COMMUNITY
COMMISSIONING STRATEGY

DRAFT

Northern, Eastern and Western Devon
Clinical Commissioning Group

NHS

PLYMOUTH
CITY COUNCIL

INTRODUCTION

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

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

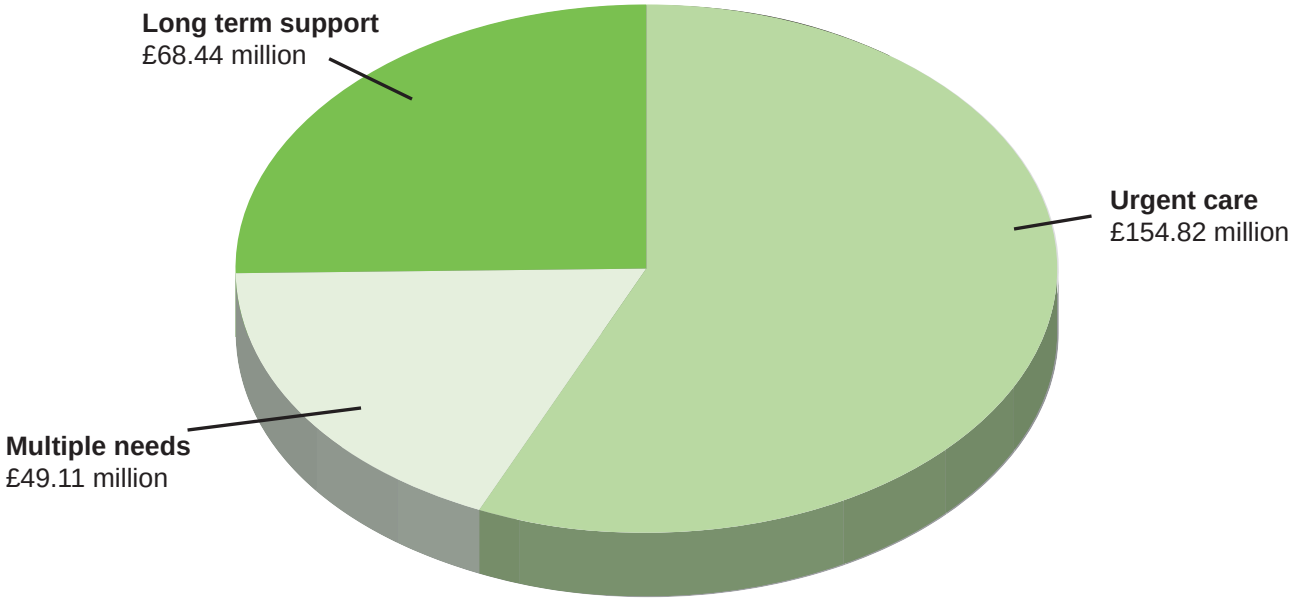
Four integrated commissioning strategies have been produced; **this strategy sets out the approach for health and social care community based services and related commissioning intention**s, which includes an integrated commissioning and delivery approach for services, putting the person at the centre with support services wrapped around them. **The integrated Community Based Care Strategy focuses on promoting people's independence within the community; providing appropriate and quality care in all settings, preventing needs escalating and so avoiding unplanned admissions to hospital.**

In 2015/16 the identified spend on services within scope of the Community Strategy is £272.37 million. This comprises the CCG and PCC's relevant spend within the Plymouth Integrated Fund and the CCG's relevant spend for South Hams and West Devon. The approximate breakdown of this is shown in the chart below.

Once we have implemented this strategy, people will be able to:

- Access a range of personalised and responsive services that meet their needs, which will be integrated where it makes sense to do so
- Tell their story once, to one individual who will make a difference
- Stay in their own home, wherever that happens to be, with support co-ordinated by their GP and wrapped around them
- Guide the care and support that is available in a way that suits them and is not prescribed by the system

The identified spend of serices within the scope of Community £272.37m



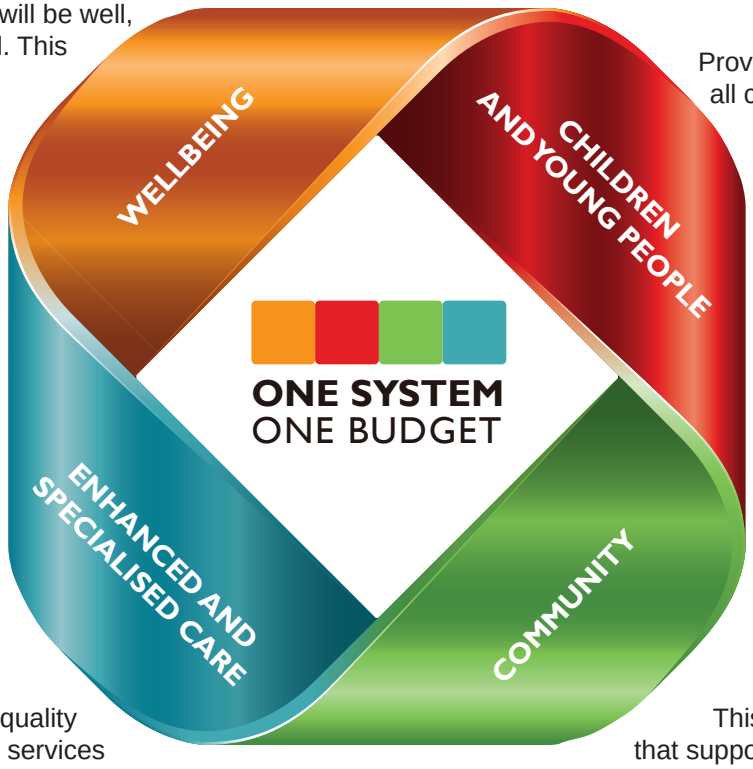
ONE SYSTEM...
FOUR COMMISSIONING STRATEGIES

WELLBEING

People and communities will be well, stay well and recover well. This strategy supports healthy and happy communities by putting health and wellbeing at the heart of everything we do.

CHILDREN AND YOUNG PEOPLE

Provide the best start to life for all children from pregnancy to school age, and the right support at the right time for vulnerable children and young people.



ENHANCED AND SPECIALISED CARE

A system that consists of quality specialist health and care services that promotes choice, independence, dignity and respect.

COMMUNITY

This strategy targets services that support people to maintain their independence in their own home within their own community.

Commissioning an Integrated System for Population Health and Wellbeing Overall strategic direction and response to national strategy

- Integrated commissioning – now and future
- Needs assessment

- Healthy and happy communities
- Supporting and utilising social networks
- Increasing investment in public health
- Health and wellbeing at the heart of everything we do
- Carers
- Domestic abuse
- Housing conditions
- Planned health care

- Universal early help and best start to life
- Integrated education, health and care plans
- Family support
- Safeguarding children and preventing vulnerability
- Support to keep children and young people stable at home, in alternative family arrangements, in foster care or alternative placements

- Quality specialist health and care services
- Promoting choice, independence, dignity and respect
- As close to home as possible
- Targeted resources for those who need long-term support in the community

DEFINITION OF COMMUNITY BASED CARE

Community Based Care delivers targeted services for people who need support in the community to maintain independence or those who may be at risk in the future of losing their independence. The services support:

- People with multiple care and support needs
- People requiring urgent care: responding to a crisis and providing a timely response, reablement and recovery
- People with long-term support needs who need ongoing personalised support

The opportunity that the integrated health and wellbeing commissioning agenda presents is to undertake a whole system review of a wide range of service provision in order to consider what changes are required to meet the needs of and deliver better outcomes for people who access health and social care services.

It is recognised that the health and wellbeing of the population of Plymouth is impacted by a wide range of organisations working across Devon, but within the scope of this strategy are services currently commissioned for the people of Plymouth by NEW Devon CCG and Plymouth City Council. Examples of these include social care, community nursing, domiciliary care, day opportunities, supported employment, reablement, community equipment, supported living, homelessness support, substance misuse treatment, mental health services and Telecare.

