given to utilising a risk stratification tool to identify those individuals most at risk of repeated admissions or an out of area placement and target resources to support these individuals appropriately.

4.2.9 Care Home Quality Collaborative Vision (2014)

- People living in care homes will have the same opportunities to live a good quality, healthy life as part of their community
- People will feel at home and have a voice
- People will be able to have fun and enjoy life
- People will have a care and support plan that describes their needs and those needs are met by someone who understands them and is able to meet them
- People working in care homes will feel valued as part of the whole health and social care system

4.2.10 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, 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.

4.3 Key legislation

4.3.1 Health and Social Care Act 2012

The Health and Social Care Act 2012 provides the basis for better collaboration, partnership working and integration across local government and the National Health Service (NHS) at all levels. The act also identifies 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, with an emphasis that care is integrated around the needs of the person.

4.3.2. Care Act 2014

The proposals for integration are supported by the provisions of The Care Act 2014, which has been designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. It also places a new duty on Local Authorities to promote integrated care, mirroring the duties in the *Health and Social Care Act 2012*.

4.3.3 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

4.4.1 Summary

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
- The Devon, Plymouth and Torbay Care Homes Health needs assessment www.devonhealthandwellbieing.gov.uk

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

4.4.2 Dementia Care[9]:

There is good evidence that providing pro-active case management within primary care to people with dementia improves their mental health which should prolong their ability to remain living at home.

- Cognitive Stimulation Therapy was found to benefit people with mild to moderate dementia in relation to cognitive function, quality of life and well-being.
- Information provision was found to improve quality of life.
- Improved environments within care homes was found to improve patient engagement and reduce violence, aggressive behaviour, falls and staff morale;
- Reminiscence therapy was found to improve mood between 4 – 6 weeks;
- Exercise was found to improve cognitive functioning;

4.4.3 Care Homes[10]

There is limited evidence to support the assumption that the care of people with dementia in special care units is superior to care in traditional nursing units and quality standards for dementia should be met regardless of setting – NICE 2013

There is some evidence that exercise is important to preventing falls and to delaying the onset of dementia. Social interaction and activity is important to quality of life.

One of the major problems identified was that older people in care homes do not have access to enough activities or ways to occupy their time. It has also been reported that many care home residents have problems accessing NHS primary and secondary healthcare services. A lack of activity and limited access to essential healthcare services can have a detrimental impact on a person's mental wellbeing.

'Transforming our Health and Care System' (Kings Fund 2013) includes ten high impact changes for commissioners including care co-ordination through integrated health and social care teams.

'Co-ordinated Care for People with Complex Needs' (Kings Fund 2013) highlights that programmes should be localised so that they address the priorities of specific communities. Models of care co-ordination are likely to be more effective when operating as 'fully-integrated' provider teams with some operational autonomy. The paper raises some principles that are applicable to integrated care for care home residents.

A systematic review (Davies 2011) on integration between health services and care homes yielded inconclusive results and despite evidence about what inhibits and facilitates integrated working there was limited evidence about what the outcomes of different approaches to integrated care between health service and care homes might be. The review identified a need for more research to understand how integrated working is achieved and to test the effect of different approaches on cost, staff satisfaction and resident outcomes.

No conclusive research exists to suggest that any nursing model or skill-mix model would be effective at improving patient or staff wellbeing in a residential aged-care facility.

Evans undertook an evaluation that adopted a mixed methods approach, combining quantitative performance data with semi-structured stakeholder interviews and emergency bed use costings. The

[9] Llewellyn, D. Dr; Lang, I. Dr.Current evidence on dementia prevention, treatment, and care, *University of Exeter Medical School and Devon County Council. 2014*

[10] Care Home Residents Health Needs Assessment, Public Health Devon, April 2014 http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/

evaluation suggested that the project made significant steps towards integrating care homes with the health and social care community and demonstrated cost savings through reduced hospital bed use. Health and social care interventions aimed at upskilling care home staff can increase standards of care and quality of life for residents; they are also likely to highlight unmet needs. The project demonstrated the need for better integration of health and social care services with care homes in order to improve quality of life for residents. (Evans 2013)

The Better Care Fund has been developed to support integration of local health and care services. The integration work needs to demonstrate a reduced demand through a reduction of permanent admissions to care homes and reduce potentially avoidable hospital admissions both rely on integrated effective local services

4.4.4 Reducing Harm and Hospital Admissions from Care Homes

Brownhill (2013)[11] undertook an observational study looking at training in care homes to reduce avoidable harm. This study investigated the effectiveness of using workshop-based education and service-improvement models in care homes. The models were designed around both threshold and predictive modelling and were intended to raise awareness of the symptoms that may result from a fall, pressure ulcers or urinary tract infections. The project exceeded targets. Preventive assessments, care planning and timely referrals resulted in a reduction in avoidable hospital admissions and district nurse and GP visits.

Each home was set the following reduction targets:

- Falls-40%
- Recurrent falls - 60%
- Care home-acquired grade 2 pressure ulcers - 75%
- Care home-acquired grade 3 and 4 pressure ulcers - 95%
- Urinary and catheter-acquired infections - 40%
- Hospital admissions - 60%
- District Nurse visits - 40%
- GP visits - 40%

Once the targets had been reached, the study aimed to sustain the levels through continuing to work with the care homes. Through a robust training package and tailored support, the study reported a reduction the number of avoidable hospital admissions from participating care homes by 51%. By raising awareness of symptoms and encouraging early risk assessment and care planning, the study reported that the level of care delivered to vulnerable patients was raised. It reported a significant link between falls and urinary tract infections. Early assessment by care staff, including recognition of symptoms and urine dip test results, reduced the number of recurrent falls in care homes.