A specific Strategy for Children and Young People's Strategy is one of the four co-dependent commissioning strategies. However, it is important to highlight the importance that services covered within the scope of this community strategy have on the lives of children and young people in terms of transitions, children requiring urgent care services, and in relation to the role services have on the ability of parents and other significant adults to maintain their independence and so continue in their caring / parenting role.

Other key elements that run through this strategy are the ability to access and sustain appropriate housing, safeguarding vulnerable people and medicines management.

AIMS OF THE COMMUNITY STRATEGY

We will:

Aim One

Provide integrated services that meet the whole needs of the person by developing:

- Single, integrated points of access
- Integrated support services & system performance management
- Integrated records

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

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

Aim Two

Reduce unnecessary emergency admissions to hospital across all ages by:

- Responding quickly and appropriately in a crisis
- Providing appropriate and quality care in all settings
- Providing advice and guidance, recovery and reablement

Aim Three

Provide person centred, flexible and enabling services for people who need on-going support to help them to live independently by:

- Supporting people to manage their own health and care needs within suitable housing
- Support the development of a range services that offer quality & choice in a safe environment
- Further integrating health and social care

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

WHO WILL BENEFIT FROM THIS STRATEGY?

The current Community Based Care system is described in three strands detailed below, but also addresses issues relating to medicines management, housing and safeguarding, which heavily impact on the provision of community based services.

People with multiple care and support needs

This strategy is for people who have multiple needs and use care and support services that relate to homelessness, substance misuse, offending, and mental health as it is widely acknowledged that there is significant overlap of need in the people accessing each of these services areas. Whilst no one issue alone may trigger a statutory or secondary care service, the combination of support needs creates a complexity that requires a more specialist intervention in the community.

For the purposes of this strategy, we are using the Making Every Adult Matter (MEAM) definition which describes adults who experience several problems at the same time that impact on families and communities, have ineffective contact with services, and live chaotic lives (http://meam.org.uk/).

People in need of an urgent care response

Urgent care responses meet the needs of people who are in crisis and need care and support to prevent attendance at or admission to hospital or a care home. These people may also need support to recover in order to regain maximum independence, regardless of the cause of the crisis. They may need services such as rapid response home care, standard home care, mental health support services, reablement and/or community equipment.

The key to both reducing and delivering effective urgent care is ensuring that the whole system supports:

- Prevention
- Self-care, pharmacies, primary care
- Assessment and immediate management that reduces the necessity for admission
- Appropriate and high quality care where admission to a hospital setting cannot be avoided
- Timely and safe discharge from a hospital setting.

Unplanned paediatric admissions

In addition to ensuring the needs of adults are met appropriately through the urgent care pathway, there is also a need to focus resources on avoiding unplanned paediatric admissions to hospital.

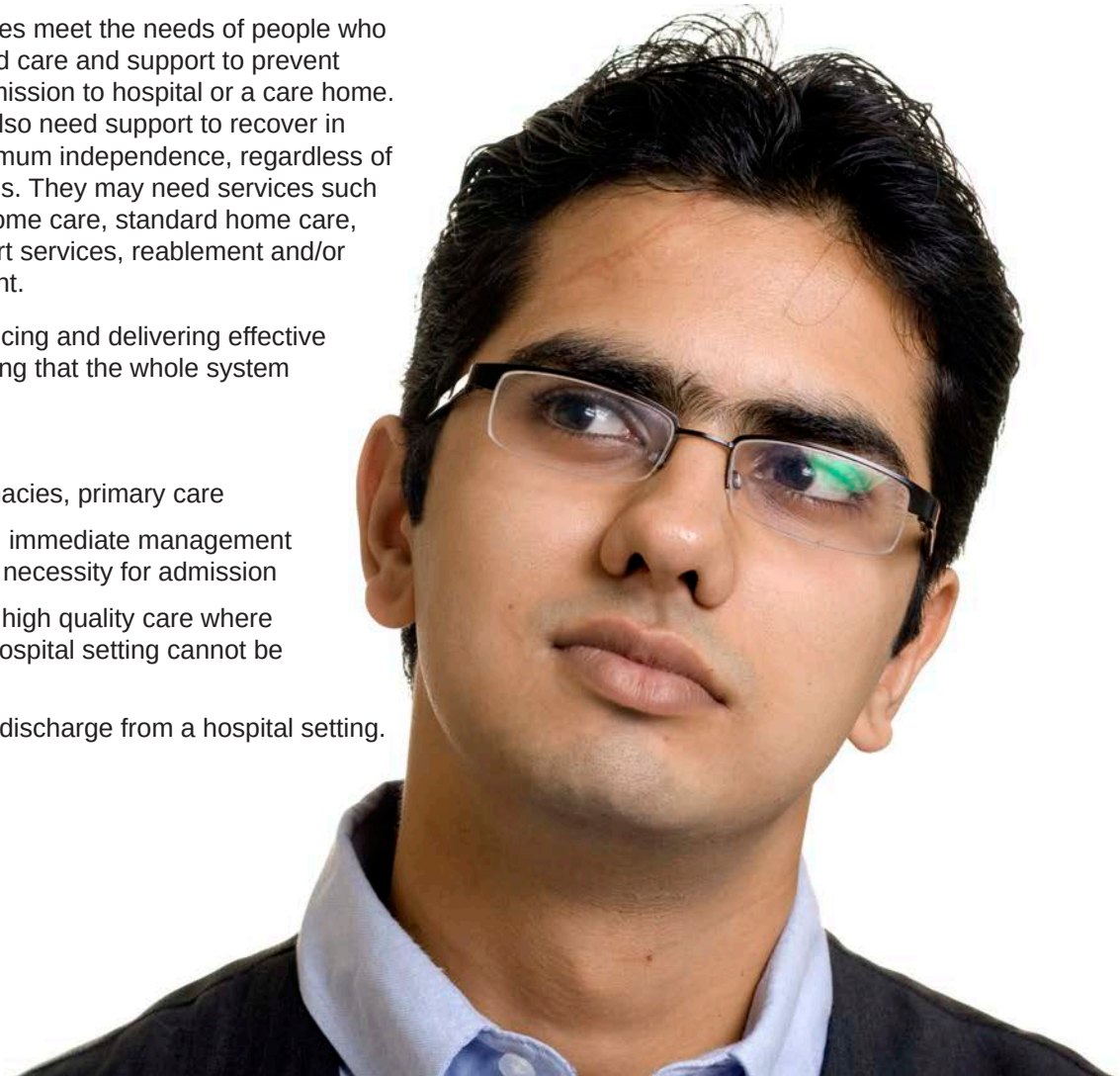
People needing long-term support

Older people form the largest group in this population. Not all older people need support, and the fitter and healthier we help them stay, the less likely they are to need help from others; However, some do need long-term support. Older people falling into the following groups are more likely to need long-term support: frail older people, older people with dementia and those with hearing and/or sight loss.

Other people whose health and social care needs are incorporated within this element of the strategy include those with a learning disability, mental health needs, sensory loss, autism or physical disabilities.

Carers

The National Census 2011 indicates 27,247 unpaid carers were living in Plymouth, with 28% of them providing more than 50 hours of support a week. Support services for carers are covered within the Wellbeing Commissioning Strategy.



WHY DO WE NEED TO CHANGE?

Plymouth's rising population, described in the demographic profile of Plymouth in the Community Based Care Needs Assessment, is likely to put increasing pressure on a range of public services; especially community based provision within the definition of this strategy.

The needs assessment also highlights that one of the most significant factors that will impact on further demand for community services is the growing number of older people in Plymouth.

A report by Sir John Oldham describes perfectly our current system, and his challenge, "I want you to care for the whole of me and act as one team", is one that we will embrace.