5.0 CURRENT PROVISION

5.1 The Care Home system

There are three routes into a care home;

- Following an Adult Social Care assessment
- Following a health assessment (Continuing Healthcare or Funded Nursing Care)
- People choosing to move into a home who are not eligible for public funding and who pay for themselves (referred to as 'self-funders)

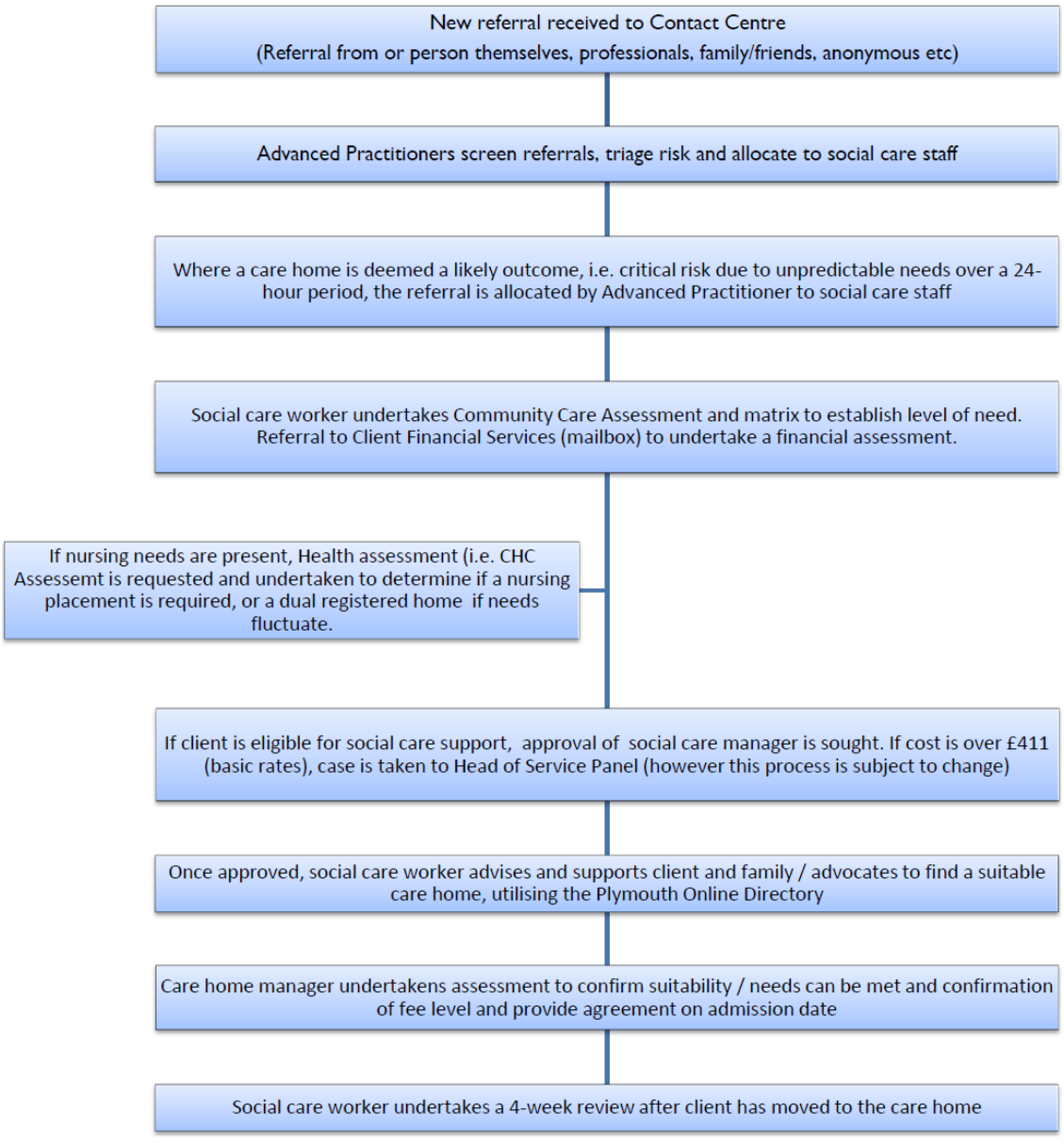
[11] As quoted in Care Home Needs Assessment Final, April 2014, Public Health Devon

Often a move into a care home is suggested because of an illness or a fall - but it is not always the only reason. It is also possible to have a short stay in a care home for a trial period or get respite care to give the service user or carers a break. When choosing a home, it is important to make sure that the one chosen is the right one. To help with this, a person should get advice and information from their social worker or care manager, a district nurse, a health visitor or their family doctor.

Care homes have to make it very clear what level of care they provide and how they will meet each resident's needs. If a resident is unable to leave the bed, or has a medical condition or illness that requires frequent medical attention, they may possibly need to look for a care home that provides nursing care. This type of home should have a qualified nurse on duty 24 hours a day.

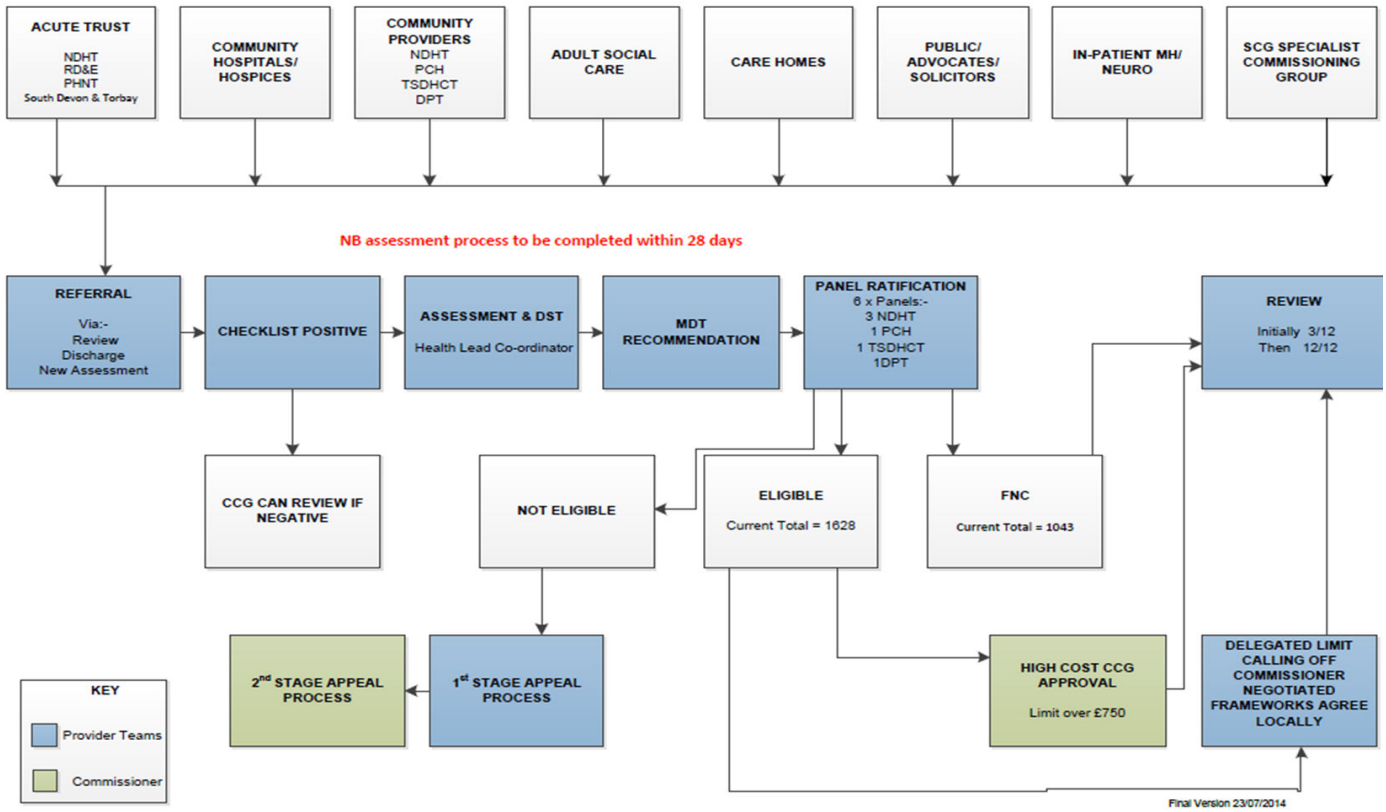
5.1.1 The process for assessing people for Adult Social Care funding

If a person is thinking of moving to a care home or has been paying for their own care in a care home and want to see if the local authority can help with the fees, they must first have their needs assessed by the Council to see if they are eligible for adult social care support. After the social care needs have been assessed, and if the person is eligible for social care support, the local authority will conduct a financial assessment. This will decide whether or not the person has sufficient money to pay towards some or all of the cost of the support they need. If a person has capital or savings worth over £23,250 they will have to pay the full cost of care.



5.1.2 Continuing Health Care and Funded Nursing Care process

The diagram below describes the complexity of ensuring the statutory obligations for assessing and awarding eligibility for CHC funding across the NEW Devon CCG footprint. An assurance programme is underway to ensure all responsibilities are discharged lawfully, ensuring people are assessed against the National Framework.



Currently there is no central point for referral and collation of the activity so whilst we know who we have assessed and who is eligible and when the review is due, we don't know how many people have not yet been assessed who should be. Risks associated with non-assessment at appropriate time equate to those surrounding inappropriate care packages, missed opportunity for recovery or improvement, safeguarding issues not being picked up, poor outcomes therefore poor value for money.

As can be evidenced from the above two diagrams, both the social care and health processes for accessing funding are complex, with clear opportunities for future join up.

5.1.3 Quality in Care Homes

There is an established Quality Assurance & Improvement Team (QAIT) within the PCC's Co-operative Commissioning Team. It was developed to have a structured and proactive approach to monitoring and supporting the improvement of the quality of care in the care home sector. The team includes care home practitioners who undertake quality reviews based on a risk assessment framework. The quality reviews take place in the care home, in collaboration with the registered manager, over a period of 2 days. The care home practitioners review documentation within the home, including various audits, staff files and care plans. The review also involves speaking to various staff members and, where possible, residents, to gain their feedback on the running of the home. Since the team was established in July 2012, a total of 95 full Quality Reviews have been undertaken, which represents 89% of the Plymouth care homes.

The Quality Assurance & Improvement Team has developed a quality assurance framework, and are encouraging care homes to develop their own framework to support continuous service improvement.