From his report on whole person care 'One Person, supported by people acting as One Team, from organisations behaving as One System' (February 2014):

> "… Mrs P is widowed and lives on her own a few miles away from her daughter. She is 85, has breathing problems, high blood pressure and diabetes. In a good month (without an emergency visit), she will see ten different professionals from the health and care world – each of whom has a specific task, Most of her days are spent waiting for someone to come and carry out her care. The value of each intervention doesn't last much longer than the visit itself, because no one is making these interventions add up to more as a whole. Mrs P is a sick woman, but her life is not only dominated by her ill health – it is also dominated by fragmented health and social care.
>
> Last year Mrs P went to A&E five times and on two occasions she had to be admitted to hospital for breathing trouble. Both her periods in hospital came about because the various elements of care did not help to identify early deterioration. In total she spent 30 days in hospital in emergency beds. This is what happens to millions of people as a result of our fragmented system of care. It would be better for Mrs P if she saw fewer people who were better coordinated and better informed about her care and health. "

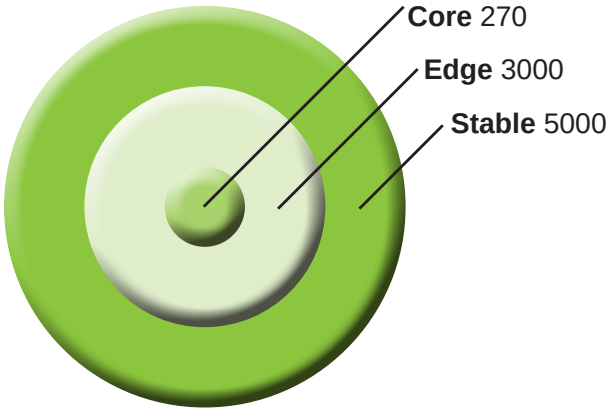
People with multiple care and support needs

Current services supporting people with multiple needs are often commissioned by different organisations and are therefore not always joined up. As a consequence, the provider market has developed into specialist areas and, although there are some good examples of joint working, there are only a small number of meaningful partnerships that respond to the range of needs an individual often experiences.

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

Services are also performance-monitored separately and it remains difficult to gauge a comprehensive picture across the whole system.

Local information, combined with national modelling, indicates that adults experience complex needs at different levels. Core - approximately 270 people require intense support for a number of issues at the same time; Edge - approximately 3,000 people are not in immediate crisis but could shift into core without intervention; Stable - approximately 5,000 people have complex needs but are stable and engaging with support.



In addition, research into the needs of the most vulnerable families where children become subject to child protection plans indicates children's health, development and safety is significantly impacted upon where parental capacity is compromised due to domestic abuse, substance misuse, learning disability and / or mental health.

A wide range of research into early intervention, alongside the work undertaken by the Department for Education under the "Think Family" and "Families at Risk" agenda and by the Department of Children & Family Services under the "Troubled Families" agenda, demonstrates that family-based interventions delivering packages of support to the whole family, co-ordinated through a key worker, produce longer term change and impact on outcomes for all members of the family. This provides a clear driver for an approach to developing closer alignment of the system of services around the whole family's needs to meet a wide range of outcomes.

People in need of an urgent care response

The current system does not sufficiently prevent people from going into a crisis and too many people attend or are admitted to hospital in an emergency.

Census data indicates that:

- 6.5% of people in Plymouth identified their health as bad or very bad
- 10% of people in Plymouth find their day-to-day activities are limited a lot (self-definition as per the Census)

These figures are an indicator of the potential need for domiciliary care or people at risk of needing urgent care if not supported to remain stable in their own homes.

Emergency hospital admissions

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

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

Demand on the urgent care system is known to be seasonal. Older people are much more susceptible to the effects of the cold weather and, as a consequence, have higher rates of emergency admissions in the winter months. Winter pressures are not restricted to acute hospitals and most health and adult social care service areas alsoexperience this increase in demand. Ensuring efficient patient flow through the whole urgent care system is a key element in ensuring high quality patient care.

Community domiciliary care, reablement and hospital discharge

The demand for community domiciliary care, reablement and hospital discharge services has continued to increase due to people growing older and wanting to remain living independently in their own homes for as long as possible. This fits with the Care Closer to Home agenda, as set out within The Five Year Forward View published by NHS England.

Mental Health

Agencies and individuals often report that mental health services are confusing and can be difficult to access until a person reaches crisis point. In addition, the current system contains a significant number of different services, access routes and pathways that are dependent on individual diagnosis, resulting in difficulties for people navigating the system particularly where they have co-morbidities.

In recognition of the inadequate responses to people in mental health crisis across the country, a national mental health Crisis Concordat was published in 2014. The Concordat has been adopted on a multiagency basis including health, social care and criminal justice agencies involved in the support and care of people in mental health crisis.

Unplanned paediatric admissions

Data from NEW Devon CCG shows that there are a significant number of children and young people who present to emergency departments and require no procedure or active intervention. This suggests that the default place to send a child (particularly under-5s) presenting with a ‘Big 6’ condition (bronchitis, fever, gastroenteritis, head injury, asthma or abdominal pain) is to an emergency department.

People needing long-term support

The purpose of long-term support is to enable people with on-going needs to live as independently as possible for as long as possible. There are a variety of services available; however, the systems for adult social care and health care are not clearly interlinked in all situations.

Demographic data evidences that health and social care needs amongst most client groups will increase, as shown within the needs assessment, thus placing increased pressure on community based services.

Housing

Housing is a social determinant of health and has a major impact on community health and wellbeing.

Recent research has shown large disparities in life expectancy and other health indicators between the wider population and homeless people. In addition:

- Demand for social housing substantially exceeds supply
- Levels of statutory homelessness rose in 2014/15 and rising numbers of homeless households are accommodated in temporary accommodation
- A third of Plymouth’s dwellings (approximately 30,000) are classified as being ‘non decent’

- With Universal Credit due to be introduced in Plymouth in January 2016, housing affordability has become a critical issue. Plymouth has higher levels of problem debt than any other local authority area in the South West.

Medicines Optimisation and Management

Getting the most from medicines for both patients and the NHS is becoming increasingly important as more people are taking more medicines. Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare. However, it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended.

The safety of medicines is another important consideration when optimising medicines. A report commissioned by the Department of Health, 'Exploring the Costs of Unsafe Care in the NHS', found that 5% to 8% of unplanned hospital admissions are due to medication issues which will have an impact on urgent care.

Effective systems and processes can minimise the risk of preventable medicines-related problems such as side effects, adverse effects or interactions with other medicines or co-morbidities. The risk of people suffering harm from their medicines increases with the use of four or more medication.

In Plymouth, over £40 million is spent on medicines prescribed in primary care, which is above the national average. There may be multiple contributory factors for this and it will be reviewed alongside other needs assessment measures in order to understand the reasons for this variation.

Adopting a system-wide approach to medicines optimisation will provide accountability for ensuring that best value for the investment in medicines is embedded and shared by all involved in the care pathway.

Success Regime

The Northern, Eastern and Western Devon (NEW Devon) health and care economy has been selected by NHS England as one of three areas in the country to enter a new Success Regime.

The Success Regime aims to support local leadership development across organisational boundaries within both commissioner and provider sectors to deliver change and build on the potential for new models of care and support so that our health and care economy is stronger and able to sustain the improvements made for local people.

The regime will support local leaders across the NEW Devon health and care community, including the CCG, local authority commissioners and health and social care providers.

WHAT HAPPENS NOW?