QAIT Quality Framework

Plymouth established a Dignity in Care Forum in February 2009 which is now led and facilitated by the Quality Assurance & Improvement Team. The purpose of the forum is to look at operational issues around training, help and advice with improving quality of commissioned services. It also aims to improve dignity standards in care home settings and raise awareness of current local and national initiatives in the sector. The Forum is focused around the 8 key themes of the My Home Life programme. Every third forum is dedicated the topic of 'Celebrating Excellence' and sharing best practice. The forum will also deliver best practice sessions on themes identified through local CQC compliance, hospital admissions and safeguarding. The Forum supports a multi-agency approach and is attended by colleagues in Plymouth Hospitals NHS Trust, the Medicines Optimisation Team, NEW Devon CCG and the voluntary sector.

Plymouth City Council's Older Person's Charter: Adult Social Care have been working with partners and groups of older people in the City to develop a charter made up of a series of 11 pledges which outline the standards and approaches to service delivery that older people should enjoy. The Quality Assurance & Improvement Team will encourage care providers to sign up and embed the pledges from the Charter, through the Dignity Forum and the quality assurance framework.

The Dementia Quality Mark model was created in 2010 by David Francis and was established in Plymouth in 2011. The Dementia Quality Mark was established to:

- Establish a local accreditation system
- Improve person-centred care
- Improve the quality of commissioned services
- Reduce admissions into acute settings
- Reduce substantiated safeguarding alerts
- Improve discharge pathways into good quality services

36 care homes have been awarded the Dementia Quality Mark and further applications are in progress.

Plymouth has established a Leadership Programme for registered care home managers.

"The Government's White Paper, *Caring for our Future: Reforming Care & Support*, emphasises the importance of leadership at all levels from strategic leaders to practice leaders. And leadership is important for the future of social care: the sector needs to develop a pipeline of new talent, comfortable with working across traditional boundaries and capable of inspiring the workforce of the future." (*Norman Lamb MP, Minister of State for Care and Support*).

The Leadership Programme is intended to:

- Embed the principles of the Leadership Qualities Framework
- Provide individuals and organisations with a benchmark against which to measure their current leadership capabilities
- By quality and innovative training, it will improve the public and professional awareness and understanding of leadership
- It will maintain and support the quality framework for care homes
- Good leadership is crucial towards delivering excellent social care and will make a significant difference to the lives of people who use the service

The Quality Assurance & Improvement Team also offer support and advice to providers and professionals across the City and endeavour to build relationships with key stakeholders, such as Healthwatch Plymouth, Public Health and health professionals.

The Care Home Quality Collaborative is a collaboration of people from across the health, social, independent and voluntary sector from Devon, Plymouth and Torbay. This is a strategic group managing a programme of work that supports the work undertaken in local fora. For example:

- Implementing a reporting and learning system for serious incidents requiring investigation in care homes with nursing
- Working with the independent sector to provide an analysis of emergency admissions and work together to reduce inappropriate admissions
- Defining what good looks like across a number of key strategic priorities: medical and community care, medicines management, falls prevention, mental health and wellbeing
- Reducing the prevalence of key harms (pressure ulcers, catheter acquired infection, fall) through whole system working

5.1.4 Supply of Care Homes (Source: Plymouth City Council and CCG data)

There are currently 65 care homes in Plymouth providing care for people over 65. There are 99 care homes in total including those for the under 65s.

At December 2014 the total numbers of residents in care homes break down is:

- 800+ over 65 years are funded by Plymouth City Council
- 250+ adults under 65 are funded by Plymouth City Council
- 582 are funded by Health which breaks down as (a snapshot taken at the end November 2014) :

  402 – Continuing Health Care

  180 – Funded Nursing Care

This does not include placements by the Care Co-ordination teams or Reablement

- 103 self-funders – i.e. full cost payers where Plymouth City Council contract for their care and they are charged the full amount. Many of these will have a deferred payment arrangement based on the capital value of their own home which will be sold when the person dies or no longer requires long term social care either because they become eligible for funding by Continuing Health Care or they go into hospital at end of life.
- 577 private residents – i.e. those who admit themselves and fund all of their care

At a snapshot taken in July 2014 there were 101 vacant beds across the care home sector in Plymouth (not including Learning Disability). At the end of January 2015 there were 67 vacancies in nursing & residential (not including LD). This is lower due to the development of 39 step down beds in response to pressure on the urgent care system.

There are 99 care homes in Plymouth, which are provided by private sector providers and 1 care home which is a Local Authority service.

Approximately 85% of these met all CQC standards when inspected, 14% did not meet all standards with minor improvements required, and 1% has enforcement action due to major non-compliance.

Only 2 homes in Plymouth have had CQC reports published in the new inspection process which started in October 2014 and both have been classified as 'Good'. Whilst several homes have been inspected, the outcome has to go through a panel system for adjudication and the report can take 2 – 3 months to be published.

The fees currently paid by Plymouth City Council are as follows:

Nursing – older frail £437

Nursing – dementia £463 not including FNC

Residential – older frail £411 or £431

Residential – dementia £431 or £453 if a Dementia Quality Mark home

At the time of writing the CCG rates had not yet been agreed.

We currently place in 90 care homes which are out of the Local Authority area, accounting for approximately 138 placements.

5.1.5 Care Home Performance

Table 11

Performance Indicator	National	Local
PHOF 2.24i Injuries due to falls	2011	2032
Local Proxy - Avoidable hospital admissions (2013/14)	1898.3	2187
Social care related quality of life	19.0	19.3
Satisfaction rates amongst social care clients	64.9%	67.8%

5.2 The Adult Individual Patient Placements system

Individual Patient Placements generally refer to locked rehabilitation and locked and open specialist mental health placements that fall outside of the service specification for forensic secure services (low, medium and high secure) for adults 18 years plus with mental health difficulties as follows:

- Planned mental health hospital placements and planned independent sector supported placements required due to the assessed **primary** mental health needs of the individual, including individuals with other diagnoses and conditions such as Huntington's disease, Acquired Brain Injury, Physical Disability, Learning Disability where the assessed primary need is mental health.
- The client's needs cannot be met through contracted services.
- Specialist Mental Health Assessments
- Health funded contribution for adult mental health placements on Section 17 leave. This would normally be for a maximum of 1 month.
- Full or part (jointly) funded adult mental health placements in accordance with agreed local section 117/17 aftercare policy
- Mother and Baby specialist individual support packages as an alternative to hospital care.
- People aged up to 65 years old with the diagnosis of early onset dementia.
- Psychiatric Intensive Care Units
- Clients accessing locked placements will usually be subject to detention under the mental health act. In exceptional circumstances, clients who have an informal mental health act status may require a diagnostic assessment for complex needs but treatment needs of informal clients should be met locally.

It also includes physical disability requiring neuro rehabilitation with specific therapy outcomes. eg people with a Brain Injury requiring neuro rehabilitation or who have challenging behaviour or people with a complex mix of physical and mental health problems. S117 aftercare describes the duty of Local Authorities and CCG's to arrange or provide after care for individuals who have been previously detained under Section 3 of the Mental Health Act. Individuals often have a combination of both health and social care needs.

5.2.1 Commissioning of Individual Patient Placements

This is commissioned mainly by the Clinical Commissioning Group. The following functions are required in order to commission safe and high quality care through individual placements:

- **Quality Assurance:** Winterbourne View brought the importance of quality assurance of out of area providers into stark relief**.** Quality Assurance nurses reside within the Individuals Commissioning team
- **Care Coordination** including monitoring of care against treatments outcomes, review and discharge planning. This is currently provided through the Plymouth Community Healthcare

mental health and Learning Disability teams. There is no clear arrangement for people with physical difficulties or a complex mix of physical and mental health problems. There are also a number of clients who are in secure accommodation commissioned by NHS England. There remains some disclarity about roles and responsibilities with NHSE Care Managers and care coordinator roles for clients in secure settings outside the IPP budget.

- **Process Control**. There is no current IPP panel (for the consideration of applications for out of area placements and care reviews), established in Plymouth although there has been a panel in the past. Control processes could be improved with the greater inclusion of both clinical staff and commissioners in decision making processes and it is the intention to develop this.

5.2.2 Supply of Individual Patient Placements

This provision is provided by a wide number of providers on a spot purchase basis. Most of the providers of hospital placements are currently provided out of area.

There is very little national benchmarking data available to be able to compare our performance with other areas.

Currently there are approximately 60 people who are registered with a Plymouth GP who have a s117 aftercare package with a health funded component. (PCC will need to provide the number of people solely funded by LA).

There are currently 23 people in an IPP placement of which 15 are placed outside of Devon

5.3 The End of Life system

This provision is commissioned mainly by the Clinical Commissioning Group

The hospice provider is St Lukes and 70% of their funding is from their own sources, providing specialist intervention. However, hospital and palliative care is also provided by statutory community teams. Other end of life provision is provided by Marie Curie nurses**.**

Table 12: Performance - Place of death[12]

Place of Death	Plymouth Score %	England Average %
Hospital	45	54.5
Own Home	20.7	20.3
Hospice	7.2	5.2
Care Home	24.5	17.8

At December 2014 there are 402 people who have continuing health care funding for domiciliary care at home and 180 who have Funded Nursing Care

5.4 Community asset mapping

Asset mapping will be utilised to determine existing informal provision, assets and resources that care homes, other providers and individuals have access to in the community. A co-production approach working with providers and service users 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*).

[12] http://www.endoflifecare-intelligence.org.uk/home Viewed October 31st 2014

6.0 THE FUTURE 'COMPLEX CARE' SYSTEM MODEL

The Complex Care system will consist of quality specialist health and care delivered close to home that promotes choice, independence, dignity and respect.

Figure 4: The future model for each element of the system is described below:

<table>
<tr><th colspan="5">Complex Care - System Overview</th></tr>
<tr><td colspan="5">"Quality specialist health and care delivered close to home that promotes choice, independence, dignity and respect"</td></tr>
<tr><td>Individual Placements
"Care provided at home or as close to home as possible in the least restrictive environment"</td><td colspan="2">Residential and Nursing Care
"Meeting the needs of people with dementia or multiple long term needs and avoiding unnecessary hospital admissions"</td><td>End of Life
"People supported to die with dignity in the settings they chose"</td><td>Acute
"Admissions only when necessary and discharge to appropriate settings"</td></tr>
<tr><th colspan="5">System Enablers</th></tr>
<tr><td>Prevention and Wellbeing</td><td>Pro-active
Primary Care</td><td>Seamless Integrated Care Pathways</td><td>Skilled professionals, supported by Clinical Effectiveness and Medicines Optimisation</td><td>Excellent preventative services and services that can support complex needs</td></tr>
<tr><th colspan="5">System Outcome</th></tr>
<tr><td colspan="5">Reducing Reliance on Acute Provision and Acute Episodes of Care</td></tr>
</table>

6.1 Care Homes

A good care home system will be one that meets the needs of people with dementia or multiple long term need, avoiding unnecessary hospital admissions.