The current Community Based Care system is described in three strands:

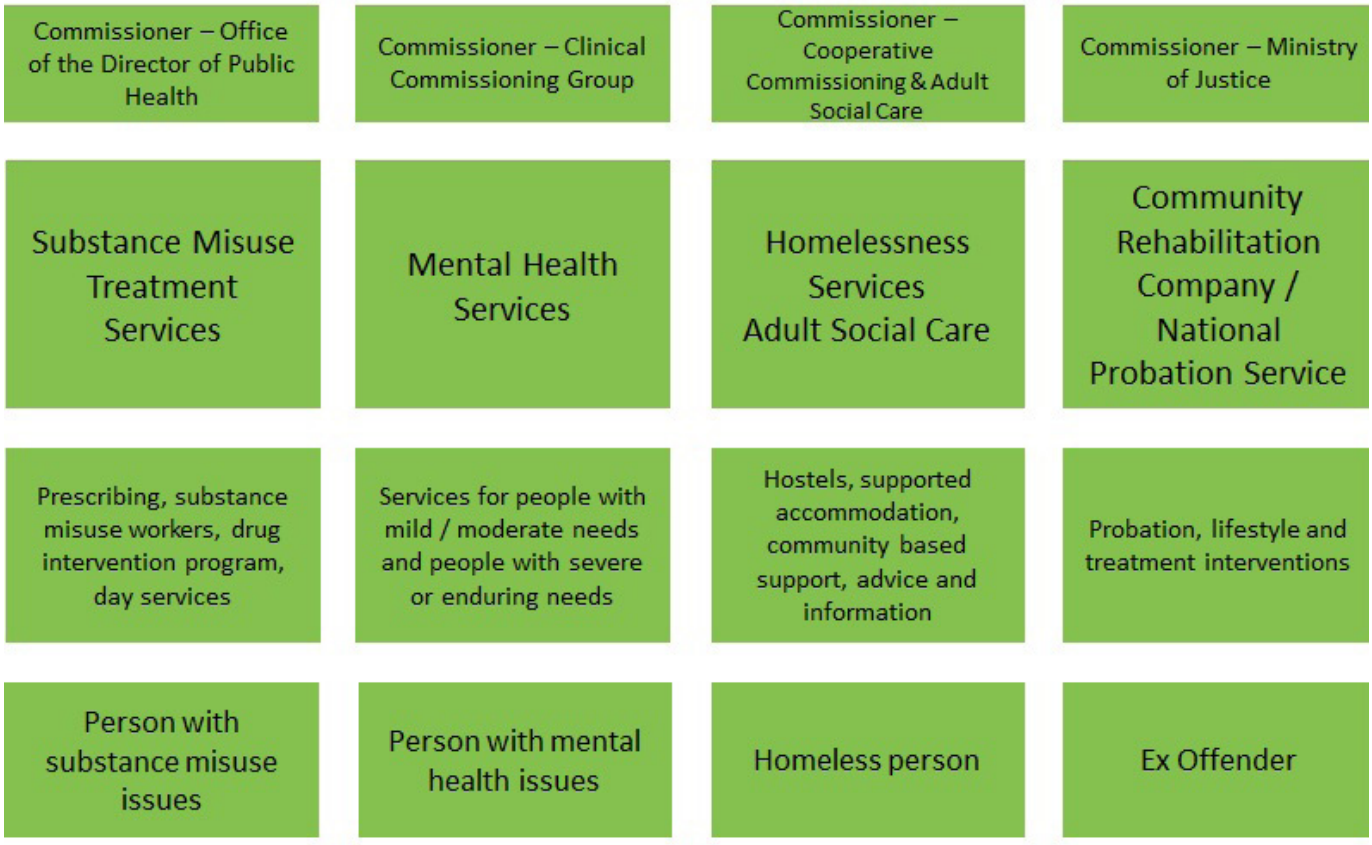
- Multiple Needs
- Urgent Care
- Long-term Support

Multiple needs

The term 'multiple needs' applies to adults who experience more than one issue at the same time (for example mental health and/or substance misuse and/or homelessness and/or offending). Any combination of these needs can have a significant impact on families and communities. Often people are living chaotic lives and have ineffective contact with services.

In Plymouth, services to support adults with multiple needs are generally commissioned by organisations in isolation, resulting in specialist services which are not always joined up. This can lead to duplication, with the people accessing a range of services to meet their needs or some people not receiving the support they need.

The diagram below demonstrates the current silo approach to commissioned services.



Although a range of services are delivered in a more integrated manner, the diagram raises the following questions:

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

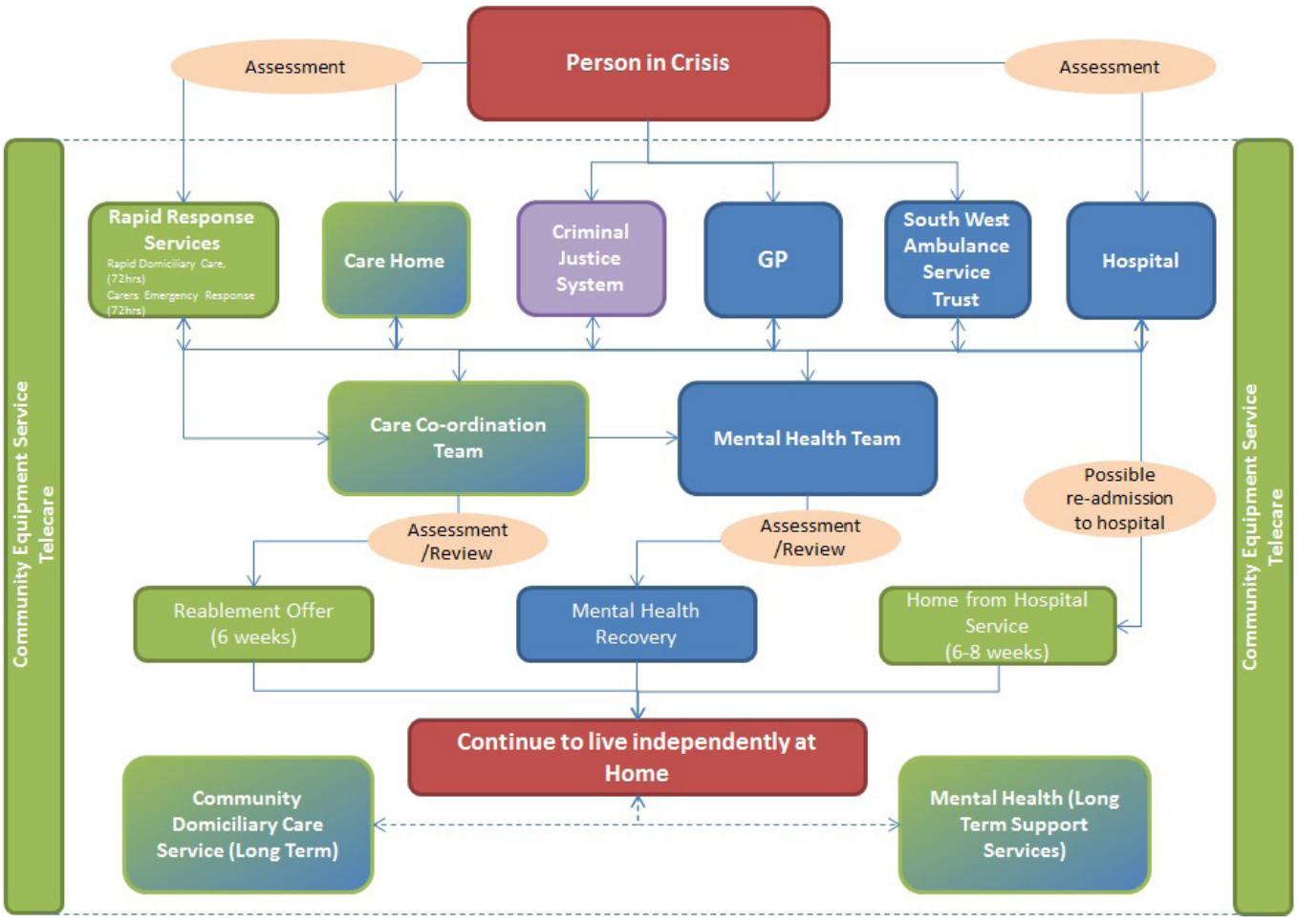
The national outcomes frameworks provide an indication of how Plymouth is performing overall compared to other areas.