<u>What will Success Look like?</u>

- ✓ Well defined, transparent and fair assessment and placement process
- ✓ Consistent oversight of the market across health and social care
- ✓ Quality health and care placements to meet individual need that promotes choice, independence, dignity and respect
- ✓ People are supported to die with dignity in settings they choose
- ✓ Reducing demand on health system by promoting healthier lifestyles
- ✓ Good advice and Information around financial planning and paying for care
- ✓ Reduction in length of stay in care homes whenever possible

- ✓ Admissions to hospital only when necessary

6.2 Individual Patient Placements

The aim is to provide care at home or as close to home as possible in the least restrictive environment. Reduction in IPP, particularly out of area placements, is a clinical as well as a financial necessity. This will be achieved and sustained in the long term by developing the ability of local services to work with greater levels of complexity and risk - supported by specialised services where necessary.

This will be achieved through 6 broad strategic aims:

- Ensuring effective quality assurance of placements
- Improved process control
- Greater focus on prevention and early intervention strategies
- Better commissioning to meet more needs locally
- Improved community services including access to psychological therapy and crisis response
- Improved systems flow – making best use of existing commissioned local services

<u>What Will Success Look Like?</u>

- ✓ Less people will be placed out of area and more people cared for closer to home
- ✓ Reduced Length Of Stay
- ✓ Better monitoring against treatment outcomes
- ✓ Improved patient experience
- ✓ More people cared for closer to home
- ✓ Decreased acute admissions
- ✓ Improved transition processes
- ✓ Improved community services for Personality Disorder
- ✓ Improved access to therapy
- ✓ Less spend out of city and greater investment in local services

6.3 End of Life

Medical advances allow us to keep people alive for longer and there will be a continuing increase in the number of people who are living with increasingly complex conditions. Whilst the number of people dying at home is gradually increasing, the public expectation to die at home will mean increasing resources in terms of the cost of nursing complex conditions. A future system will need to respond to these expectations whilst recognising that this will not always be possible. There will be opportunities to support this, for example by enabling all parts of the system to understand the importance of recognising when someone is approaching End Of Life, referring the right people for the appropriate conversations and supporting people to die well across all settings. This will include staff enabled to have difficult conversations and to discuss advanced care plans.

<u>What will success look like?</u>

- ✓ Increasing numbers of people dying at home
- ✓ Care provided closer to home where possible

- ✓ Carers supported in the care they provide at End of Life
- ✓ Consistent and joined up assessment of needs at End of Life
- ✓ Preventing avoidable hospital admissions
- ✓ Fewer delayed transfers of care from hospital to the community for EOL care
- ✓ Good quality End of Life Care across all providers

6.4 Available Resources

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

Table 13: Current Complex Care budgets

System Element	Approximate current budget
Individual patient placements	£7,622,129
Residential and nursing	£30,592,245
End of life	£4,378,084
Acute	£154,023,614
Total	£196,616,072

6.5 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.

Table 14: Performance dashboard

Indicator	National	Plymouth	Impact on system – why is this a measure?	Trajectory
PHOF 2.24i Injuries due to falls	2011	2032	Falls are preventable and increase pressure on the urgent care system with some evidence that they advance onset of other health conditions e.g. Dementia	
Local Proxy - Avoidable hospital admissions (2013/14)	1898.3	2187	BCF has set a target to reduce non-elective by 3.5%	
Local Proxy - Non-elective admissions (2013/14)	N/A	26,423	Waiting times in A&E is a proxy for effective working of the urgent care system	25,498
PHNT - 4hr wait in A&E (2014/15 ytd)	90.8%	91.6%		95%
PHOF 4.16 Estimated diagnosis rates for Dementia (December 2014)	57.4%	52.3%	A diagnosis of dementia is key to ensuring an appropriate service response is available	66.7%

Local proxy - % of people dying at preferred place of care	TBC	TBC		
Local proxy - Number of out of area IPP's	TBC	TBC		

7.0 FIVE YEAR COMMISSIONING INTENTIONS

7.1 Care Homes

- To develop the integrated commissioning of care home placements to ensure consistency, transparency and quality including assessment processes, review processes, care planning and case management
- To ensure there is sufficient local market provision of placements to meet need
- To ensure the commissioning model allows for the effective management of the market and in particular manage market failure
- To develop an integrated commissioning approach to quality assurance and safeguarding that challenges poor practice including an integrated Quality Assurance and Improvement Team
- To further develop the Quality Assurance and Improvement framework to ensure that care home staff are able to implement preventative assessments, care planning and make appropriate referrals to reduce the risk and impact of falls, secondary fractures, pressure ulcers, urinary tract infections, dehydration and COPD
- To develop excellent care-coordination for frail older people with support for the most complex patients from geriatricians, community pharmacies, the voluntary sector and older persons mental health services.
- To commission an effective Dementia Pathway that includes prevention, early diagnosis, carer support and case management and co-ordination to best support people to live well for as long as possible and ensure they are not admitted to hospital unnecessarily. *Early diagnosis will often take place when the person is living in their home and the full commissioning intentions for dementia will straddle the Wellbeing, Community and Complex Care strategies*
- To ensure that people living in care homes will be able to access the same level of healthcare as anyone living elsewhere in the community:
    - In assessment, review and treatment by their GP and Consultant Gerontologist and Consultant Psychiatrist
    - The specialist knowledge of community nurses, tissue viability, continence, nutrition and end of life practitioners should be equally accessible to people living in care homes with nursing
    - Dentist, Optometrists and Pharmacists, Allied Health Professionals
- To reduce the length of stay of people in care homes by ensuring that there are excellent delivery mechanisms to reduce long-term placements including reablement, respite support at home and end of life support at home

7.2 Individual Patient Placements

The aim is to provide care at home or as close to home as possible in the least restrictive environment. This will be achieved and sustained in the long term by developing the ability of local services to work with greater levels of complexity and risk, supported by specialist services where necessary.

The CCG has developed commissioning intentions to devolve responsibility for IPP commissioning for Plymouth GP registered individuals to Plymouth Community Healthcare as the main local provider of specialist mental health services in Plymouth. This would strengthen clinical decision making in the process of making an individual patient placement out of area. It would also allow the provider to be more creative in the utilisation of resources to offer alternatives to admission in the community.

Improving quality and reducing the usage of out of area placements requires the implementation of a range of both transactional and transformational strategies:

- Quality control and improvement of processes such as referral for IPP and clinical and placement reviews. This will also include improved exacerbation and contingency planning, blue light policies etc. A greater focus on information about clinical outcomes related to placements.
- Excellent provider assurance processes
- Improved system flow including through local recovery services
- Detailed needs assessment
- A strategic commissioning approach, with local services better commissioned to meet the needs of all but people with the most specialised needs
- Market management - the potential development of new providers within the market
- Improving processes for assessment and spend of Section 117 money
- Continued commissioning of cost effective enhanced community support packages
- New ways of working within existing providers for example the strengthening of integrated approaches to dual diagnosis and personality disorder and more staff trained in therapeutic approaches such as DBT
- Improved transition processes for young people with complex needs in community services or out of area
- An increased focus on effective packages of support for complex young adults 16 to 25 years
- Primary preventative approaches such as Families With a Future
- The potential role of risk stratification in identifying people at risk of out of area placement and complex individuals who would benefit from integrated personalised packages of care and/or integrated case management
- Identification of timely repatriation plans for services uses placed out of Devon.

7.3 End of Life

The aim is to have coo-ordinated care through good communication with individuals and professionals across the wider health and social care system.

We will achieve this by:

- Working with providers to make sure that the right services are in place to support people at home and in care homes and provide support for carers.
- Continuing to improve the quality of care in hospital for those at the end of life
- Continue to develop good quality care across all providers
- Joined up assessments through integrated services
- Continuing to develop bereavement services for families

8. COMMISSIONING PLAN 2015/16

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
Residential and Nursing Care	To develop care co-ordination for frail older people with GP practices	Better access to primary care for care home residents Reduced admission to hospitals from care homes	**CCG**	**By March 2016**
	To review the current Dementia Pathway and to develop a commissioning plan	Better management of complex people in care homes Reduced admission to hospital for people with dementia	**JOINT CCG and PCC**	**By March 2016**
	QAIT to develop a pilot project based on the Brownhill study 2013 to develop reduction targets in relation to falls, pressure ulcers, UTIs and overall hospital admissions QAIT to identify the Top 10 care homes with emergency admissions to hospital and action planning with those homes	Better trained and skilled care home staff Reduced admission to hospital from care homes Improved CQC Quality Ratings and User satisfaction	**PCC**	**By March 2016**
	To start the process towards the integrated commissioning of care home placements	Pooled budget with full joint contracts in place	**JOINT CCG and PCC**	**By April 2016**
	Continue to raise the quality of care homes through- ➢ QAIT Reviews ➢ Roll out best practice through Dignity Forum	Improved CQC Quality Ratings and User satisfaction	**PCC**	**By March 2016**
	Complete Market Needs Assessment to determine capability and capacity of market to meet future demand	Completed Market Needs Assessment	**JOINT PCC and CCG**	**By April 2016**
	Develop and implement a fair fee model for Care Homes	Fair Fee Model Implemented Improved CQC Quality Ratings and User satisfaction	**JOINT PCC and CCG**	**By March 2016**

System Element	Commissioning Activity	Key Outcomes	Lead Commissioner	Timeframe
Individual Patient Placements	Review and redesign local pathways and provision in order to prevent and reduce out of area IPP's	Reduction of placements	**CCG**	**By March 2016**
	Potential devolvement of IPP budget to main mental health service provider	Improved operational processes in place	**CCG**	**By April 2015**
	Develop market including new local providers	Market assessment completed		**By end of 2015**
	Develop Clinical Quality and Innovation Payment Schemes for all main healthcare providers which identifies children likely to transition to adult services and improves transition care.	Improved transition from children's services to adult care	**CCG**	**By March 2016**
	Implement Winterbourne View Action Plan and Concordat Agree repatriation trajectories with providers	Reduction of placements	**CCG**	**2015**
End of Life	Develop a commissioning plan for end of life care	Publication of EOL Plan	**CCG**	**June 2015**
	Develop the health and social care workforce to support people to die at their preferred place of care (usually the home setting)	Training needs assessment completed	**CCG**	**2016**
	Deliver CQUIN target	CQUIN achieved	**CCG**	**April 2016**
	To continue to develop bereavement services for families	Increased access to bereavement services	**CCG**	**March 2016**

APPENDIX 1 Resources for Evidence base and good practice

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.

APPENDIX 2

Demographics

Population

Plymouth currently has a population of 258,000 (Office of National Statistics (ONS) 2012 mid-year population estimates).

Overall 50.5% of Plymouth's population are female; this reflects the national figure of 50.8%.

Population growth and change since 2001 (Draft 'Plymouth Report 2014', Rob Sowden)

Population change occurs as a result of two factors:
- 'natural change', the difference between the number of births and the number of deaths,
- 'net migration', the difference between the number of people migrating into an area and the number migrating out of the area.

These components combined affect whether the population increases or decreases over the course of a year.

In Plymouth live births are increasing whilst deaths are decreasing resulting in an increase in the population due to natural change. From 2001 to 2012 Plymouth's population increased by 6,600 people due to natural change alone. This accounts for 38.4% of all change in Plymouth over that time.

Plymouth's population has increased by 17,100 (7.1%) since 2001. This is below the growth rate in both the South West region (8.0%) and England (8.2%).