Public Health Outcome Framework (PHOF) Indicator	England	Plymouth (RAG)
1.06ii Secondary MH in stable & appropriate accommodation (2013/14)	60.8%	54.5%
1.08iii Gap in employment rate between MH and overall (2013/14)	65%	67.2%
1.13i Reoffending levels (2012)	25.9%	24.2%
1.15i Statutory Homelessness (rate per 1000 households) (2013/14)	2.3	2.5
2.15i Successful completions (opiate) (2013)	7.8	7.2
2.18 Alcohol- related hospital admissions (rate per 100,000 population) (2012/13)	637	708
2.23iv Self reported wellbeing (high anxiety) (2013/14)	20.0%	21.3%

Urgent care

The purpose of the existing provision of urgent care services is to support people and their carers when in crisis in order to avoid admission to hospital or care unless essential, to promote recovery and reablement as quickly and effectively as possible and where people are admitted appropriately enable them to receive high quality care that allows them to be treated and recover quickly. There are a variety of services within this area but the system is difficult to navigate and there are increasing pressures due to demand and complexity.

The next diagram describes the current system.



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

Currently the system does not sufficiently prevent people from going into a crisis and too many people attend or are admitted to hospital in an emergency. At any point in time in the region of 30% of people are admitted to hospital when their needs could be met elsewhere. For some, particularly the frail elderly, there is the risk that they will recover slowly, potentially become more unwell, be isolated from their usual support networks and become more dependent on health and social care services. This may result in long lengths of stay (delayed transfers of care) and admissions to care homes (nursing and residential), and the current system does not provide a seamless and speedy recovery journey.

Last winter (2014/15) was one of the most difficult for the health and social care system, with Plymouth Hospitals NHS Trust spending over 6 weeks at “black escalation”, resulting in poorer than expected emergency department performance, longer lengths of stay in hospital for people, cancellation of over 1,000 operations and an increased cost to the system as emergency measures were taken to support the hospital. Whilst acknowledging the difficulties in the system in the recent past, there has also been a range of new services developed which should stand the system in good stead for winter 2015/16.

There has been significant pressure within the capacity of our domiciliary care and reablement service providers and, with people needing to be discharged from hospital quickly; the demand is only likely to increase as described within the supporting needs assessment.

Mental Health - urgent and emergency access to crisis care

In 2015 the system undertook two multi-agency pilots involving NEW Devon CCG, Devon & Cornwall Constabulary, Plymouth City Council and Plymouth Community Healthcare to ensure that people who come into contact with the police received an appropriate response.

The pilots incorporated:

- Street Triage which resulted in an improved multi-agency response to people presenting in crisis. Funding to continue and extend the service has been agreed between NEW Devon CCG / South Devon and Torbay CCG and Devon & Cornwall Constabulary
- Liaison and diversion services being provided in Police custody

A purpose-built place of safety for adults has been established in Plymouth to support those in crisis, including people detained by the Police on a Section 136 order. In addition, an interim place of safety has been established for children and young people.

A protocol has been established with the South Western Ambulance NHS Foundation Trust to support the Police to convey individuals to the Place of Safety when possible to avoid conveyance in police vehicles unless necessary.

Psychiatric liaison services are available 24 hours a day, 365 days a year at Plymouth’s emergency department, although the services across the hospital are not resourced to the levels which will be required to meet future standards.

The acute mental health inpatient unit in Plymouth is acknowledged as requiring modernising and a substantial modernisation project has now commenced to improve the quality of the environment at the unit.

The local system lacks psychiatric intensive care beds, which means that all individuals requiring such services are required to travel away (significant distances on occasion) from the area and their friends and families.

Unplanned paediatric admissions

A significant number of children and young people present at emergency departments with one of the following conditions: bronchitis, fever, gastroenteritis, head injury, asthma or abdominal pain. Evidence shows that current levels of attendance could be avoided.

Performance indicators that can be used to indicate how well the urgent care system is operating are detailed below.

Performance Indicator	National	Plymouth (RAG)
Local Proxy - Avoidable hospital admissions (2013/14)	1898.3	2187
Local BCF - Delayed transfers of care (days delayed) from hospital per 100,000 population (aged 18+) (Q3 14/15)	915.3	1045.7
ASCOF 2A Permanent admissions to residential and nursing care homes (aged 65+)	650.6	649.7
ASCOF 3A Percentage of adults using services who are satisfied with the care and support they receive (2013/14)	64.8%	67.8%
ASCOF 2B Proportion of older people still at home 91 days after discharge (2013/14)	82.5%	80.8

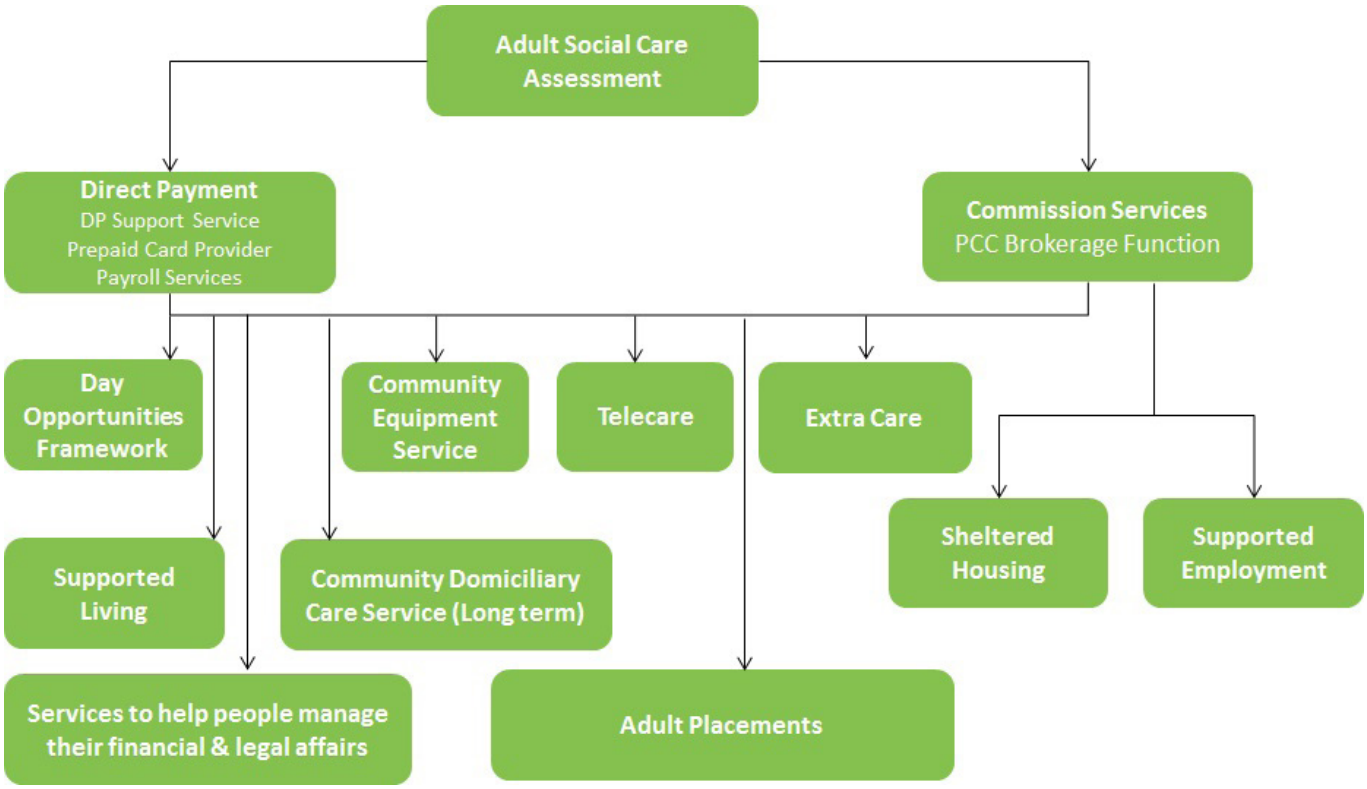
Long-term support

The type of services currently commissioned to respond to this need include:

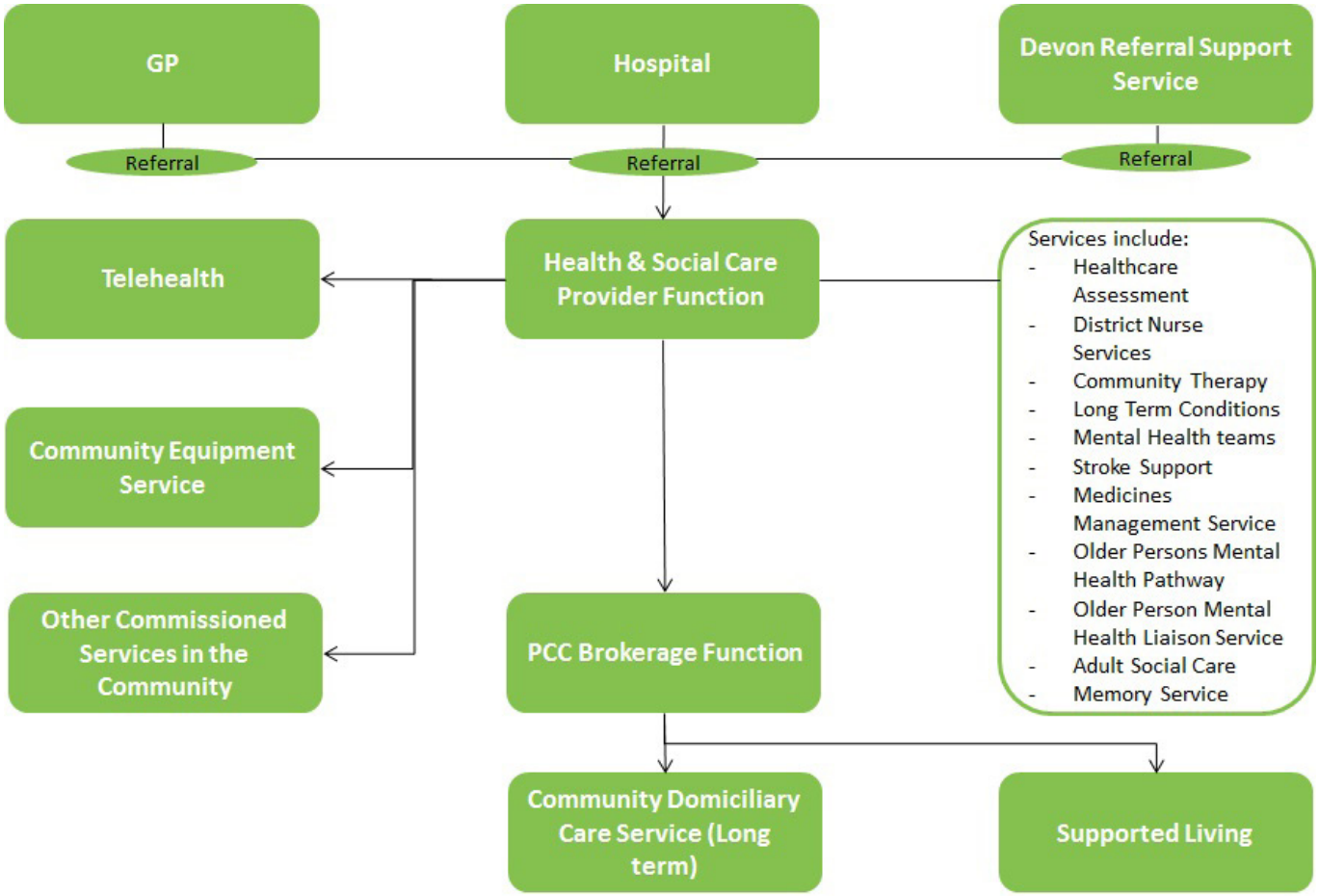
- Day Opportunities
- Supported Employment
- Supported Living
- Appointee and Deputyship
- Adult Placements
- Home Care
- Extra Care Housing
- Sheltered Housing
- Housing Adaptations
- Telecare

The purpose of the existing provision is to enable people with ongoing needs to live as independently as possible for as long as possible. The services also target support at those who may be at risk in the future of developing more complex needs. There are a variety of services within this area and most are currently commissioned through Plymouth City Council. However, the systems for adult social care and health are not clearly interlinked in all situations.

The diagram below shows existing provision of long-term support for people following an adult social care assessment accessed via a direct payment and/or commissioned service.



The next diagram shows the services available for long-term support following a healthcare assessment.



The opportunity for joining up the two systems is clear and responds to the feedback from people who use the services about the need for an integrated health and social care system.

Personalisation gives people the freedom to decide how they wish their social care and health needs to be met. Currently, Plymouth City Council allocates personal budgets following an assessment of need, and these can be deployed as a direct payment. The NHS provides personalised health budgets to those people receiving continuing healthcare funded services; for example personal care at home, physiotherapy, speech therapy and counselling.

Those people managing personal health budgets are reporting significant benefits, enabling them to plan and manage their individual care requirements.

Performance indicators on long-term support are described below.

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

General Practitioners (GPs)

The majority of people in Plymouth are registered with a GP and access their services for a significant amount of advice, guidance, support and treatment. primary care (GPs) and its future role is described in the Wellbeing Strategy, but there is a clear and central role for primary care in meeting the needs of people described in this community strategy. Very often the GP is the cornerstone, the pivotal point in people's care.

Housing

There is a growing evidence base that shows housing-related services can improve outcomes and reduce costs for health services and other areas of public expenditure. Housing is a social determinant of health and has a major impact on community health and wellbeing. Recent research has shown large disparities in life expectancy and other health indicators between the wider population and homeless people.

In light of this evidence, Plymouth has actively supported the development of appropriate and sustainable housing schemes and has a range of options for various client needs, including:

- Supported temporary accommodation for people who are homeless, people with mental health needs and people with substance misuse needs
- Sheltered housing
- Extra care sheltered housing
- Supported accommodation for people who have a learning disability
- Adult placements
- Housing adaptations

Medicines Optimisation and Management

Medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use to ensure people obtain the best possible outcomes from their medicines. Medicines Optimisation ensures that patients get the right choice of medicine, at the right time.' By focusing on patients and their experiences, our aim is to help patients:

- Improve their health outcomes
- Take their medicines correctly and safely
- Avoid taking unnecessary medicines
- Reduce wastage of medicines

As the population ages and life expectancy increases, more people are living with several long-term conditions that are being managed with an increasing number of medicines (poly-pharmacy).

As the number of medicines increases it is important to ensure a careful balance between appropriate poly-pharmacy to improve quality of life and extend life expectancy, and inappropriate poly-pharmacy causing adverse effects or where the intended benefit is not achieved.

Safeguarding

In 2014 and 2015 Plymouth City Council recorded in excess of 1,600 safeguarding alerts, continuing the increasing trend which started in 2013. This increase is assumed to be a result of the raising of awareness among professionals in the city and supplemented by improved recording practices. Approximately 76% of these alerts were for people receiving a service in the community. Approximately 24% of these alerts were for people in long-term residential or nursing placements.

The country as a whole is seeing a rising trend in safeguarding alerts; Plymouth is in line with the national trend. On average, over 40 alerts will proceed to investigation each month; in 2014 and 2015 there were 542 completed investigations across the whole year. One of the focuses of internal monitoring will be the outcomes for individuals who are the subject of the safeguarding investigation; for example, has the risk been reduced or removed altogether.

WHAT DOES THE FUTURE LOOK LIKE?