People aged 65 years and over account for 16.8% of Plymouth's total population. This is comparable to that found nationally (16.9%).

An aging population will put pressure on Plymouth's public services, supported housing, and adult social care in particular. For example it is expected that those aged over 65 years with a limiting long-term illness will rise from 21,682 in 2013 to 24,061 in 2020, while those in this age group with dementia are predicted to rise from 3,107 to 3,667. The number of people aged 85 and over will increase from 5900 to 10,400 by 2030.

Current and Projected Population of Plymouth (18 – 64)

Ages	2014	2015	2016	2017	2018	2020	2025	2030
18 – 24	35,600	35,900	36,000	35,900	35,500	34,200	33,600	37,300

25 – 34	34,900	34,900	34,900	34,900	35,100	35,300	35,600	34,200
35 – 44	30,200	29,700	29,300	29,200	29,200	29,600	30,600	31,100
45 – 54	34,400	34,300	34,100	33,700	33,200	31,500	27,700	27,600
55 – 64	28,500	28,800	29,300	29,700	30,200	31,500	32,300	29,900
Total population 18 – 64	163,600	163,600	163,600	163,400	163,200	162,100	159,800	160,100
Total population all ages	260,400	261,300	262,300	263,100	264,000	265,300	269,300	274,500

Source: PANSI – Projecting Adult Needs Service Information website, Oxford Brookes

Current and Projected Population of Plymouth (65 and over)

Ages	2014	2015	2016	2017	2018	2020	2025	2030
65 – 69	14,200	14,200	14,000	13,300	12,900	12,500	14,000	15,200
70 – 74	10,400	10,800	11,400	12,400	12,900	13,100	11,600	13,000
75 – 79	8,500	8,600	8,500	8,600	8,900	9,600	11,800	10,500
80 – 84	6,400	6,500	6,600	6,700	6,800	7,100	8,100	10,100
85 – 89	3,700	3,800	4,000	4,100	4,200	4,500	5,100	6,000
90 & over	2,200	2,300	2,300	2,400	2,500	2,700	3,500	4,400
Total population 65 and over	45,400	46,200	46,800	47,500	48,200	49,500	54,100	59,200
% of total population 65 and over	17.43%	17.68%	17.84%	18.05%	18.26%	18.66%	20.09%	21.57%
% of total population 85 and over	2.27%	2.33%	2.40%	2.47%	2.54%	2.71%	3.19%	3.83%

Source: POPPI – Projecting Older People's Population Information website, Oxford Brookes

Provision of unpaid care (Draft 'Plymouth Report 2014', Rob Sowden)

In the England and Wales, there are around 5.4 million people providing unpaid care for an ill, frail or disabled family member or friend. Using data from the 2011 Census revealed there were 27,247 of these carers in Plymouth. The majority (57.3%) provided 1-19 hours of care per week but nearly 30% (7,566 individuals) were committing over 50 hours.

Across the Plymouth neighbourhoods the total number of carers ranged from 212 in Mutley to 1,133 in Honicknowle. The same two neighbourhoods respectively had the lowest and highest numbers of individuals providing 50 hours or more care.

Estimated 2014 prevalence of mental health problems in 18-64 year olds in Plymouth

Common mental health problems, including depression, anxiety and obsessive-compulsive disorder, constitute the greatest proportion of the mental health burden in Plymouth. Drug and alcohol dependence; as well as psychiatric co-morbidity are also very significant. However, the need for

services is not necessarily proportionate to the numbers; for example a person with a psychosis may require repeated episodes of inpatient care and greater input from specialist services than a person suffering from a mild depressive illness.

In 2014 nearly 10,000 people in Plymouth aged 18-64 years, of which 7,204 are male, are predicted to be alcohol dependent; whilst over 5,500 are estimated to be dependent on drugs.

According to the 2014 health profiles almost a quarter of adults in Plymouth's alcohol consumption is 'increasing and higher risk'. Rates of hospital stays for alcohol related harm in Plymouth is higher than England average and Southampton, Sheffield and Portsmouth.

Personality disorders

Personality disorders are longstanding problematic personality features which cause a person to have difficulty functioning in addition to making and sustaining relationships. There are various types of personality disorders but two are particularly important in terms of need for health and other services:

(1) Borderline personality disorder is significant because this condition involves high levels of emotional instability, self-harm, and suicide. In 2014 more than 730 people in Plymouth aged 18-64 years are predicted to have borderline personality disorder.

(2) Antisocial personality disorder, characterised by an aggressive and irresponsible pattern of behaviour, also has a wider impact on society as it is linked with crime and violence. In 2012 almost 580 people aged 18-64 years in Plymouth are estimated to have antisocial personality disorder.

Psychosis

Psychosis is a term for disturbance of perception, thought, and insight. For example, people may experience hallucinations, or distorted sensations such as hearing things, that are not there in external reality. These experiences may be frightening and distressing. A lack of insight means that sufferers may not recognise that they are unwell or that they could benefit from treatment. Psychotic symptoms occur in illnesses such as schizophrenia, and can also accompany mood disorders such as bipolar affective disorder. In 2014 over 650 people aged 18-64 in Plymouth are estimated to have some type of psychotic disorder.

Psychiatric co-morbidity

It is quite common for people to meet the diagnostic criteria for two or more mental health problems and suffer from psychiatric comorbidity. This is an important issue as it is associated with greater disease severity, longer illness duration, greater functional disability, and an increased use of health services. Over 11,500 people in Plymouth aged 18-64 years are estimated to have more than one mental health problem.