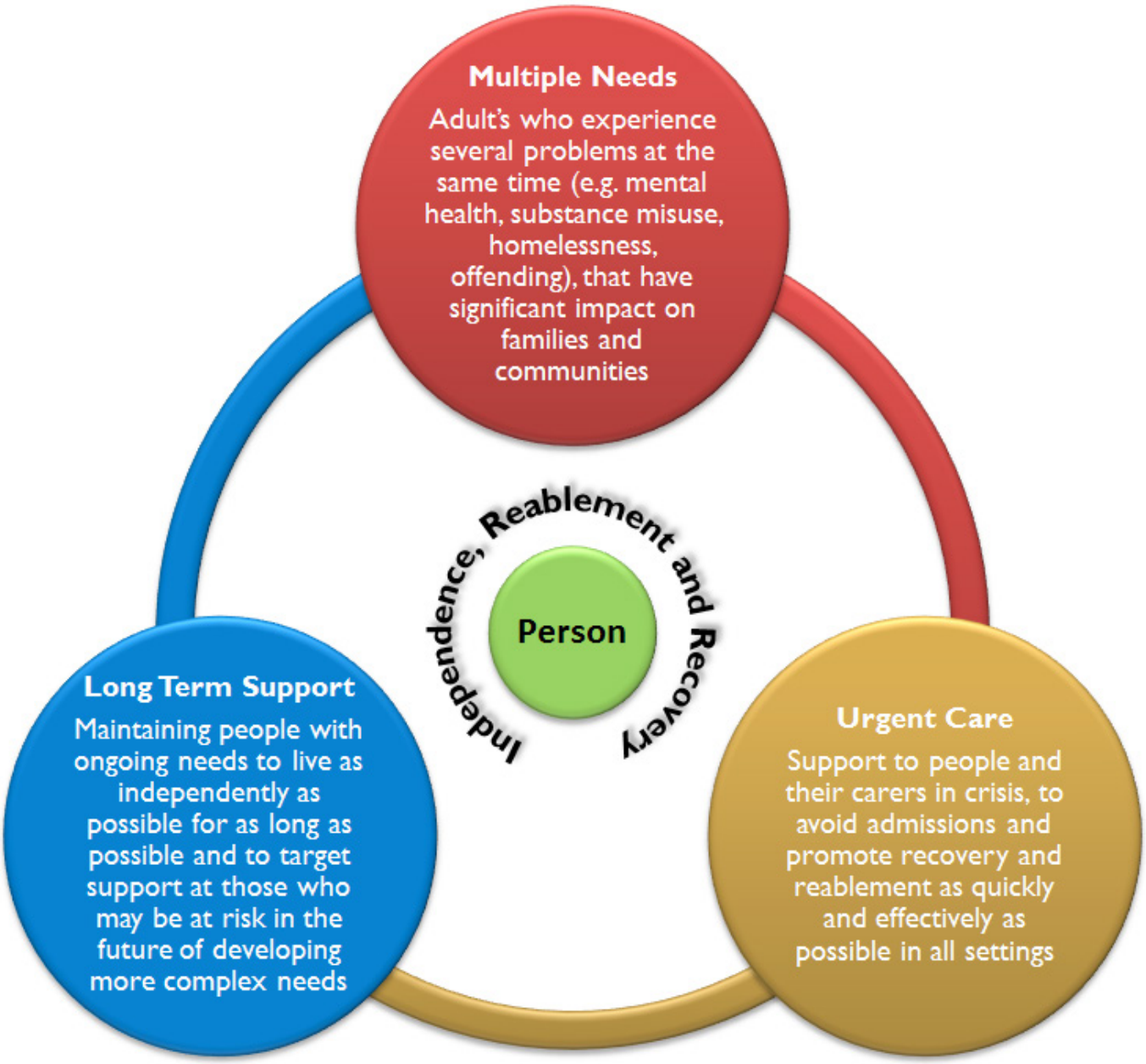
We will commission far more integrated services in order to avoid the handovers of people between GP and specialist care services as well as between health and social care providers. We will commission services that maintain the focus of people as individuals and not patients, people who (generally speaking) have their own beds in their own homes and want to stay there.

It is very important that health and social care services are focused on doing things with people rather than to them. The role of community support is vital to achieving this goal. It is also important to recognise that solutions need to be locally flexible to suit the different demographics found across the city and their specific needs and priorities.

Individuals are often experts in their own long-term conditions and the system will encourage and enable individuals to co-ordinate and manage their own care with appropriate support from professionals as and when requested.

As stated earlier in this strategy, the GP/primary care is often the cornerstone of people's health and wellbeing. We will build on this co-ordinating role by further integrating services around people and their GP, removing the barriers and boundaries that currently exist.

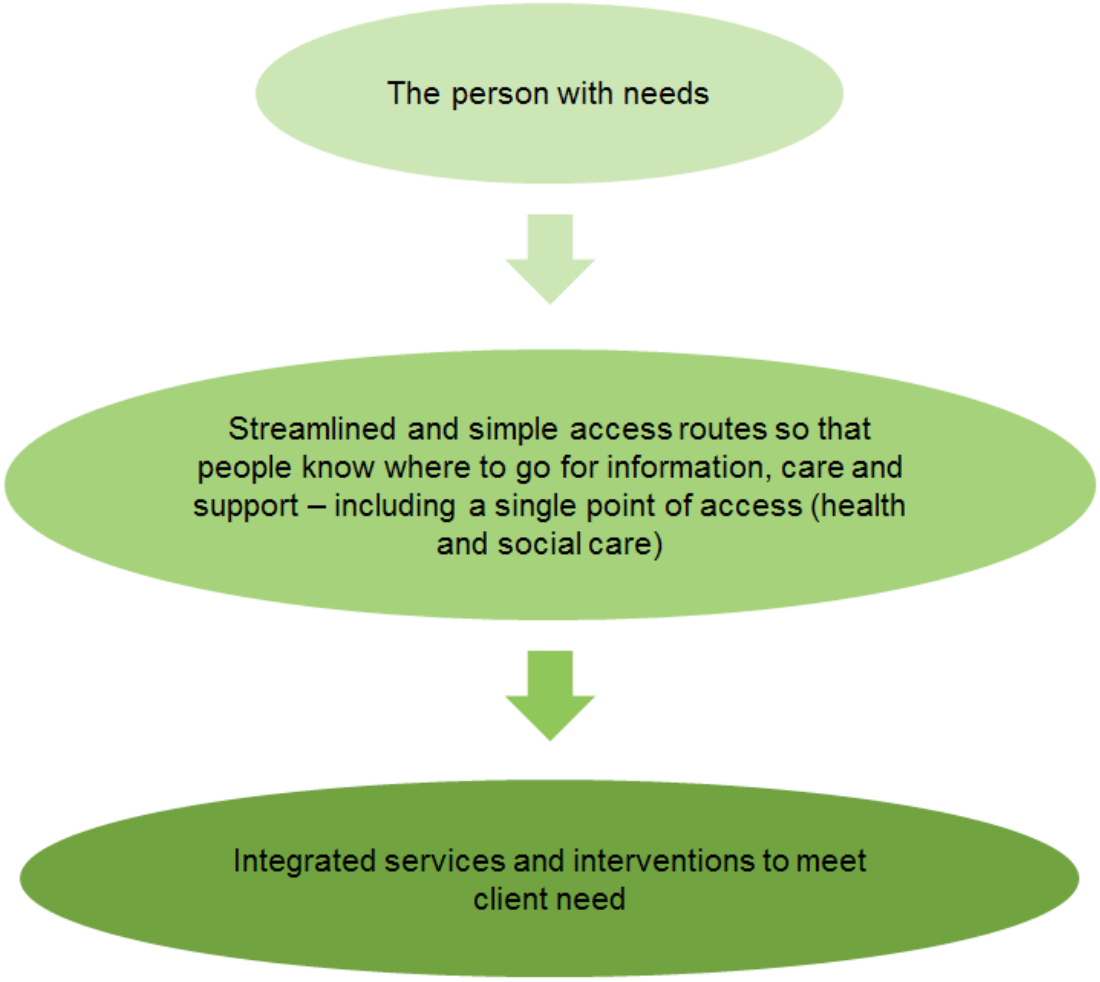
In future our system will look like this:



The needs assessment, strategic context and analysis of the current provision require a future system that

responds to individual need through streamlined and integrated provision. Whether a person needs support for multiple needs, around urgent care or long-term care the solution should be clear, simple, joined up and flexible.

An individual view for the future looks like this:



Multiple needs

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

Urgent care

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

This work will be underpinned by the following key design principles:

- Work with primary care providers to develop an enhanced offer that prioritises prevention, timely interventions and promotes self-care
- Admit only those people who have evidence of underlying life-threatening illness or a need for surgery – they should be admitted as an emergency to an acute bed
- Provide early access to specialists, ideally within the first 24 hours, to set up the right management plan
- Appropriate and high quality care where admission to a hospital setting cannot be avoided; timely and safe discharge from a hospital setting
- Discharge and assess as soon as the acute episode is complete in order to plan post-acute care in the person's own home
- Provide comprehensive assessment and reablement during post-acute care to determine and reduce long-term care needs
- Enable a range of services to be "wrapped around" the person so that the number of handovers between services is reduced

Mental health

Support for recovery and staying well requires a whole systems approach recognising the importance of a range of psychological, social and economic factors which are important to an individual's mental and physical health.

For mental health provision, this work will need to achieve the following:

- A single point of access to mental health services
- A shared improved protocol / process for Section 136
- Implementation of mental health crisis triage, learning from pilots elsewhere in the country
- Ensure appropriate levels of psychiatric liaison services are in place in acute hospitals
- Develop and implement an improved approach to mental health-related conveyance
- Explore applicability of opportunities created in other places for meeting mental health crisis needs, such as crisis houses or 'safe places', as opposed to health-based places of safety
- Appropriate numbers of local beds for individuals who require admissions
- Deliver first episode psychosis waiting times and targets

Unplanned paediatric admissions

Evidence from Gloucestershire's implementation of the 'Big 6' assessment and associated pathways in relation to children's presentation at emergency departments demonstrated how unplanned paediatric admissions for the six most common conditions that children present with for urgent care can be avoided.

Implementation of the Big 6 assessment and pathways will have an impact on quality and productivity and is a key commissioning priority.

The key to both reducing and delivering effective urgent care is ensuring that the whole system supports:

- A reduction through prevention
- Care in the community, including self-carers, pharmacies, primary care and shifting care to or near the home (where safe and appropriate)
- Case work at the community/secondary care level delivered by appropriately trained and supported staff
- Provision of assessment and immediate care management that reduces the necessity for admission
- Timely and safe discharge

Long-term support

Our aim is to support people who have ongoing personalised support needs, or those who may be at risk in the future of developing more complex needs, to live as independently as possible within the community for as long as possible.

The long-term support system will target resources at those who need ongoing support in the community, or those who are identified at risk of needing support, with the aim of:

- Promoting independence and reducing dependency
- Enabling people to maximise their potential to live full and rewarding lives
- Promoting self-care
- Promoting choice and control

In line with the personalisation agenda, an increasing number of people from all age ranges will direct their own care through Direct Payments and Personal Budgets. This will mean a more personalised market tailored to individual needs.

Long-term support should be focused on those who would most benefit from these interventions.

Commissioners are currently working towards an integrated delivery approach for health and social care with a single point of contact for people. The effective use of resources and delivery of services requires the alignment of health and social care. The Better Care Fund, integrated commissioning budgets, and the integration of health and social care will help provide the vehicles to enable this to happen.

Medicines optimisation

We aim to ensure that we make every contact count and use every opportunity to highlight medicines optimisation whenever patients interact with health and social care or any partner stakeholders. This will range from engagement with the development of social capital and community self-help approaches through social care providers to healthcare professionals including GPs and pharmacists.

Adopting a system-wide approach to medicines optimisation will provide accountability for ensuring that best value for the investment in medicines is embedded and shared by all involved in the care pathway.

Further Overarching Principles

Prevention

The Care Act 2014 places more emphasis than ever before on prevention – shifting from a system which manages crises to one which focuses on people's strengths and capabilities and supports them to live independently for as long as possible.

Safeguarding Adults

The Care Act 2014 has set out the following six principles which provide us with a safeguarding framework:

- Empowerment – People being supported and encouraged to make their own decisions and informed consent
- Prevention – It is better to take action before harm occurs
- Proportionality – The least intrusive response appropriate to the risk presented
- Protection – Support and representation for those in greatest need
- Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse
- Accountability – Accountability and transparency in delivering safeguarding

Achieving equality between mental and physical health

In our society, mental health does not receive the same attention as physical health. People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services. This is exemplified in part by lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.

Giving mental health equal status with physical health (parity of esteem) will result in major improvements in the health and wealth of the nation and is achievable through interventions that can save money in both the short and the longer term.

Protecting social care services

Protecting social care services in Plymouth means ensuring that those in need continue to receive the care and support they require to remain healthy, well and independent for as long as possible. This entails implementing the national eligibility criteria for those assessed as needing statutory services, and also promoting a population-based comprehensive universal offer for those who are not eligible, based around the promotion of wellbeing, information and advice and low level preventative services. For people who use services this means we will continue to ensure those who are at risk of harm, abuse or neglect are safe, as well as helping people to live independently as long as possible through person-centred support.

Adult social care services will be available to those with long-term conditions and/or age- related multiple health needs at the start of their involvement with health and social care, and not only as a result of crisis or hospital stay. Adult Social Care is committed to facilitating independence and avoiding admission to hospital. A key responsibility of social care services will be to ensure that high quality reablement services are available to improve the independence and wellbeing of service users and carers.

Adult Social Care Services will be part of a whole system integrated approach that ensures there is capacity to offer choice and availability of care at home and, where necessary, care and nursing home placements.

Transitions

When a young person turns 18 they are legally an adult. Under the SEND (Special Educational Needs and Disability) agenda and Leaving Care agenda, children's services retain the responsibility to ensure the right package of care is in place for young people up until 25 and 21 respectively.

Services need to recognise some of the challenges that face people transitioning from children and young people's services into adult services. Transition plans need to begin at the age of 15 /16 years in order to identify and promote the attainment of additional life and independence skills.

It is important to consider building in flexibility across the four commissioning strategies in order to support transition planning and enable young people to access the service that is best placed to meet their needs.

HOW DO WE KNOW IT'S WORKING?

The following outcome performance indicators have been identified as key to measuring how this strategy contributes to improvements across health, wellbeing and social care forming part of a comprehensive performance and monitoring system.

System Element	Key Outcome / Indicator	Source
Multiple care and support needs	2.18 - Hospital admissions for alcohol-related conditions (narrow definition), all ages, directly age standardised rate per 100,000 population European standard population.	Public Health Outcomes Framework
	2.15i - % of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months	Public Health Outcomes Framework
	2.15ii - % of non-opiate drug users that left treatment successfully who do not re-present to treatment within 6 months	Public Health Outcomes Framework
	Number of households prevented from becoming homeless	Housing
	1.13i - % of offenders who re-offend from a rolling 12 month cohort	Public Health Outcomes Framework
	1.06ii - % of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support.	Public Health Outcomes Framework
People who need urgent care	Proportion of people still at home 91 days after discharge from hospital into reablement / rehabilitation services	Adult Social Care Outcomes Framework
	IAPT access rate	National Health Service Outcomes Framework
	IAPT recovery rate	National Health Service Outcomes Framework
	Discharges at weekends and bank holidays	NHS quality premium
	Delayed transfers of care from hospital (days)	Adult Social Care Outcomes Framework
People with long-term support needs	People helped to live in their own home through the provision of major adaptation	Housing
	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Adult Social Care Outcomes Framework
	Permanent admissions of older people (aged 18-64) to residential and nursing care homes	Adult Social Care Outcomes Framework
	1.08ii - % point gap in the employment rate between those with a learning disability and the overall employment rate	Public Health Outcomes Framework
	1.08iii – gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons)	Public Health Outcomes Framework
	Self-reported wellbeing	Adult Social Care Outcomes Framework
	Proportion of people who use services who have control over their daily life	Adult Social Care Outcomes Framework
	The proportion of carers who report that they have been included or consulted in discussions about the person they care for	Adult Social Care Outcomes Framework

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